How to Talk about Healthy Weight and Healthy Eating:
A Cross-Disciplinary Dialogue on Messaging to
Promote Healthy Behaviors and Positive Body Image
March 29, 2019
Meeting Minutes

Prepared by the HHS Office on Women's Health

The Office on Women's Health (OWH) convened a meeting on Friday, March 29, 2019 from 9:05 AM to 4:00 PM at the Renaissance Washington DC Hotel in Washington, DC.

The purpose of this meeting was to foster an interdisciplinary conversation about communications issues surrounding body image, obesity, and eating disorders in women.

Participants (by group)

Group A Participants
Ann Abercrombie, MLS, DHHS/OWH; **S. Bryn Austin, ScD,** Adolescent Med, Boston Children's Hospital; **Dorothy Fink, PhD,** DHHS/OWH; **Kimberly Gudzune, MD, MPH, FTOS,** John Hopkins University School of Medicine; **Allison Ivie, MPP/MA,** Eating Disorders Coalition for Research, Policy & Action; **Sarah Marshall, BA,** Uniformed Services University; **Janell Mensinger, PhD,** Drexel University; **Claire Mysko,** National Eating Disorders Association; **Christine Peat, PhD,** National Center of Excellence for Eating Disorders; **Rebecka Peebles, MD,** The Children's Hospital of Philadelphia; **Tirissa Reid, MD,** Columbia University College of Physicians and Surgeons; **Natasha Schvey, PhD,** USUHS; **Martine Solanges, MD,** FDA; **Chevese Turner, BA,** National Eating Disorders Association; **Lisa Zingman, MSPH,** DHHS/OASH/Office of Adolescent Health

Group B Participants
Kaitlin Bagley, MPH, CPH, HRSA; **Rebecca Begtrup, DO**, Children's National; **Steven Crawford, MD,** Center for Eating Disorders at Sheppard Pratt; **Maliha Hussain, MPH,** HRSA; **Theodore Kyle, RPh, MBA,** ConscienHealth; **Candace Marhsall, MPH,** OWH; **Beth McGilley, PhD, FAED CEDS-S,** Path Clinic, LLC; **Kristy Mugavero, RN, MPH,** CDC; **Elissa Myers, MA, IOM, CAE,** Academy for Eating Disorders; **Tracie Pogue, MSW, MDIV, LCSW,** SAMHSA; **Rebecca Puhl, PhD,** University of Connecticut; **Ursuline Singleton, RDN,** OWH; **Kendrin Sonneville, ScD, RD,** University of Michigan School of Public Health; **Idia Thurston, PhD,** University of Memphis; **Katrina Velasquez, Esq./MA,** Eating Disorders Coalition for Research, Policy & Action

Group C Participants
Chase Bannister, MDIV, MSW, LCSW, CEDS, Eating Disorders Coalition for Research, Policy, & Action; **Humberto Carvalho, MPH,** SAMHSA; **Nancy Dickinson, PharmD,** FDA; **Jillian Lampert, PhD, RD, LD, MPH, FAED,** The Emily Program; **Finza Latif, MD,** Children's National Health System; **Brooke Leggin, MPH,** OWH; **Sabrina Matoff-Stepp, PhD,** HRSA; **Dianne Neumark-Sztainer, PhD, RD, MPH,** University of Minnesota; **Adrianne Phenix, CHES,** OWH; **Tracy Richmond, MD, MPH,** Boston Children's Hospital; **Sara Sliwa, PhD, MS,** CDC; **Marian Tanofsky-Kraff, PhD**, Uniformed Services University; **Janet Tomiyama,**

PhD, UCLA Department of Psychology; **Pamella Vodicka, RD,** HRSA; **Heidi Wehring, PharmD, BCPP,** Maryland Psychiatric Research Center, University of Maryland School of Medicine; **Susan Yanovski, MD,** NIDDK

Welcome and Opening Remarks

Valerie Borden, MPA, ACC, Senior Advisor for Public and Private Partnerships, Division of Strategic Communications, *Office on Women's Health*

Ms. Borden opened the meeting by thanking the participants for their commitment to working with and addressing the complex topics related to communication within the fields of eating disorders and obesity prevention. She then introduced Dr. Dorothy Fink.

Dorothy Fink, MD, Deputy Assistant Secretary for Women's Health, Director, *Office on Women's Health*

Dr. Fink discussed the passing of the 21st Century Cures Act, which was critical for raising awareness about eating disorders as a public health priority and for increasing access to treatment in the United States. The 21st Century Cures Act mandates that the Department of Health and Human Services (HHS) fulfill two key priorities: first, providing information and raising awareness about eating disorders; and second, increasing training for early identification and intervention for eating disorders. In response, HHS established a federal Eating Disorders Working Group comprising a number of multidisciplinary agencies across HHS. All of these agencies were to ascertain what actions the department should take to address eating disorders and how they could collaborate to meet the objectives outlined by the 21st Century Cures Act.

During their time together, the agencies involved in the Eating Disorders Working Group accomplished a number of tasks, including:

- Organizing a listening session with the National Eating Disorders Coalition to better understand treatment and prevention strategies;
- Updating web content on Womenshealth.gov and CDC's Healthy Weight website;
- Promoting social media messages related to body image and publishing educational blog posts on weight-based teasing;
- Partnering with the Strategic Training Initiative for the Prevention of Eating Disorders (STRIPED) of the Harvard T.H. Chan School of Public Health in the development of a webinar for pediatric health care providers on identification and intervention for eating disorders; and
- Working with the Eating Disorders Coalition for Research, Policy & Action and STRIPED to improve messaging directed at women.

Dr. Fink explained that there is a history of contention between the eating disorder and obesity fields, especially regarding the best prevention and treatment approaches. As a result, there is a need to bring together subject matter experts from both areas to address the strengths and challenges of working in a field with such complex, abundant messages. In her professional experience, Dr. Fink has seen significant overlap in many of the issues faced by people who are obese and/or who struggle with disordered eating. She acknowledged that issues such as generational influence, the menstrual cycle, and polycystic ovary syndrome (PCOS) play a role in women's lives across the weight spectrum. Consequently, the Office on Women's Health (OWH) aims to work towards improving the effectiveness

and inclusivity of weight-related messaging, including communications related to body image and weight stigma. Successful messaging can empower individuals, helping them feel like a healthy lifestyle is achievable, and ultimately help them get the care they need. To this end, OWH convened this meeting with three objectives:

1. To open a dialogue with obesity and eating disorder prevention groups;
2. To educate federal agency staff on how to integrate information on eating disorders into obesity messaging; and
3. To collect input about messaging related to weight stigma as well as other considerations about weight stigma as they relate to various programs, grants, and initiatives.

Dr. Fink concluded her introduction by acknowledging those who helped to create the meeting, including the HHS Federal Eating Disorder Working Group and the Coordinating Committee on Women's Health.

Mr. Chase Bannister, President of the Eating Disorders Coalition for Research, Policy and Action, spoke briefly on the advancement of eating disorders as a mental health priority in the United States. He expressed his gratitude for the scholars and advocates who are collaborating to create change and bring legislation before Congress to be incorporated into the 21st Century Cures Act.

Overview of the Meeting Program and Introduction of Opening Plenary Speakers
Valerie Borden, MPA, ACC, Senior Advisor for Partnerships, Division of Strategic Communications, *Office on Women's Health*

Ms. Valerie Borden introduced the two speakers who presented their research on working to reduce weight-based stigma and victimization.

Presentations

Addressing Weight Stigma in Efforts to Improve Communication about Healthy Eating and Healthy Weight
Rebecca Puhl, PhD, Director for the Rudd Center for Food Policy & Obesity, *University of Connecticut*

Dr. Puhl presented an overview of her research, which focuses on weight stigma and discrimination from perspectives of emotional and physical health, their nature and extent across societal settings, and policy-level strategies to address these problems on a broader scale. She has collaborated with scholars in both the eating disorder and the obesity fields, so her approach to these issues encompasses the perspectives and challenges emerging across multiple disciplines. Both eating disorders and obesity share critical factors – such as mental and physical health consequences, lifelong personal costs, impaired quality of life, and body dissatisfaction – that can leave individuals vulnerable to societal stigma.

In Dr. Puhl's experience, there are a number of strengths and challenges related to collaboration between eating disorder and obesity fields. When scholars and advocates from these disciplines come together, their collective action, strong impact, and diverse insights are assets in advancing prevention and treatment strategies. However, differing perspectives, lack of communication, and cross-disciplinary tensions can distract from shared goals. Despite these challenges, both the eating disorder and obesity

fields tend to agree that weight stigma impairs health, interferes with effective health messaging, reinforces societal prejudices, and creates barriers to prevention and treatment.

Dr. Puhl explained that *weight stigma* is a social devaluation and denigration of people because of their body weight, leading to negative attitudes, stereotypes, prejudice, and/or discrimination. These *weight-based stereotypes* include generalizations that people with higher body weight are lazy, gluttonous, lack self-discipline, are unmotivated to improve their health, and are to blame for their weight. When these stereotypes are expressed overtly as prejudice and unfair treatment, *weight-based discrimination* occurs. This kind of discrimination can occur in multiple life domains, including unfair treatment in the workplace, inequities in education, and unequal treatment in health care settings.

National trends indicate that about 40 percent of adults in the United States have reported being teased, victimized, or treated unfairly because of their weight. These rates are even higher for women and for people with higher body weight. For children, weight-based discrimination typically manifests in bullying and teasing. Among youth who participated in weight loss programs, 90 percent reported being teased or bullied about their weight by peers, and 37 to 60 percent reported that teasing or bullying came from parents or family members. Those who experience weight stigma are prone to adverse health outcomes such as maladaptive eating, avoidance of physical activity, psychological distress, and health care avoidance. As a result, weight stigma is not just a social justice issue but an issue of public health.

Current research estimates that adolescents who experience weight-based victimization are 80 percent more likely to engage in severe binge eating, and those who are motivated to lose weight as a result of teasing are more likely to use unhealthy behaviors (such as starving or skipping meals) to do so. These maladaptive eating habits tend to persist from adolescence into adulthood. A 15-year study of adults in their early 30s found that those who were teased about their weight in childhood were twice as likely to be obese and have poor body image in adulthood, even if they were not overweight as children. In fact, studies of sexual and gender minority youth suggest that individuals experience weight stigma across the body weight spectrum, leading to harmful health implications regardless of body size. Poor health outcomes are also linked to internalized weight bias, which occurs when negative external judgments become self-directed. People who express internalized weight stigma are more likely to binge eat, have poor body image, exercise less, and have metabolic syndrome.

Weight stigma exists across life domains, including social relationships, educational settings, employment, mass media, and health care settings. When health care providers fall victim to weight bias, their ability to effectively address stigma with patients becomes a substantial problem. Weight stigma among providers is associated with shorter appointments, less discussion with patients, and less respect for patients of higher body weight. On the other hand, patients who have experienced weight stigma have less trust in providers, are reluctant to discuss their weight, and are more likely to avoid health care.

Research suggests that 97 percent of health professionals agree that health care providers should receive sensitivity training to prevent weight stigma in their clinical practice. However, Dr. Puhl explained that in her experience, there are a number of important barriers to this goal. For example, provider-patient communication about weight is often inadequate, and public health campaigns targeting obesity are often unsuccessful. Despite positive intentions to improve eating and physical activity, many of these campaigns have been criticized for promoting stigma, and there has been little assessment to determine their effectiveness. Studies of existing health campaigns show that those that

use stigma to target obesity are the least motivating, while non-stigmatizing campaigns are the most favorable and produce the highest intentions to improve health. Critically, the most motivating campaigns were those that made no mention of obesity and didn't focus on weight.

When patients receive stigmatizing communication about weight from their health care providers, they are more likely to seek a new doctor or avoid health care settings altogether. A study of primary care patients with obesity found that patients prefer to hear terminology such as "weight" or "BMI" rather than "fatness," "obesity," "large size," or "heaviness." Among adolescent girls, terms such as "fat," "obese," or "overweight" often elicit feelings of sadness, embarrassment, or shame. However, because weight is such an emotionally charged topic, even more neutral language such as "weight problem" or "BMI" can cause negative emotions among youth. Many young people were unsure about which words they were most comfortable using to communicate with their providers about weight, and preferences differed according to gender, BMI, and the extent of internalized stigma. As a result, there is a need to acknowledge demographic and language diversity, and in the absence of universally accepted terminology, it is important to respect individual preferences.

Dr. Puhl concluded her presentation by noting that any communication about weight should seek to support and empower individuals rather than evoke blame or stigma. Supportive communication should exist across multiple levels, from individual attitudes, interpersonal relationships, societal norms, and public policy.

Harmful Health Effects of Weight Stigma

A. Janet Tomiyama, PhD, Associate Professor, Department of Psychology, *University of California Los Angeles*

Dr. Tomiyama discussed her research on the relationship between weight stigma and stress. In her experience as a stress researcher, Dr. Tomiyama learned that the body has the highest physiological stress response to stressors that are social and involve evaluation or judgment from others. One of these physiological responses is the release of *cortisol,* a stress hormone that has been associated with weight gain, fat collection in the stomach area, and increased eating. Because weight stigma is a highly social and evaluative stressor, Dr. Tomiyama hypothesized a vicious cycle in which people experience weight stigma, release cortisol as a stress response, gain weight as a result, and then experience more weight stigma.

Dr. Tomiyama described this process as a Cyclic OBesity/WEight-Based Stigma (COBWEBS) Model. To test her theory, she conducted four studies related to weight stigma and stress. First, she sought to determine the relationship between weight stigma and cortisol. The first study asked participants about their personal experiences with weight stigma and then measured their cortisol levels, finding that increased weight stigma is associated with higher cortisol levels. Critically, this held true for participants across the weight spectrum, suggesting that the stress response is more dependent on a person's perception of their body size than their actual body size.

Despite the apparent association between weight stigma and stress response, Dr. Tomiyama needed to conduct a second study in order to determine a causative relationship between the two. In this study, participants were told that they were engaging in a study about the psychology of shopping. In reality, a randomly selected group of participants was told that their body size and shape was not suitable to try on designer clothing. Dr. Tomiyama measured the cortisol levels of these participants compared to the

control group, who were "accepted" into the shopping study and were told their body size was suitable to wear the clothing. The participants who experienced the stressful stigmatizing events had significantly higher cortisol levels than the control group, suggesting a causative relationship between weight stigma and cortisol release. This effect only occurred among participants who perceived themselves to be heavy; that is, even participants with normal or low BMI with negative self-perception of their own weight experienced increased cortisol levels.

Dr. Tomiyama was also interested to determine if everyday stigmatizing events are directly related to increased eating. Using a texting-based model, she asked college students to text a designated phone number when they experienced a weight stigmatizing event in their daily lives. These events included external stigma as well as internalized stigma, such as distress after stepping on the scale. She found that participants who experienced a stigmatizing event were likely to consume, on average, an extra serving of food in the 24 hours following the event, at which point food consumption dropped to normal.

Lastly, Dr. Tomiyama used data from the National Heart, Lung, and Blood Institute (NHLBI) Growth and Health Study to examine the effects of weight stigma on weight gain over time. She found that girls whose family members called them "too fat" in childhood were 66 percent more likely to be obese by age 19, even when they did not have high body weight as children. Girls who were called "fat" in childhood were also 61 percent more likely to engage in unhealthy weight control behaviors such as extended fasting, vomiting, taking diet pills, and using laxatives to control weight.

Dr. Tomiyama concluded by reiterating that obesity prevention is largely dependent on prevention of stigmatizing messages. She pointed out that existing interventions – such as empathy interventions and weight stigma awareness – are minimally effective in preventing weight stigma, even though these interventions are known to work for other stigmatized domains, such as racism and sexism. She welcomed new perspectives from conference members, whose clinical insights are invaluable in the pursuit of reversing weight stigmatizing messaging.

Breakout Sessions

After the presentations, the meeting participants proceeded into three separate breakout session rooms to discuss two key topics: 1) body image and 2) dietary behaviors. The goals of the breakout sessions were:

1. Opening up a dialogue with the eating disorders and obesity prevention groups
2. Educating federal agency staff on these important messaging issues
3. Getting input about messaging related to weight stigma as well as other considerations around weight stigma for various programs/grants/etc.

Each breakout session room was led by a meeting facilitator, who provided the participants with guiding questions to consider in their discussion. A notetaker was also present to document highlights of the participants' discussion.

Body Image

Group A

Group A participants discussed effective messaging strategies for promoting healthy body image in young people. They agreed that messages need to reach children as young as two to five years old, as this can be a critical window for the development of lifelong habits. Because children this young cannot rely on written communication strategies, campaigns should be visual and typically reach children through role modeling. As a result, there is a need to educate parents about how to communicate with their children about developing a health body image. The participants also agreed that parent-to-parent communication can be an effective way to spread messaging related to these issues.

The participants talked about words, phrases, and messages that could be acceptable and productive in both the eating disorder and obesity communities. They determined that "quality of life" is potentially acceptable, but that this terminology is vulnerable to impact from stigma. They generally agreed that "size diversity" and "body acceptance" are valuable terms to include in a public health campaign about body image. The participants also discussed the relationship between intersectionality and body image, and they were careful to point out that an inclusive, representative public health campaign should consider that body image is dependent on more factors than weight.

Group B

Participants in Group B devoted much of their discussion to the idea that an effective public health campaign for body image should focus on decoupling self-worth from weight and appearance. They concurred that body image messaging should primarily emphasize the body's power and abilities rather than the body's appearance. Obesity prevention experts and eating disorder prevention experts agreed that messaging should represent people of diverse sizes engaging in diverse activities. Critically, people of higher body weight should not be depicted visually with only pictures or video of parts of their body rather than a whole body or be shown only engaging in unhealthy behaviors, as this perpetuates weight stigma and the misconception that an individual's body size is solely under their control. The participants suggested that the definition of health should be broadened and that weight should not be considered a measure of health independent of other outcomes, but that health behaviors that lead to health outcomes should be emphasized instead. The participants concurred that messaging should be different in public health contexts and clinical settings, but the core of the message should frame health as a function of the body and quality of life.

The participants also discussed the role of modeling and advocacy for body image. They agreed that parents are key role models for behaviors related to healthy body image, such as self-affirmation and body appreciation, but adolescents may seek role models outside of the home environment. As a result, they concurred that messaging should also target bystanders as potential advocates who can intervene when they observe weight stigmatization. The participants suggested that a public health campaign should build a communication toolkit for bystanders to teach individuals how to stand up for others and respond to weight stigmatizing comments.

Group C

Group C participants discussed effective messaging for encouraging healthy body image in young people. They generally agreed that an effective, representative message should incorporate the voices of impacted individuals, but they pointed out that there is also a critical need to target peers, influencers, and parents. Especially for young children, parents are key role models who can facilitate healthy choices in the home and encourage children to focus on healthy behaviors rather than weight.

Both obesity and eating disorder experts tended to agree that advocates and champions can play a significant role in reducing the ubiquitous weight stigma that young people face every day.

The participants further discussed similarities and differences in perspectives between the obesity and eating disorder fields. They concurred that across both fields, body image is related to upstream issues, which are not always emotional in nature. They also agreed that core differences between clinical care settings and public health contexts drive a need for individualized messaging strategies. For example, both obesity and eating disorder experts agreed that the term "weight" should never be used in a public health campaign, but there was less consensus about the use of "weight" by health care providers in clinical settings. The participants also pointed out that the eating disorder field fundamentally differs from the obesity field in that weight gain is typically not an intentionally prevented outcome in eating disorder messaging. In general, however, experts agreed on predominant themes of positive role modeling, focusing on behavior over weight, and reducing weight stigma.

Dietary Behaviors

Group A

Group A participants discussed the food industry and its toxic effect on dietary behaviors in the United States. They agreed that best practices in messaging about the food industry should ensure that any campaign should seek only to negatively evaluate certain products rather than the people who consume those products (for example, stigmatizing cigarettes rather than smokers). The participants also agreed that messaging should target parents, who can also play a significant role in perpetuating weight-based stigma.

They pointed out that clinical settings can be additionally problematic in propagating misconceptions about weight and dietary behaviors. Participants in both the obesity and eating disorder fields generally agreed that clinical settings focus too narrowly on BMI rather than health. There was consensus that health care providers should conceptualize weight as a spectrum rather than compare weight to a "norm," especially considering that some patients who do not meet this norm may be denied health services (such as surgery) because of their weight. Some participants noted that individuals with higher body weight are not only denied surgery on this basis. In some cases, individuals are denied surgery because high body weight is known to put people at risk for certain conditions that can complicate surgical outcomes (e.g., diabetes), even if the individual does not have these conditions. The participants suggested that medical school education about weight stigma may provide clinicians with a toolbox for appropriate, productive conversations about weight and health with their patients.

Group B

The participants in group B extensively discussed the negative impact of the food industry on health, particularly among adolescents. They pointed out that messaging in the food industry is often directed at young people, who may not have the tools to understand nuanced marketing strategies. External cues from food advertising can override natural hunger cues, causing difficulties both for people who struggle to regulate their weight and for people recovering from eating disorders, whose internal cues tend to be significantly disrupted. However, they pointed out that previous public health examples, have successfully mobilized young people against consumer industries, such as the tobacco industry, so there may be potential to translate these strategies to the food industry.

The participants also agreed that effective messaging should be as individualized to specific communities as possible. They pointed out that global or national campaigns cannot adequately capture diverse populations, including marginalized communities, people of low socioeconomic status, and those who experience food insecurity. Furthermore, they agreed that a public health campaign for body image should not attempt to divorce food from its role in family, culture, and pleasure. Rather, meals should be framed as a meaningful, emotionally satisfying experiences. The participants also agreed that value judgments should be entirely removed from conversations about food. That is, rather than categorizing food as "good" or "bad," encourage individuals to make dietary choices based on fueling the body and promoting health.

Finally, the participants discussed messaging targeted specifically for adolescents. Experts from both the obesity and eating disorder fields agreed that unhealthy sleep habits are a significant problem for youth and may contribute to poor health outcomes. For high school and college students in particular, irregular mealtimes and poor sleep habits are both a result of and are exacerbated by stress, which in turn is associated with unhealthy outcomes. Parents and other influencers can help by modeling healthy behaviors, engaging the whole family in meal time and healthy eating, promoting self-affirmation, and focusing on appreciation of the body and its abilities.

Group C

Group C participants began their discussion of dietary behaviors by considering cross-disciplinary differences and similarities in traditional dietary messaging. Both groups of experts agreed that the present food environment is toxic for people with obesity and people with eating disorders, limiting individuals' ability to consistently make healthy choices. As a result, they concurred that messaging should encourage people to avoid an "all or nothing" mentality, which can be dangerous for people of higher weight and people with eating disorders. Experts in the obesity field noted that traditional obesity prevention moralizes food as "good" or "bad" in order to promote healthy behaviors. However, recent consensus is that moralizing food is damaging for both obesity prevention and eating disorder prevention, so there is a need to shift focus away from which foods a person eats towards why and how a person eats. The participants also pointed out that practitioners in the obesity world may promote restraint, which can be counterproductive in people with eating disorders. The participants agreed that across disciplines, a universal approach of balance and moderation is the healthiest and most effective messaging strategy.

Members of the obesity prevention field pointed out that the obesity world has been more open to perspectives from the eating disorder than vice versa. The eating disorder experts countered that, although they are open to the obesity prevention perspective, it may be less safe to raise the issue of higher weight in eating disorder settings. Despite this tension, the participants agreed that an effective message should incorporate both perspectives and should consider the impact of low socioeconomic status and racial/ethnic marginalization on weight-related behaviors. To conclude their discussion, the participants suggested that a successful public health campaign should combine messaging with coordinated stakeholder initiatives. They agreed that messaging alone is effective in increasing knowledge, while grassroots coalitions are the most effective in promoting change.

Debrief and Summary

After the breakout group meetings, all meeting participants reconvened to review the highlights of their discussion. Ms. Valerie Borden reviewed the objectives of the meeting and spoke of the importance of the discussion and taking action in the next few months. She invited the notetakers from each breakout group to review the highlights of their groups' discussion.

Group A Body Image Highlights:

- Intersections for different groups, empowering girls, social determinants of health, ACEs and childhood obesity, weight stigma as trauma
- Communication with children versus adults and preventing health problems versus obesity
- Developmental difference across many ages
- Healthism and the moral value of foods
- How to define and communicate and terms overall
- The need more diverse imagery
- Weight discrimination is currently legal in most states, policy needed
- Current focus on BMI is a concern
- Need for cross-cultural change within size diversity, body acceptance

Group A Dietary Behaviors Highlights:

- There was consensus that there should be some messaging around health and foods, but this shouldn't be the focus
- Role modeling is important, but also movement and interacting with environment overall
- At all ages, make sure the individual patient/client/consumer is the driver of their health-related goals
- Don't always correlate health problem with weight
- More need for research
- Educate parents so they can do better about role modeling
- Stigmatize products instead of people.
- Target parents as well because that helps perpetuate stereotypes
- Health at every size and what that would mean
- Health and eating rather than healthy eating

Group B Body Image Highlights:

- Need to emphasize messages about both positive eating behaviors and enjoyment of food and avoid connecting health behavior to weight rather than health outcomes
- Separate ideas of weight and appearance from self-worth; removed from physical identity
- Depict full diversity of bodies, and engaged in all types of healthy behaviors
- Health as a function of the body and individualizing those conversations; what do you want to be able to do in your body
- Modeling self-affirmation, how to teach young people to think about and feel about their bodies

Group B Dietary Behaviors Highlights:

- Focus on overall purpose (to fuel the body) and experience of meals rather than just thinking about food and eating
- Balancing ideas related to different reasons for eating
- Understanding that the cultural contexts matter in specific communities and health promotion strategies are not going to be successful at a national level
- Awareness raising related to food industry practices in messaging, especially for adolescents, such as the definition of healthy eating promoted by the food industry. Suggested using cognitive dissonance approaches for raising awareness that the food industry is manipulating adolescents

Group C Body Image and Dietary Behaviors Highlights:

- Should "weight" be used in either field?
- Stigma is an issue and there are ongoing movements, such as body positivity and social justice related to weight, that could be considered
- Look to past interventions that have worked to reduce stigma among other marginalized populations
- Target messages for PE teachers, parents, peers as influencers of youth that certain behaviors are good for everyone in every body

Closing Remarks

Dr. Matoff-Stepp closed the meeting by suggesting that we currently live in a toxic food culture that is difficult to work against. She also suggested that it is very important to understand what people with lived experience think and feel when developing a communication campaign. She reminded the participants that there is much still to understand about eating disorders and obesity, and this meeting is just part of the cultural phenomenon toward change.

Dr. Matoff-Stepp stated that OWH will review the thoughtful input that was generated at this meeting and use it to move towards future discussions about next steps.

Appendix A: Breakout Group Discussion Themes

Table 1. Group A Discussion Themes for Body Image

Group A: Body Image		
Factors to consider in building a public health campaign for body image		
Effective words, concepts, images	Weight/Body Acceptance	• Focus on what the body can do rather than the body's size (function vs. aesthetics) • Focus on healthy behaviors, not size or weight • Avoid using "weight" • Promote "body acceptance" • Promote empowerment, especially for girls • The word "healthy" has been coopted by the wellness/diet industry, "health" is a better term • Beauty at any size/health at any size • Take care using the word "prevention" • Embed intersectionality/diversity across both body types and healthy behaviors • Consider that "healthy" may not be important to children • Need a toolbox of messages because there is too much heterogeneity

	Food	• Avoid moralizing food as "good"/"healthy" or "bad"/"unhealthy"
		  ○ Children may be more likely to develop eating disorders when they hear moralizing language at a young age
		• Food as fuel or medicine
		  ○ Potential language for youth: "What food is the best fuel for your rocket?" (this still could potentially moralize food)
		• Avoid stratifying food, any food in moderation, making everything okay with no food stigmatized

Prevention	Role Modeling	• Family modeling of healthy behaviors
		  ○ Kids will continue behaviors into adulthood
		  ○ Promoting healthy lifestyle is most effective when the entire family adopts the behaviors
		  ○ Focus on starting early

Group A: Body Image		
		• Consider the words that could stick • Not making comments about bodies • Parents need resources • Peers who can come together
	Diversity/Intersectionality	• Promote size diversity • Promote racial and social diversity • Consider SAMHSA meeting on ACEs and childhood obesity • Consider lived experience and moralization of food
Campaigns and Programs	Current	• Body Positive Movement • OWH online training for providers on the importance of addressing weight bias (coming soon)
	Future	• Toolbox of different campaigns for different environments (i.e., schools, healthcare providers, communities, parents)
Factors to consider in a clinical setting		
Clinical practice/training changes	Practice Changes	• Focus on size diversity • "Weight friendly" practices and accommodations (chairs without arms, bigger arm cuffs etc.) • Don't weigh as soon as you walk in; have thoughtful conversation around weight first • Re-assess use of BMI (there are other types of measurements, but more time and cost intensive) • Don't make everything about obesity • Develop weight-neutral materials • Moving towards a weight norm • Focus on clinical training in residency • Include other healthcare providers
	Communication Tools	• "Toolbox of Messages" rather than one single message
Factors to consider for public policy		
Social Determinants of Health	Social and Behavioral Policy changes	• Legality of weight discrimination
		• Insurance system – stigmatization in explanation of benefits that lists them as 'extremely obese' for example

Table 2. Group B Discussion Themes for Body Image

Group B: Body Image		
Factors to consider in building a public health campaign for body image		
Effective words, concepts, images	Size	• "Size Diversity" • Promote body acceptance • Emphasize self-worth as separate from physical appearance • Decouple morality from weight • Focus on what the body can do rather than how it looks • Depict people of diverse sizes doing diverse activities ○ Stigmatizing to only show thin people engaging in healthy behaviors • Avoid physical visuals to represent weight (e.g., a bucket of fat) • Avoid images of body parts rather than whole person • Implication that "it's your fault" • Reduce the fear element, that obesity is the worst that could happen
	Physical activity	• Encourage people to move their bodies and engage in enjoyable "prosocial activities" rather than "exercise for weight loss" • Begin depicting exercise as messy to remove stigma for people who are afraid to appear "out of shape" (ex. people sweating while exercising) • Reducing the message that exercise will change size

Reversing stigma	Modeling	• Empowering families and parents as role models
		  ○ Health behavior as a family enterprise rather than focusing on changing the behaviors of one child/member of the family
		  ○ Parents should be aware what they say about themselves and their own bodies
		  ○ Parents should point out examples of weight stigma
		  ○ Learn media literacy and use it to engage with child about weight-related issues
		  ○ Permission to be happy with body they have
		  ○ Focus on what the body can do
		  ○ Remind what words not to use
		• Social media
		  ○ People sometimes use social media to speak out on weight stigma, but it is unclear if this filters down to young girls
		  ○ Teach youth what is realistic and what is untruthful in social media

Group B: Body Image		
	Diversity	• Promote size diversity • Understand the specific challenges faced by marginalized groups
Campaigns and Programs	Positive	• Fat activism space – may educate on how to include size diversity • Uniquely Me program teaches parents how to talk to their kids about body image
	Negative	• Many stigmatizing campaigns use obesity as an outcome to be feared ○ Map Me project instills fear in parents by showing them what their kids will look like in the future as a result of obesity • In both the obesity and eating disorder worlds, ineffective campaigns use language centered on laziness, lack of motivation, and blaming • Negative campaigns predicated on the concept that people of higher body weights need to be told they are obese • Let's Move uses images of thinner kids
Factors to consider in a clinical setting		
Training and education	Define Risk Factors	• Re-assess use of BMI • Stop using weight as a measure of health • Don't assume a behavior change will change obesity • Screen patients for weight-based bullying and provide adequate support systems
	Communication Tools	• Ask patient what terms make them feel most comfortable • Educate health providers about the harmfulness of weight stigma ○ Provide them with a toolkit to address their own practices and implicit biases • List outcomes separately from discussion of weight rather than identifying them as "obesity-related" outcomes • Give clinicians the power to intervene to help parents use better language
Factors to consider for policy		
	Fashion industry	• Follow in steps of other countries; require that fashion models be above a certain BMI • Require that photoshopped images are clearly labeled
	Schools	• Consider school-based screenings that are stigmatizing

Group B: Body Image		
		• Ensure that spaces can physically accommodate students of all body sizes, such as desks with separate chairs • Reform to end bullying, discrimination shouldn't be the burden of the bullied
	Legal	• Body weight discrimination in terms of civil rights

Table 3. Group C Discussion Themes for Body Image

Group C: Body Image		
Factors to consider in building a public health campaign for body image		
Communication	Weight/size-related terms	• Talk about **health**, **body**, or **nutrition** rather than weight • Problem with using the words **dieting**, **weight**, & **eating** is that eating disorders are rarely about those words • Change words/dialogue at a young age - Body is good, you want to protect it and help it grow • From public health perspective, it's okay to not bring weight into the conversation • Preventing excessive weight gain is a very different goal to promoting weight loss • How do you make loving/accepting your body easier when it is not the 'norm'? • Talk to all kids rather than just one weight category
	Perception of Messages	• Key to a communication campaign is how people perceive the message o Need training on how to understand communication preferences and how to deliver them • Talk to people about their own experience, as dictated by social constructs • Have every day influencers teach kids about spectrum of weight
Diversity		
Diversity		• Improve campaign access/intersectionality to reach marginalized groups
		• Understand the specific needs of diverse groups to ensure that campaign doesn't harm or increase stigma
		• Consider other marginalized groups –LGBT groups have higher rates of EDs
Risk & Protective Factors	Risk Factors	• Genetic and environmental factors involved • Weight stigma, teasing, bullying (society/culture) • Underlying trauma (interactions with clinicians, stigma from different sources, family) • Models may be different for different ages o For young children, parents are the most salient models

Group C: Body Image		
		○ For adolescents and adults, peers and social media influencers can serve as models • Family modeling of healthy behaviors ○ Kids will continue behaviors into adulthood ○ Promoting healthy lifestyle is most effective when the entire family adopts the behaviors
	Protective Factors	• Some people don't have an emotional experience with food • Positive body image tracks with future positive body image and lower BMI (even if not losing weight or a low BMI) • Understand the specific needs of diverse groups to ensure that campaign doesn't harm or increase stigma • Improve campaign access/intersectionality to reach marginalized groups
Campaigns and Programs	Positive	• Body positivity (BoPo) vs. body acceptance • Health at Every Size • Fat acceptance movement • OWH ran the BodyWorks program that focused on overall health • President's Council on Sports and Nutrition
	Negative	• BoPo, Fat is Beautiful might not be great campaigns
Factors to consider in a clinical setting		
Clinical Care	Clinical Communication	• Need tools to communicate about weight concerns, using the language patients want to hear • Ask if it is okay to talk to patients about weight • Normalize; take onus off the patient
	Clinical Training	• Ask patient what terms make them feel most comfortable • Use of the term "weight" may be needed in clinic • Maintenance of certification – CME courses on weight stigma, etc. • Weight is only a single clinical indicator among many
Research Gaps		
Future Research/Evaluation	Under researched areas	• Rural areas aren't considered; understand/research these areas
		• Focus testing needed
	Evaluation	• Evaluation of effectiveness of programs

Table 4. Group A Discussion Themes for Dietary Behaviors

Group A: Dietary Behaviors		
Factors to consider in building a public health campaign for healthy eating and behaviors		
Effective words, concepts, images	Weight/Size	• "Weight concerns" is more appropriate than "weight problems" • Health at Every Size – an example of effective, productive language to talk about these complex issues • When we say eradicating obesity, it makes people in larger sized bodies feel like we want to get rid of them • Get terminology from people with lived perspective: "living in a higher weight body" and "larger bodies"
	Food	• Not using "diet" • Healthy icons on packaging—was it effective and not harmful? • Food affects body in different ways. • "Health" and "wellness" have become synonymous with diet • Target the product (food), not the person who consumes it • Consider how the food industry will react to messaging • Focus groups to identify healthy food choices • Consider socioeconomics in food choices
Changing public attitudes and perceptions	Health and wellness ≠ dieting	• What is a "healthy" option to one person may not be a healthy option for another person
	Stigma	• Reducing weight stigma is the burden of the person who is creating the stigma • Less judgment, more sustainability • Moralize the food industry, not the person or the food
Social Determinants of Health	Socioeconomic	• WIC benefits and SNAP • High rates of eating disorders among populations who experience food insecurity
	Race	• Racial/ethnic food preferences tied into choices
	Other Marginalized Communities	• LGBT • Individuals with disabilities
Early childhood education	General	• Lifelong behaviors are often built in early childhood • Avoid moralizing food as "good" or "bad," as this can spark eating disorders in children

Group A: Dietary Behaviors		
		• Children may not be able to understand the nuances of current messaging strategies • Non-verbal communications for young age groups (i.e. role modeling)
	Parents	• Parental guidance with some child autonomy (e.g. allowing them to choose food sometimes without judgment) • Role modeling
Factors to consider in a clinical setting		
Clinical Attitudes and Perceptions		• There is a need to think about promoting sustainability and educating people about the concept of "diet" holistically rather than "dieting" • Health care providers often prescribe dieting as a treatment (e.g. the ketogenic diet) without considering the long-term negative outcomes associated – this needs to change • If clinicians won't provide adequate informed consent about the risks of dieting as a treatment, there is a need to educate people about the likelihood of keeping weight off after completing a short-term diet and the damage it can do to the body
Factors to consider from other behavior change campaigns		
Environmental Scan for Best Practices		• Can you compare food industry/obesity prevention to tobacco industry? • Consider how sexual assault prevention is not about the individual at risk but about the people around that individual • Harm reduction models

Table 5. Group B Discussion Themes for Dietary Behaviors

Group B: Dietary Behaviors		
Factors to consider in building a public health campaign for healthy eating and behaviors		
Effective words, concepts, images	Food	• No good food or bad food, everything in moderation or "sometimes" foods • Instead of "diet", promote intentional eating in mindful, emotionally satisfying contexts ○ Family dinner table • Successful messaging goes beyond educating about nutrients – it should include culture, background, and eating for pleasure

Group B: Dietary Behaviors		
		• Consider regional and cultural differences when using words • Decouple food from weight

	Health related activities	• Avoid depicting thin people engaging in healthy activities and people of higher body weight engaging in unhealthy activities
		• Address teen stress culture and trend that poor sleeping habits are a point of pride
		  ○ Mental health and wellbeing as critical for a healthy lifestyle
		  ○ Eating regularly

Increasing awareness	Health and wellness versus dieting	• "Dieting" as a short-term activity has fallen out of favor, but diets in disguise such as ketogenic, Paleolithic, etc. are being marketed as "lifestyles" • Distinction between how someone uses food and what they use it for – fueling the body, or changing the body?
	Modeling	• Peers become more influential than family when a child reaches adolescence, but parents should continue to model healthy food choices • Teaching families to trust hunger cues • Celebrity influencers have untapped potential ○ Could work to reverse the pervasive concept on social media that "healthy eating" is equivalent to obsessive clean eating • Parents should encourage children to find healthy coping mechanisms rather than using food to soothe emotional distress
Diversity	Community-based messaging	• A campaign that tries to address a global audience likely will not be effective • Important to consider which culture's food will be depicted in public campaigns • Unsuccessful public health campaigns attempt to divorce food from love, culture, and pleasure • Food marketing often targets parents, particularly mothers • Challenges to making mealtime a positive experience for low SES families, whose time and funds are limited
Current campaigns	Positive	• Moms Rising • Truth Campaign (tobacco industry)

Group B: Dietary Behaviors		
		• Fat activism • Health At Every Side
	Negative	• Stigmatizing campaigns perpetuate the misconception that body size and shape is necessarily a product of diet
Factors to consider in a clinical setting		
Attitudes and Perceptions		• There is a need to think about promoting sustainability and educating people about the concept of "diet" holistically rather than "dieting" • Health care providers often prescribe dieting as a treatment (e.g. the ketogenic diet) without considering the long-term negative outcomes associated – this needs to change
Education		• If clinicians won't provide adequate informed consent about the risks of dieting as a treatment, there is a need to educate people about the likelihood of keeping weight off after completing a short-term diet and the damage it can do to the body

Table 6. Group C Themes for Dietary Behaviors

Group C: Dietary Behaviors		
Factors to consider in building a public health campaign for healthy eating and behaviors		

Definitions & Messaging	Definitions/Underlying Assumptions	• What is healthy eating & behaviors?
		  ○ Think in terms of taking care of yourself/avoiding disease
		  ○ Balance/holistic approach
		• Intuitive eating/mindful eating
		  ○ The 'how' of eating rather than the what of eating
		• What is a risk factor? Working to change someone or their body as if it is wrong

	Messaging	• Focus on what to eat rather than what not to eat—dieting increases cortisol • Food as fuel for both ED and obesity worlds • Give permission to eat some foods in moderation or on occasion (no bad/good foods) • Improve relationship with food • Enjoy both the orange and the bonbon (the traditionally labeled 'good' and 'bad') • Don't talk about weight at population level, but may need to at clinical level when associated health problems are present • Target and end stigma
Food & weight culture	Toxic food environment	• Big food industry and marketing—consider how food industry will respond • Food lobby is very powerful, more so that obesity lobbyists, who are more powerful than ED lobbyists • Low access to healthy foods in areas (food deserts) • Food companies are creative in capitalizing on new trends
	Racial & ethnic diversity	• Larger body size is accepted/valued • Stress, social issues, racism along with weight stigma • Increase in weight has plateaued over time, but not in lower income and racially diverse populations
Intergenerational Approach	Children	• Children model parents' behavior and are more likely to model behaviors they knew growing up • For young children, 'healthy' isn't as relevant because it is too abstract

Group C: Dietary Behaviors		
		• Enjoy a treat, but care taken in enjoying the treat/mindfulness
	Parents	• Role modeling • Help guide some choices
	Schools	• Limited time to eat/be mindful about eating especially in school context • Primary prevention in schools can make a difference; need to make sustainable
Factors to consider in a clinical setting		

Recommendations for Clinical Care		• When you tell someone to lose weight, that is not a behavior
		  ○ There are behaviors that are healthy for everyone independent of weight
		  ○ Weight is something you monitor, but you can also treat for behaviors
		• Focusing on behaviors may be less stigmatizing than focusing on weight.
		• Taking away stigma makes it easier to change behavior.
		• Genetics haven't changed, but stress & other environmental factors can be changed to help reduce the pathway to obesity/EDs for some people.

Factors to consider from other behavior change/public health campaigns		
Breast Cancer Prevention		• Grassroots movement • Coalition and funding is vital
Oral Health		• Consensus statement to share messaging to pregnant women • Trickle-down effect with real change
HIV Prevention		• Involve multiple agencies, there is strength in numbers