Weight Inclusive Care

Workshop #3

November 21st 2023

Drs. Katarina Wind & Anne McGladdery



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Summer

35F

PMHx: “Obesity”, BMI 36

Prior surgeries: None

Meds: None

Allergies: None

Soc Hx: Teacher, lives alone. 1-3 drinks per week. No cigarettes, no drugs.

- Back to Summer!
- When we left off, she had “failed” her diet, still had ongoing knee instability, and was avoiding doctors
- However, she has recently joined a Fat-Positive social media group, and someone recommends you (a recent family medicine graduate) as a weight-inclusive medical provider
- Her first appointment with you is booked for tomorrow

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Summer

35F

PMHx: “Obesity”, BMI 36

Prior surgeries: None

Meds: None

Allergies: None

Soc Hx: Teacher, lives alone. 1-3 drinks per week. No cigarettes, no drugs.

- Hopefully you had a chance to review this week – you’re also welcome to add ideas you think of on the spot

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Case Review

- Question #1: **How has weight stigma affected Summer's medical care?**
  - Lack of accessible chairs in ED
  - Less reliable physical exam, students not taught how to examine patients in larger bodies
  - Weight loss prescriptions in ED and ortho office
  - Assumption of activity status – surgery is "less important"
  - Denial of surgical repair
  - Yo-yo dieting, feeling "disgusted with herself"
  - Heath care avoidance
- Question #2: **What is the presenting problem, and what are some of the underlying problems?**
  - Presenting problem: Knee injury, ACL tear
  - Underlying problems: Weight stigma, weight cycling

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Case Review

- Question #3: **What might a typical care plan be for this patient, and in what ways might that reflect implicit weight bias and perpetuate weight stigma? Are there other harms this plan might cause?**
  - Typical care plan: Weight loss , required for surgery
  - Reflects bias: Other patients get surgery (her knee is more stable, cannot participate in games), physiotherapy for strengthening
  - Other harms: Weight cycling, eating disorder, mental health / self-hatred, health care avoidance (ex: avoiding paps)
- Question #4: **How will you manage her ongoing knee discomfort and instability as a HAES provider?**

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Case Review

- Question #4: **How will you manage her ongoing knee discomfort and instability as a HAES provider?**
  - Advocate for surgery (letter to orthopedic surgeon, finding orthos with higher BMI cut-offs – or ideally, none at all)
  - Knee brace – appropriate sizing
  - Physio, strengthening exercises
  - If pain - Topical diclofenac, tylenol, advil
  - Cooling devices (likely earlier on, not as useful now - ex: aircast cryo, Polar care)
  - Physiatry referrals if ortho still refuses – ex: tenotomy for partial tears

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Case Review

- Question #5: **What actions could you take to reduce this patient's experience of weight stigma in visits at your clinic?**
  - Setting – chairs, imagery, equipment, diversity of staff
  - Acknowledge weight stigma she has received
  - No automatic weighing of all patients
  - Provide the same evidence-based care you would provide a patient in a smaller body

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Case Review

- Question #6: **Summer states: “Learning about the fat justice movement has been helpful, but I still know I need to lose weight for my health. I am a binge eater. Can you refer me to a weight-loss clinic?” What do you reply?**
  - See next page for sample reply
  - Validate - you have heard from many doctors that weight loss is important for your health. I worry that the data they use is very biased and most of the long-term data shows that there are harms of focusing on weight, and there are better ways to improve health.
  - “I worry that the weight loss clinics focus on restriction and that has been shown to worsen binge eating”
  - Would you be interested in an eating disorders support group?
  - BUT be sure to respect patient autonomy also

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When a patient/physician wants to talk about weight loss

- "Higher weights seem to be associated as a risk factor for this disease.
- However, our evidence lacks proof of causation - there are other factors that could be driving this association, including weight stigma at doctor offices.
- As well, outside of weight-management clinics, which often rely on strict calorie restriction, the evidence is strong that focusing on weight loss is unsuccessful long-term for the vast majority of people, and causes harms such as weight-cycling and eating disorders.
- However, there are many ways to manage diseases, and risk factors, without focusing on weight - both with medications/interventions, and lifestyle.
- The Health at Every Size (HAES) approach to lifestyle modification is evidence-based and incorporates intuitive eating, joyful movement, and body respect, as well as other risk factor modifications including smoking cessation, sleep, stress, alcohol. Weight loss may or may not be an unintended side effect, but is not viewed as a measure of success or failure." - KW

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The message we send patients: “Your body CANNOT be trusted”.

- “You are addicted”
- “Do not trust your inner cues, rely on calorie and carbohydrate counting instead”

- What if we encouraged patients to **trust** their bodies?

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Eating Disorders – Weight Inclusive Perspectives

Eating Disorders – What you will learn in medical school

- Anorexia Nervosa
- Bulimia
- Binge-eating disorder

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Eating Disorders – What you will learn in medical school

- Anorexia Nervosa – DSM 5 Criteria:
    - Restriction of energy intake relative to requirements – leading to significantly low body weight
    - Intense fear of gaining weight
    - Body dysmorphia
  - Restricting or binge/purge type
  - Classified by BMI
    - Mild: BMI > 17
    - Moderate: BMI 16-16.9
    - Severe: BMI 15-15.9
    - Extreme: BMI < 15

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Questioning traditional teaching:

- Anorexia Nervosa:
  - “Atypical” If BMI > cutoffs
  - No acknowledgment of starting weight
  - Not based on **symptoms/signs** of starvation

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Eating Disorders – What you will learn in medical school

- Binge eating disorder – DSM 5 Criteria:
  - Recurrent episodes of eating:
    - During a discrete time period (< 2 hours) an amount of food that is “definitely larger” than what most people would consume
    - A sense of **lack of control**
  - Episodes associated with at least 3:
    - Eating more rapidly than normal
    - Eating until feeling uncomfortable and when no longer hungry
    - Eating alone (due to shame)
    - Feeling disgusted with oneself
  - Marked distress at binge eating

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Eating Disorders – What you will learn in medical school

- Bulimia Nervosa – DSM 5 Criteria:
  - Recurrent binge episodes (same as defined above)
  - Recurrent compensatory behaviors to prevent weight-gain
    - Self-induced vomiting
    - Laxative/diuretic misuse
    - Lack of insulin use (IDDM)
    - Excessive exercise
    - Fasting

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Questioning traditional teaching:

- Binge eating disorder:
  - Generally treated as an **addiction**
    - Frequently weight-loss is prescribed for patients with “above normal” BMI
    - Medications such as Contrave (naltrexone/bupropion)
  - Often a **protective mechanism** against restriction/starvation
    - Therefore should addressing the **restriction/starvation** be first line treatment?

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Eating Disorders

- Disordered eating behaviors are **praised and encouraged** in people who are “overweight”
- It is hard to know the precise prevalence of eating disorders in people above “underweight” because we rarely screen for or diagnose EDs in this population, despite identical behaviors and symptoms/signs
- “A review of nearly fifty years of research confirms that anorexia nervosa has the highest mortality rate of any mental disorder (Arcelus et al, 2011).” – VCH, http://www.vch.ca/about-us/news/lets-talk-about-weight

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Signs of starvation

- General:
  - Fatigue, sleep disturbance, weakness, light-headed, poor concentration
  - Cold intolerance, hair loss – hypothyroid-like state “euthyroid-sick syndrome”
  - Electrolyte disturbance, anemia, dermatologic (xerosis, lanugo, acne)
- GI:
  - Gastroparesis (resulting in bloating), constipation
- Cardiac
  - Bradycardia, hypotension, structural changes
- Growth/development
  - Growth hormone resistance
- Sexual function
  - Low libido, menstrual changes
- Recurrent infections
- Psych – depression, anxiety, social withdrawal

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Signs of starvation confused with “idiopathic” illness

- Fatigue , sleep problems
- Feeling ”foggy”, concentration difficulties
- Dizzy, POTS, “athletic heart”, pre-syncope, syncope
- IBS / Constipation / Diarrhea /diarrhea
- Recurrent injuries (RED-S)
- PCOS vs. HPA suppression
- Cardiopulmonary stress vs. “deconditioning”
- Other signs of starvation – impaired growth/development, menstrual changes, decreased libido, osteoporosis, cold intolerance

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Minnesota Starvation Experiment

- 36 conscientious objectors – young, healthy men
- Dietary intake of 1560 calories / day
- Behaviors during the study
  - Preoccupation with food (conversations changed from a focus on current events to on food – ex: recipes, next meals)
  - Excessive gum chewing, licking plates clean, guarding food
  - Social withdrawal / isolation , depression
  - Decline in concentration, comprehension, judgement (subjective)
  - Decrease in basal metabolic rate
  - Dizziness, GI upset, cold intolerance, etc
- Behaviors in long-term follow up
  - Self harm
  - Difficulties reading hunger cues, urge to “binge eat”, purging behaviors
  - Ongoing food preoccupation (3/36 became chefs)

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Eating Disorders Ctd

- Screen for emotional and behavioral symptoms of EDs:
  - *** These behaviors have become so normalized in our "diet culture" that we often don't realize they are symptoms of a disorder*
  - Preoccupation with weight, food, calories, "macros", and dieting
  - Refusal to eat certain foods, progressing to restrictions against whole categories of food (e.g., no carbohydrates, etc.) - think about **Orthorexia**
  - Food rituals (e.g. eats only a particular food or food group [e.g. condiments], excessive chewing, doesn't allow foods to touch)
  - Skipping meals or taking small portions of food at regular meals
  - Withdrawal from usual friends and activities
  - Frequent dieting
  - Extreme concern with body size and shape
  - "Checking" behaviors – ex: checking in the mirror for perceived flaws in appearance, looking at old photos for weight changes

Source: https://www.nationaleatingdisorders.org/warning-signs-and-symptoms

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Eating Disorders Ctd

Jessie's Legacy Eating Attitudes Screening: https://jessieslegacy.com/resources-and-information/eating-attitudes-screening/

Have you felt that you give too much time and attention to thinking about food?
I often find myself thinking about what I should or should not eat.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Almost always

Have you worried about being overweight or gaining weight?

○ Never ○ Rarely ○ Sometimes ○ Often ○ Almost always

Have you avoided certain foods because you think they are too high in calories?
Like bread, rice, potatoes, pizza, fried foods, sweets candy.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Almost always

Have you felt guilty after eating?

○ Never ○ Rarely ○ Sometimes ○ Often ○ Almost always

Local Eating Disorders / HAES Resources:

- Jessie's Legacy: https://jessieslegacy.com/
- Let us eat cake podcast: https://www.letuseatcakepodcast.com/
- VCH - Let's talk about weight: https://www.letuseatcakepodcast.com/
- VCH – The focus is on health, not weight: http://www.vch.ca/Documents/VCH-Healthy-Weights-Key-Messages.pdf
- VCH –Resources to build a positive relationship with food and body http://www.vch.ca/Documents/Backgrounder_Journey_from_Dieting_to_Healthy_Eating.pdf

Eating disorders you may not learn in med school

- Orthorexia (not yet DSM-5 classified)
- Relative Energy Deficiency of Sport (RED-S)

Relative Energy Deficiency in Sport



IMPAIRED GROWTH & DEVELOPMENT

IMPAIREMENT OF OTHER ENDOCRINE SYSTEMS

POOR REPAIR, REGENERATION TISSUE MAINTENANCE (STRESS FRACTURES)

MENSTRUAL DISTURBANCE

IMPAIRED RECOVERY & ATHLETIC FATIGUE

INABILITY TO ACHIEVE MAX ADAPTATION TO TRAINING

OPTIMAL BODY COMPOSITION AND ENERGY

ENERGY EXCESS INCREASED FAT STORES AND BODY WEIGHT

*MENSTRUAL CHANGES ARE HIGHLY VARIABLE AMONGST INDIVIDUALS AND CAN OCCUR AT DIFFERING THRESHOLDS OF ENERGY DEFFICIENCY

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Relative Energy Deficiency in Sport (RED-S)

- Energy expenditure > Energy intake
  - Formerly known as the “Female athlete triad” (excluded men, people without full ”triad”)
- Higher risk sports:
  - Competitive athletes
  - Endurance sports (distance running, biking, XC skiing)
  - Aesthetic sports (ballet, gymnastics)
  - Sports requiring form-fitting outfits (swimming)
- Signs/symptoms
  - Recurrent illness (colds/flu), recurrent injury, decreased sport performance,
  - Psych – low mood, obsession with body image, training, food intake

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Relative Energy Deficiency in Sport (RED-S)

- Health Complications:
  - Endocrine
    - Menstrual dysfunction ? Long term fertility
    - Glucose – reduction of glucose use, slowing metabolic rate
    - Increased growth hormone resistance (** keep a high suspicion for youth)
  - Bone
    - Stress fracture, osteoporosis
  - Cardiovascular
    - Endothelial dysfunction, abnormal lipid metabolism
  - Psych
    - Depression, anxiety, poor concentration
- Performance consequences
  - Decreased muscle strength, increased injury, decreased endurance

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THE ORTHOREXIA ICEBERG



Things aren't always what they seem...

@NOURISHINGMINDSNUTRITION

Children are 252 times more likely to develop an eating disorder than T2DM

Weight Stigma in ED Treatment

- "We won't let you gain too much weight"
- Weight based diagnosis
- Missing signs of starvation in higher weight clients
- Underfeeding or allowing attuned eating for larger bodied patients or even teaching "flexible restraint"
- Differentiating "health reasons" from "body image" reasons for dietary restriction/exercise
- Focusing on weight gain in larger bodied patients as a health concern
- Accessibility of furniture/space
- Body diversity of clients/staff

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Questions? Reflections?

FOURTH EDITION

FULLY REVISED AND UPDATED

MAKE PEACE WITH FOOD

FREE YOURSELF FROM CHRONIC DIETING FOREVER

REDISCOVER THE PLEASURES OF EATING

Intuitive Eating

OVER 500,000 COPIES SOLD

A Revolutionary Anti-Diet Approach



EVELYN TRIBOLE, MS, RDN, CEDRD-S

ELYSE RESCH, MS, RDN, CEDRD-S, FAND

Intuitive Eating

- What it is:
  - **Honoring** the body's hunger and fullness cues and cravings
    - Full and **satisfied**
  - Rejecting diet mentality, not aiming for specific weight changes
  - Making peace with **all** foods – foods are not "good" or "bad"
  - Practicing self-compassion
  - Gentle, flexible nutrition
- What it is not:
  - "Against" healthy eating
  - Expectation that if you "allow" yourself to eat all foods you will eat "too much" and "only bad foods" forever
    - "If I keep ice cream at home I will eat the whole bucket"

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Intuitive Eating

- Caveats
  - Food insecurity / lack of timely access to a variety of foods
  - Eating when not hungry:
    - Lack of hunger cues (ex: suppression from a prolonged eating disorder)
    - You know you won't have time to eat later
    - You want to taste a new food / other social reason

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Questions? Reflections?

But What About…

Health at Every Size for specific conditions

Knee Replacement

Agarwal, N., To, K., Zhang, B. *et al.* **Obesity does not adversely impact the outcome of unicompartmental knee arthroplasty for osteoarthritis: a meta-analysis of 80,798 subjects**. *Int J Obes 45, 715–724 (2021)*.

Weight Loss Before Joint Replacement Surgery: Episode 27 Unpacking Weight Science Fiona Willer AdvAPD

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Diabetes:

Meghan CichyRD-Diabetes one page
HAES Health Sheet- Diabetes
Weight Neutral 4 Diabetes Care (programs for providers and patients)
Lauren Newman RD groups
Rebecca Stritchfield and Glenys Oyston Online Group

- **You may see:**
  - Low carb or other restrictive diets
  - Weight loss, including surgery
  - Delay of medication for trial of weight loss
  - Metformin or GLP-1s for “pre-diabetes”
  - Using insulin as a threat / avoiding insulin
- **Risks of weight-centric approach:**
  - Delaying care pending weight loss
  - Patients avoiding follow up when blood sugar is higher or weight rebounds – loss of trust and engagement
  - Assumption of lifestyle based on A1C
  - Missing disordered eating
  - Lack of attention to other treatable conditions and risk factors (depression, heart disease, smoking)
  - Depression and Heart Disease risks
  - Side effects of weight-loss surgery and inappropriate medication

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Link to all of the gentle nutrition suggestions:

https://drive.google.com/drive/folders/1Sq7aLKpQbYiJxaNyXgbF9OxVjQFcetgl

GENTLE NUTRITION SUGGESTIONS

Follow as you are able.

- Eating regular meals and snacks throughout the day (not skipping meals) will help prevent major fluctuations in blood sugar levels
- Try combining carbohydrates with fat and protein at meals and snacks. Glucose is the #1 source of energy for our brains, and comes from the digestion of carbohydrates. In other words, our bodies need carbs! Combining fat and protein with carbohydrates slows down digestion and allows for a slower and more stable release of sugar into the blood
- Begin to notice how your body feels after eating, and how certain foods and food combinations change your blood sugar. Over time this will help you figure out what works for you and your body

OTHER RECOMMENDTIONS

- Prioritize sleep. Lack of sleep or poor quality sleep can lead to unstable blood sugar by disrupting hormones that control blood sugar
- Practice stress management. Stress activates the sympathetic nervous system, causing a rise in blood sugar
- Engaging in physical activity can help regulate blood sugar. This doesn't have to mean strenuous exercise. Choose an activity you enjoy!
- Seek support from friends, family, online forums, support groups, pets, etc. Talk to your dietitian or other healthcare provider if you need help finding support.

*Do not engage in any of these suggestions if they are harmful to other aspects of your health.

Diabetes:

Meghan CichyRD-Diabetes one page
HAES Health Sheet- Diabetes
Weight Neutral 4 Diabetes Care (programs for providers and patients)
Lauren Newman RD groups
Rebecca Stritchfield and Glenys Oyston Online Group

- HAES Rationale:
  - Weight cycling and weight stigma cause insulin resistance
  - Caloric restriction does result in **short-term** weight loss and improved insulin resistance in **some people**, but typically worsens long-term outcomes for the majority
  - Risks as mentioned prior

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- HAES Approach:
  - Food and movement:
    - Carbohydrate pairing
      - Rather than restriction, pair carbs with protein/fat/fiber to decrease glycemic spikes
    - STABILIZE eating and weight (ie. opposite of "yo-yo dieting") – difficult to dose medication when you are in a "starve-binge" cycle
    - Joyful movement
  - Medications
    - Question your bias – are you avoiding insulin due to fear of weight gain? Are you prescribing a medication for pre-diabetes because you think their weight puts them at higher risk?
  - Manage co-morbidities / CV risks
  - Sleep
  - Stress reduction / mindfulness, social connection
  - Mental health care

"If we took weight off the table, what do you think would most improve your wellbeing right now?"

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Diabetes Resources:

Meghan CichyRD-Diabetes one page

HAES Health Sheet- Diabetes

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What the 5% episode 12- Unpacking Weight Science podcast, Fiona Willer AdvAPD

Type2andYou with Meg podcast

My patient desires weight loss (or my kid is getting too big)

Validate: desire to reduce stigma and health is reasonable

Minimize Stigma: I will be happy to see you regardless of what you choose or what happens with this diet now or later

Honesty: I am not aware of any way to coach you in weight loss that would be both safe and sustainable, but I have lots of other ideas about improving your health and wellbeing while you pursue that/we can see where weight settles

Motivational Interviewing: What are you hoping will be better as a result of being smaller? What other ideas do you have that could help meet those goals?

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PCOS

HAES Sheets-PCOS
Meghan Cichy RD PCOS
Julie Duffy Dillon PCOS and Food
Peace Course

- **Weight-centric approach:**
  - **L**ow carb or other restrictive diets
  - Weight loss +/- surgery
  - Metformin or GLP-1s regardless of A1C
- Risks of weight-centric approach:
  - Weight stigma
  - Delay of appropriate treatment, including fertility treatment
  - Misdiagnosis- need to exclude hypothalamic amenorrhea (LH/FSH, estrogen, ED symptoms)
- Instead: Cycle/fertility management, hirsutism management, Movement, Sleep, Stress reduction, Connection, Mindfulness, Stabilize eating, Stop weight cycling, pairing carbs, manage other risks, attend to stigma, Inositol

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Pregnancy

Ragpal, T.S., **Tomiyama, A.J.,** & Incollingo Rodriguez, A.C. (in press). Beyond BMI: Pregnancy-related weight stigma increases risk of gestational diabetes. *Primary Care Diabetes.*

- Weight-centric approach : refusal of care, BMI cut offs, weight loss prior to conception, pregnancy weight control, restrictive diets, contraceptive issues
  - Weight stigma, fear
  - Missed diagnosis of hypothalamic amenorrhea
  - Triggered eating disorder/disordered eating
  - Depression, stress
  - Avoidance of follow up care
  - Lack of access to reproductive care
  - Unintended pregnancy

Instead: Careful assessment, do not defer conception for weight loss!, stabilize eating and weight, attend to stigma and mental health, acknowledge relationship to self extends long after pregnancy, manage specific risks, patient autonomy, accurate information.

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Harm Reduction in Larger Bodies

Tips and tricks for fat people, from muscling techniques to choosing emergency contraceptives

This project was made possible by support from a National Association to Advance Fat Acceptance (naafa.org) Fat Community Fund grant



https://nextdistro.org/resources-collection/harm-reduction-for-larger-bodies

Have a Plan C when taking Plan B

PLAN B	May not be effective over 155 pounds*
ELLA	May be less effective over 195 pounds*
PARAGARD (COPPER) IUD	Effective at any weight

Multiple studies have shown that emergency contraceptive pills become significantly less effective at higher weights.** The copper IUD (inserted within 5 days of unprotected sex) is the only emergency contraceptive not influenced by weight, but it can be painful and very expensive without insurance.

*Source: Planned Parenthood

** Kapp, Nathalie et al. "Effect of body weight and BMI on the efficacy of levonorgestrel emergency contraception"

https://nextdistro.org/resources-collection/harm-reduction-for-larger-bodies

Intramuscular Injection

If you inject into fat layer instead of muscle, you not only waste your product, but are also at risk of abscesses and infections.

Choosing your site:
Areas with a lot of fat may not be suitable for IM injection. Fat adults can have upwards of 2 inches of subcutaneous tissue in the dorsogluteal (butt) and ventrogluteal (upper thigh) injection sites, making most IM needles ineffective*

*Zaybak A, et al "Does obesity prevent the needle from reaching muscle in intramuscular injections? J Adv Nurs. 2007

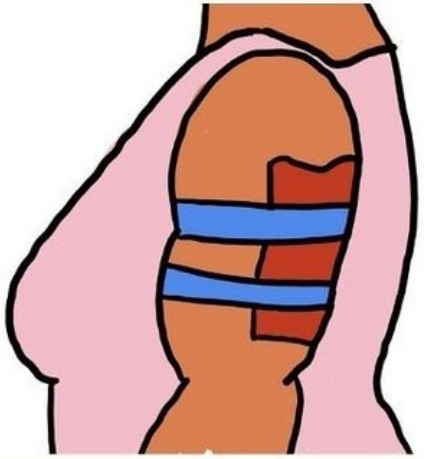
Injection technique:
Inject at a 90° angle
Use 2 fingers to stretch skin at injection site
Do not bunch/pinch skin
Use longest needle available to you
Insert needle fully

https://nextdistro.org/resources-collection/harm-reduction-for-larger-bodies

Accessing Deep Veins

Finding difficult veins:

try using two ties
hang arm down for a few minutes
soak area in warm water or apply mild heat



If ties are uncomfortable, putting them over your sleeve or a rag can help relieve pinching feeling

https://nextdistro.org/resources-collection/harm-reduction-for-larger-bodies

Naloxone

Nasal Narcan is not currently believed to be influenced by weight and may be a better choice for fat drug users. Intramuscular (IM) naloxone can still be effective, but it contains a lower concentration of naloxone and needs to reach blood-rich muscles to work properly.

One study found that IM injections in the butt and thigh do not reach muscle tissue in over 95% of fat females and 37%-57% of fat males.* The deltoid (upper arm) injection site is preferable for people with more fat in their hip area**, but still may not reach muscle dependent on thickness of fat layer and IM technique.

*Zaybak A, et al "Does obesity prevent the needle from reaching muscle in intramuscular injections? J Adv Nurs. 2007

**Palma, Sara "Are IM injections IM in obese or overweight females?" Applied Nursing 2013

Tongue Injection

If you do not believe you will be able to access a muscle in the arm, thigh, or butt, naloxone can be injected into the tongue (1/2" needle will work, you don't need an IM needle)

- Ensure that the needle does not exit the other side of the tongue and waste the shot (injecting from under the tongue may help you ensure you don't go too far)

https://nextdistro.org/resources-collection/harm-reduction-for-larger-bodies

Resource for students:

https://bodyliberationphotos.com/product-category/all-product-categories/caring-for-our-bodies/ ←-- good source for both stock photos of people in larger bodies + resources for patients (ex: shower aids for reaching difficult areas etc)

Questions? Reflections?

Homework/Exercises

1. Watch 1 TV show/movie/book
    - Notice any weight stigma:
        - For a character in a larger body:
            - Only personality is being the fat character
            - Portrayed as eating large amounts of food, unhealthy foods, sedentary
            - Assumed to be unattractive due to their weight
            - Has other negative traits that it is assumed are related to their weight (ex: poor personal hygiene, unintelligent, lazy, greedy)
        - Character improves their lifestyle and loses weight and becomes more attractive
        - Character is praised for eating disorder habits (using alcohol or cigarettes to stay thin, excessive restriction, eating the same foods etc.)
        - Foods that are not “white” are looked down upon
- If you don’t have time, just reflect on day-to-day life

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Homework/Exercises

2. If on social media, follow 3 weight-inclusive / Fat Justice accounts