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As the leading journal in its field, Healthy Weight Journal provides a critical link between research and practical application. Recognizing that weight is a complex condition of increasing concern throughout the world, we are committed to bringing together scientific information from many sources, reporting controversial issues in a clear, objective manner, and the ongoing search for truth and understanding. Recognizing that weight is an easily exploitable health and social concern, we are further committed to exposing deception, reshaping detriments to science, attitudes, and promoting good health at any size. Our mission is to be a voice of integrity and insight in a field that has been much abused and neglected.

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Eating disorders found to be clinically similar in men and women

The results of a large Canadian study found few clinical differences between men and women with eating disorders. The study used data from a community epidemiologic survey to compare 62 men with full or partial eating disorders with 212 women with eating disorders and 3,769 men without eating disorders. The men and women with eating disorders had similar psychosocial morbidity with the exception of depression, which was found to be higher among women, and substance abuse, which was found to be higher among men. However, the men with eating disorders had more psychiatric disorders than men without eating disorders. The authors stated that it was unclear whether the higher prevalence of psychiatric disorders among men with eating disorders was the result of the eating disorder or a factor contributing to the development of an eating disorder. (Woodside D, Garfinkel P, Lin E, et al. Comparisons of men with full or partial eating disorders, men without eating disorders, and women with eating disorders in the community. Am J Psychiatry 2001; 158:570–574)

Activity-related factors and body size perceptions associated with urban girls’ obesity status

Obesity-related knowledge, attitudes, and behaviors were compared between 32 obese and nonobese matched pairs of African-American adolescent females to determine how such factors may influence obesity. Researchers measured the adolescents’ self-concept, eating attitudes, body image, health behavior knowledge, dietary intake, physical activity/inactivity, and maturation status. Self-esteem, eating attitudes, health behavior knowledge, energy intake, energy intake from fat, and age at menarche were not significantly different for obese and nonobese females. However, the results did indicate that the obese girls spent significantly less time in light to moderate activity and more time engaged in inactivity than the nonobese girls. Obese adolescents were also found to have a significantly larger perception of ideal body size than the nonobese adolescents. Overall, except for ideal body size perceptions, knowledge and attitudinal factors had less of an impact on obesity among this group of adolescent females than the activity-related behaviors. The researchers emphasize the importance of school physical education programs for minority populations and suggest that health promotion efforts should be focused on reducing inactivity and increasing physical activity. They also stress the importance of developing such programs within an appropriate sociocultural context using the knowledge, attitudes, and behaviors of members of the community. (Gordon-Larse P. Obesity-related knowledge, attitudes, and behaviors in obese and nonobese urban Philadelphia female adolescents. Obes Res 2001; 9:112–118)

Smoking initiation associated with dieting frequency among adolescent females

It has been speculated that weight concerns may be an underlying factor in the initiation and maintenance of smoking among girls and women. Findings from a recent study appear to strengthen that hypothesis. Researchers followed 932 sixth- and seventh-grade girls and boys for 2 years to examine dieting frequency and smoking initiation. The results indicated that girls, who at baseline reported restricting dietary intake once per week or less, were almost twice as likely to become smokers than girls who reported not dieting. Girls with weekly restrictive dietary behaviors were nearly four times as likely to become smokers than girls who were not dieting. No association was found for dieting frequency among boys and smoking initiation. It was concluded that for girls, dieting in early adolescence increases the risk of becoming a smoker. The authors suggested that concern over weight may be the underlying factor for both behaviors, dieting and smoking, and that dieting itself may be a potentiating factor that heightens the risk for smoking. (Austin S, Gortmaker S. Dieting and smoking initiation in early adolescent girls and boys: a prospective study. Am J Public Health 2001; 91:446–450)

Night eating syndrome and related psychopathology

Although night eating syndrome (NES) was identified in the literature over 40 years ago, it has recently started to attract more attention. Individuals with NES have been described as having morning anorexia,
evening hyperphagia, and sleep disturbance as well as exhibiting specific psychopathology. It also appears that the prevalence of NES may increase with the severity of obesity. In a new study, a group of researchers found that among 76 obese individuals, 14 percent (3 men and 8 women) met the criteria for NES. The night eaters had higher depression scores and lower self-esteem, exhibited less hunger and greater fullness before a daytime test meal, and consumed more of the test meal later in the day than non-night eaters. Even though both groups received the same diet, the night eaters lost less weight than the non-night eaters. The authors concluded that NES should be considered a legitimate eating disorder with distinct features such as depression, low self-esteem, and increased meal intake later in the day. (Gluck M, Geliebter A, Satov T. Night eating syndrome is associated with depression, low self-esteem, reduced daytime hunger, and less weight loss in obese outpatients. Obes Res 2001; 9:264–267)

NIH funds large study on the effects of weight loss and exercise on type 2 diabetes

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of the National Institutes of Health (NIH) is funding a multicenter, randomized clinical trial designed to examine the effects of a lifestyle intervention program on heart attack, stroke, and cardiovascular-related deaths in people with type 2 diabetes. The program will promote weight loss through reduced caloric intake and regular exercise. The lifestyle program, named Look AHEAD (Action for Health in Diabetes), will enroll approximately 5,000 volunteers to participate in the study.

Participants will be randomly assigned to the Lifestyle Program or the Diabetes Support and Education Program. Individuals assigned to the Lifestyle Program will be involved in an intensive diet and exercise program that is designed to help individuals lose at least 7 to 10 percent of their initial weight in the study’s first year. The exercise component’s goal is 25 minutes per day of regular exercise, primarily walking. Volunteers assigned to the comparison group will be enrolled in the Diabetes Support and Education Program. This group will attend sessions on nutrition and physical activity and may attend support groups that include other individuals with diabetes. The participants will be followed for up to 11.5 years while researchers track cardiovascular risk factors, diabetes control, complication developments, general health, and quality of life factors.

To be eligible to participate, individuals must be between the ages of 45 and 75, have type 2 diabetes, and be classified according to the study’s protocol as overweight or obese. Eligible individuals who are interested in participating in the study should call (866) 55AHEAD (552-4323) or visit the study’s website at www.LookAHEADstudy.org. (NIH, NIDDK press release, Monday, June 25, 2001. www.nih.gov/news/pr/jun2001/niddk-25.htm.)

Prepregnancy weight and the risk of pregnancy complications

A recent study found that both overweight and obese women appear to be at an increased risk for the development of pregnancy complications. Researchers categorized 96,801 women by body mass index (BMI) using data obtained from Washington State birth certificates and drivers’ licenses issued between 1992 and 1996. Maternal prepregnancy weight was obtained from the birth certificates, and self-reported height was obtained from the drivers’ licenses. Women with a BMI < 20.0 were categorized as lean, a BMI of 20.0 to 24.9 as normal, a BMI of 25.0 to 29.9 as overweight, and a BMI ≥ 30.0 as obese. Findings indicated that when compared with lean women, both overweight and obese women were at a significantly higher risk for the development of gestational diabetes, pre-eclampsia, and eclampsia. The risk of gestational diabetes, preeclampsia, eclampsia, cesarean delivery, and delivery of a macrosomic infant increased consistently for women in each category of prepregnancy BMI of 20 or greater. Women who were overweight or obese were also at greater risk for delivering at or before 32 weeks gestation and slightly more likely to deliver before 37 weeks. Infants of obese women were found to have a nearly two-fold increased risk of death within the first year of life. These findings led the study’s authors to re-emphasize the importance for women to avoid excessive weight gain during adolescence and young adulthood. (Baeten J, Bukusi E, Lambe M. Pregnancy complications and outcomes among overweight and obese nulliparous women. Am J Public Health 2001; 91:436–440)
Farewell

In ending my 16-year tenure as editor of *Healthy Weight Journal*, I look back with pleasure at various milestones and ahead with confidence in passing the editorship on to Wayne C. Miller, PhD, a friend and colleague who has been a valued advisor to the *Journal* for many years.

It has been a pleasure and privilege to work with the many outstanding researchers and experts who have written for the *Journal*, and I deeply appreciate their willingness to contribute. I thank our Editorial Advisory Board, Brian Decker and his associates with whom I’ve worked at BC Decker, and my own assistants. Most of all, I’m grateful to our loyal subscribers, who have provided such great support, networking, and enthusiasm through the years.

To recap a bit of history: *Healthy Weight Journal* was founded in April 1986 as a pilot project mailed initially to 300 bariatric physicians. It made its way through several name changes—from the *International Obesity Newsletter*, to *Obesity & Health*, and finally to *Healthy Weight Journal*, as the interrelationship of obesity, eating disorders, disruptive eating, and other problems became ever clearer. We started the popular Size Acceptance feature in 1991 to showcase emerging size activist writings—a viewpoint those who had treated obese patients for years called an eye-opener that changed the way they related to their patients. In 1989, we gave the first annual Slim Chance Awards for the “worst” weight loss products; Healthy Weight Week and awards for businesses honoring size diversity began in 1995. In May 1997, the *Journal* was purchased by Decker Periodicals, now BC Decker, of Hamilton, Ontario, Canada.

I’m proud of our firsts. Ours was one of the first publications ever to report that diets weren’t working as expected or promised, a stunning revelation back in 1987. We were also one of the first to report that high-fat diets can affect body fat. Through it all, we’ve tried to search out the truth and report it objectively.

I’m looking forward to having more time for other writing and publishing, as well as some free time, and won’t miss those excruciating deadlines. But I will certainly miss the challenges, the immediacy of being there when news breaks, and personal contact with our authors and readers. As we look ahead, the need for reporting accurate information and sorting through the chaff in this field is as urgent as ever. I have every confidence that *Healthy Weight Journal* with Dr. Miller at the helm will continue to lead this effort.

Best wishes to all,
Frances M. Berg
During the past year, academic assignments have taken me from China to Romania to the Philippines to Zimbabwe. Along the way, I have observed local diets, activity levels, and obesity prevalence. It has been interesting to observe the role of human culture as perhaps the most significant force underlying the global obesity epidemic. This article briefly describes the prevalence of global obesity, outlines its development from a cultural perspective, and offers recommendations for the prevention and management of the epidemic.

Prevalence and consequences of global obesity

Based on rising levels of obesity in developed countries and the unexpected growth of obesity rates in many developing countries, it is now believed that there are as many overnourished individuals on the planet (1.1 billion) as there are undernourished (1.1 billion). As undernutrition slowly continues to decline, overweight will soon have a clear upper hand. For a condition to achieve epidemic status, it typically must spread rapidly and generate a higher than expected number of cases. At both national and global levels, obesity (body mass index > 30) seems to qualify for epidemic status. Obesity is on the rise in virtually all developed countries. In the US, for example, the prevalence of obesity increased by 55 percent between 1980 and 1994 (from 14.5–22.5%). In most European countries, the prevalence of obesity is anywhere from 10 to 25 percent, and the rate has increased by as much as 10 to 40 percent in the past 10 years. The most dramatic increase has been in England, where the prevalence rate doubled from 8 to 16 percent between 1980 and 1995.

Although obesity prevalence data for many developing countries are still sparse, regional studies indicate that obesity is a particular problem among urban women. This is exemplified by high obesity rates among this group in such areas as Cape Peninsular, Republic of South Africa (44%), Kuwait (44%), Saudi Arabia (28%), and Brazil (13%). Although obesity prevalence rates remain low in many Asian countries, they are also rising rapidly. In China, for example, the national obesity prevalence quadrupled among men (0.3–1.2%) and nearly doubled among women (0.9–1.7%) between 1989 and 1992. In Shanghai, the adult prevalence rate is 12.6 percent, similar to many European nations.

As the world population continues to put on weight, the health and economic impacts are expected to be significant. As one example, the International Diabetes Federation predicts that the number of persons with diabetes worldwide will double to 300 million by 2025, with 75 percent of the growth occurring in developing nations. Another example is seen in China, where the economic cost of overnutrition is already greater than the cost of undernutrition.

It is not surprising then that global obesity is expected to be one of the world’s most pressing public health problems in the future. At the same time, if global obesity is going to be used as a primary gauge of population health, it is important to understand and address it at the broadest level possible.

Human culture and the social environment of obesity

The public health literature is increasingly supportive of the position that obesity is expressed in response to certain social environments. Yet the nature of such environments is seldom given more than a cursory review. It is possible that human culture, as developed by anthropologic theory, may be an ideal lens for taking a closer look at obesogenic social environments.

Although there is no consensus for a single definition of culture, it is useful to think of it in terms of socially shared aspirations and the generally accepted means for achieving them. Members of a cohesive culture will by and large agree on the most appropriate goals for life, the underlying philosophy that supports those goals, and the different paths that might be expected to lead to the realization of those goals. One useful model that supports this concept of culture includes three components: economic mode of production, social order, and beliefs.

As depicted in Figure 1, the economic mode of production serves as a foundation for social organization, which, in turn, supports the ideology or beliefs that guide the aspirations of the society. In an ongoing cycle, cultural beliefs continually influence the evolution of economic modes of production and patterns of social organization—all of which may impact obesity.
Economic production

Economic modes of production include the activities and technologies that cultures devise to produce food, clothes, shelter, and other goods and to generate material wealth among the populace. The process of “development,” as it relates to less-developed countries, has been promoted primarily through the avenue of free-market, Western-style economic growth. The result has been an ongoing shift from small-scale, rural, agrarian means of production to urban, industrialized means of production.

For many, the adoption of an urban, industrial lifestyle involves a nutrition transition from self-prepared, homegrown produce to commercially prepared, processed convenience foods that are purchased from a shelf. Traditional diets high in fruits, vegetables, grains, and fiber give way to diets high in fat, sugar, and salt. At the same time, activity levels go down due to a higher number of sedentary occupations in the city. In fact, the mechanized urban infrastructure, with its automobiles, public transportation, elevators, and escalators, seems intentionally designed for the reduction of activity.

Successful economic growth in large urban centers also results in food surpluses that become available to individual families at ever-lower prices. For example, a surge in global vegetable oil production over the past four decades has added 30 g of fat to the average diet on the planet. The cost of a diet containing 20 percent of calories from fat was cut in half (in constant dollars) during the same time period.

Social order

If a free-market economy based on industrialization becomes the most desired means of economic production, the way is paved for a more complex social order that is highly stratified and subdivided into many different classes. Social class then becomes a powerful force in determining a wide variety of behaviors, including those related to diet and activity. In fact, cultural patterns of social class tend to count more than individual behaviors in predicting the consumption of certain types of food, the social role that food plays, and the meaning and desirability of various types of activity.

For example, among low-income groups in developed countries like the US, high-fat food takes on a significant cultural role in relationships (perhaps due in part to a lack of food security). Social and family occasions tend to center around food, and food becomes a form of escape and relaxation. For higher-income groups, however, food restriction is the accepted norm, and other outlets are found for building relationships and relaxing.

In developing countries, the reverse may be true. High-income groups indulge in a variety of energy-dense foods as a display of status. In many developing countries, it seems clear that patronizing a fast-food establishment was a source of pride and status. In the same countries, food restriction among the poor is dictated by economic circumstance rather than by choice.

A further impact that a free-market, industrialized economy exerts on social organization is the emphasis on corporate profitability. The food industry seeks to enhance profitability by promoting energy-dense, highly processed foods to children. By adding salt, sugar, and fat (and otherwise processing foods and thus enhancing their taste and value), more foods can be sold for a higher profit. By targeting children (e.g., Happy Meals), lifelong customers can be recruited. In an unregulated environment, a proliferation of fast-food establishments that patronize children can be expected. Not surprisingly, the first sign that greeted me at a train station in rural Romania was the golden arches of McDonald’s. Likewise, I was able to take a single picture in Manila that included McDonald’s, Kentucky Fried Chicken, Pizza Hut, and a local fast-food establishment all crowded into one small area.

Beliefs

Cultural beliefs provide the philosophical justification for social aspirations. In relation to obesity, fatness has significant cultural meaning in terms of sexual desirability, self-worth, and the perceived capacity for maternity and nurturance. In the vast majority of developing countries, an overweight body size is associated with wealth, prosperity, desirability, and high status. In Nigeria, young girls are placed in fattening huts to enhance their marriage-ability; likewise, heavier brides in Kenya receive a higher bride wealth. In Ethiopia, thin women are said to have “dog hips,” and among the Havasupai Indians in the southwest US, a fat woman may stand on the back of a thin girl so that the latter will be blessed with larger thighs like her benefactoress.

It has only been in developed countries during the last century that thinness has come to be equated with beauty. This is probably due to the reality that
for beauty, like other commodities, rarity increases value. In cultures where it is easy to be overweight, thinness becomes the desired trait. Where it is easy to be thin, most often because of food scarcity, heaviness becomes the criteria for beauty. Nevertheless, most of the world’s population falls in the thinness category. It is not easy for many populations to become overweight. Accordingly, in those countries that are undergoing the various dietary and health transitions discussed previously, a further influence that encourages obesity is a cultural ideology that favors large body sizes.

### Prevention and management of global obesity

The current emphasis on free-market industrialization, consumerism, and profitability as the primary means for achieving world development has led to a global culture characterized by increasingly similar modes of economic production, patterns of social order, and cultural beliefs. It would seem that these three components of human culture are the primary cause of the global epidemic of obesity.

Table 1 summarizes the impact that each of these cultural inputs has on the development of obesity and then offers cultural countermeasures that will be necessary if global obesity is to be dealt with in a meaningful way.

The fact that virtually all cultures value health provides a common starting point for managing global obesity. Good health, as a cultural aspiration, must be promoted along with proper nutrition and adequate activity as the proper means for achieving health. At this point, it becomes straightforward to work back through the cultural forces that work against good nutrition and activity and find new cultural avenues for promoting them.

Given that our modes of economic production promote inactivity, a conscious effort must be made to provide outlets and motivation for increased activity at schools and worksites (fitness centers, central stairways, physical and nutrition education, etc.). Communities must be planned that include adequate walking and biking trails, parks, recreation centers, and fitness facilities. The inexpensive, high-fat food surpluses that have been made available by economic development must be counterbalanced with tasty, nutritional alternatives that are readily available at restaurants, cafeterias, and public catering services at schools and worksites.

Although it poses many challenges, the food industry must be regulated through national policies similar to those imposed on the tobacco industry. Poor diet is second only to tobacco use as a preventable cause of death. Yet there is very little regulation of the food industry in terms of advertising, and the food industry is not held liable for the health consequences of its products. Additionally, the value of traditional diets (rather than fast food) must be promoted as the ideal means for bonding within social classes and as a means for preserving cultural identity. Subsidies for healthy, traditional foods, in combination with taxes on nutritionally poor foods, would certainly help the cause. Finally, nutrition education must be mass-marketed as a national media priority to offset the influence of the ever-growing fast-food culture.

In terms of cultural beliefs, it may be comforting to know that almost any body size might find a culture somewhere in the world that would honor it as the ideal. Somewhere, we would all be beautiful.

### Table 1: Cultural model for the prevention and management of obesity

<table>
<thead>
<tr>
<th>Cultural Input</th>
<th>Impact on Obesity</th>
<th>Cultural Countermeasures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic production</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free-market economy</td>
<td>Urbanization, mechanization, rising income, cheaper foods, sedentary lifestyles,</td>
<td>Walking/biking trails, activity centers at work, central stairways, school activity</td>
</tr>
<tr>
<td>Industrialization</td>
<td>leisure, loss of traditional diets</td>
<td>programs</td>
</tr>
<tr>
<td>Social order</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Division into classes</td>
<td>Aggressive food ads target children, food as a source of status, more food</td>
<td>National policies that regulate food ads, subsidies for nutritional foods, cultural</td>
</tr>
<tr>
<td>Corporate profiteering</td>
<td>processing (adding fat, sugar, salt), food as a social bond or a means of escape/relaxation</td>
<td>support for traditional diets, mass nutrition education</td>
</tr>
<tr>
<td>Cultural beliefs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body size = beauty</td>
<td>If food is scarce, big is better; if food is plentiful, thin is beautiful (both views may promote obesity)</td>
<td>Promote health at any size, focus on nutrition and fitness—not size</td>
</tr>
</tbody>
</table>
a happy medium, we need to work toward a global culture that honors the value of individuals irrespective of body size. Consciously trying to alter body size for the sake of enhancing social acceptability is likely to lead to frustration, disappointment, and unhealthy practices. On the other hand, attempts to improve health through increased activity and better nutrition (regardless of body size) are an achievable and meaningful goal.

Conclusion
A global movement will be necessary to halt rising levels of obesity. The movement will need to be sensitive to the cultural influences that promote obesity while at the same time trying to create new cultural beliefs and environments that assertively promote healthy nutrition and activity. Success will require the combined efforts of national governments, public health agencies, health and nutrition educators, and the medical field. Without this level of effort, the global epidemic of obesity will continue to spread out of control.

References

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Editorial (continued from page 81)

a cause of eating disorders, and detrimental to personal health. On the other hand, health at any size supporters have been accused of making accusations without scientific evidence while overlooking the existing data.

If one were to look at the two paradigms simultaneously, one would see that both paradigms have the same major flaw. Both paradigms are subscribing to the philosophy that “one treatment fits all.” Those who believe that weight loss through restrictive dieting and exercise is the means to health continue to search for that one optimal diet and exercise program that will solve the obesity problem. They give no consideration as to how cultural influences of various racial and ethnic groups might prohibit or undermine certain aspects of diet and exercise programming for weight loss. The proponents of the health at any size paradigm, on the other hand, assume that all obese individuals have a problematic relationship with food, that all obese persons have body image disparagement, that all obese people have low self-esteem, and that all of the obese will respond to cognitive behavior therapy. In other words, the health at any size approach is focused on Caucasian women with a single psychological profile. Although individuals of other cultures may not experience the same psychological impact of obesity as Caucasian women, the incidence of obesity occurs disproportionately in other racial/ethnic groups.

Accordingly, Ann Jacob and Steven Hawks address some culturally sensitive issues and propose alternative approaches for the treatment of obesity in various racial/ethnic groups. It seems that culturally sensitive, community-based interventions that can be individualized will be the key to fighting the global epidemic of obesity.

Wayne C. Miller, PhD
Considerations for Healthy Weight Management in Diverse Populations
by Steven R. Hawks, EdD

An ongoing goal of the health professions is to reduce racial and ethnic disparities for a wide variety of health conditions, including obesity. Although disparity clearly exists among racial/ethnic groups in relation to the prevalence of obesity, there is room for debate as to how that disparity should be addressed. In an attempt to clarify the debate, this article summarizes racial and ethnic differences in obesity prevalence, reviews corresponding health and socioeconomic consequences, and analyzes causal factors for obesity from the perspective of race and ethnicity. Implications for healthy weight management among racial/ethnic groups are presented.

Racial and ethnic disparities in obesity
The only national, randomized sample that uses actual height/weight measurements to estimate obesity prevalence is the National Health and Nutrition Examination Survey (NHANES) conducted by the Centers for Disease Control. NHANES defines obesity in terms of body mass index (BMI) with cutoff values of 25 to 29.5 signifying overweight and 30 or higher representing obesity. The most recent NHANES data (NHANES III, 1988–1994) indicate a national obesity prevalence of 22.5 percent, which represents a 55 percent increase over the 14.5 percent level reported in NHANES II (1976–1980).

The increase in obesity between NHANES II and III was similar for all age, gender, and racial/ethnic groups. As shown in Figure 1, however, the NHANES III breakdown by race/ethnicity and gender shows major differences. Racial and ethnic disparities within the adult population are primarily limited to women, with significantly higher rates of obesity among African-American and Hispanic women. For men, the prevalence remains consistent at 20 to 21 percent regardless of race.

Consequences of obesity
The health consequences associated with higher levels of obesity among racial/ethnic groups have not been clearly established. On the one hand, the Pima Indians of Northern Arizona are often cited as the classic example of obesity-related harm being experienced by a racial/ethnic group. The Pima are generally considered to be the fattest population in the fattest country in the world, and they also have the highest rates of diabetes.1

On the other hand, a recent prospective study reported that a high BMI was not predictive of increased mortality for African-American men and women.2 The authors concluded that “the risk associated with a high BMI is greater for Caucasians than for African-Americans and that African-American men and women with the highest BMI values had much lower risks of death than Caucasians, which did not differ significantly from the reference of 1.00.” Even though women in racial-ethnic groups in the US have higher rates of obesity, it is not conclusive that a larger body size (independent of other factors) is predictive of ill health or premature death in all groups.

In relation to the socioeconomic consequences of obesity, one prospective study found that for both African-American and Caucasian women, obesity was associated with lower wages, reduced occupational achievement, and lower probabilities of marriage. However, it was concluded that cultural differences in relation to ideal body types might protect African-American women from the self-esteem loss associated with obesity among Caucasians.3 Other authors have suggested that African-American women may be protected from weight-related body dissatisfaction because of a multidimensional body image that is less focused on weight or size as such. Consequently, although certain socioeconomic penalties are still associated with obesity among African-American women, there seems to be less preoccupation with dieting and fewer cases of eating disorders in this group.4

Race and the biological determinants of obesity
In general, experts agree that obesity is a function of heredity, social environment, and individual lifestyle. In the past, most obesity experts have been in agreement that metabolic factors, as determined by heredity, are the most important determinants of obesity.5 But, increasingly, it is the interface between human biology and the social environment that is receiving the most attention.6 Relevant biological variables that may vary by race/ethnicity and that may interact with obesity include resting metabolic rates (RMRs), energy expenditure, and patterns of fat deposition.
Elements of the social environment that may interact with race and obesity include the relationship between body size and social status and the social meaning of food and activity.

The thrifty gene
It has been hypothesized that repeated human exposure to famine over multiple generations has naturally selected metabolic mechanisms that support high levels of fat deposition, low levels of energy expenditure, and a preference for energy-dense foods. When placed in modern social environments that include easy access to high-fat/high-sugar foods, with limited incentives for activity, the expected result is obesity. (Ironically, this model of obesity causation places little emphasis on individual choice, and yet the focus of most weight management programs has been on changing personal behavior.)

Since different racial/ethnic groups have had vastly different experiences with famine over long periods of time, it is to be expected that resulting metabolic adaptations might influence their propensity for weight gain when exposed to new environments. This evolutionary perspective may explain why the Pima Indians have developed higher rates of obesity and diabetes than their Navajo or Apache neighbors when exposed to similar environmental conditions during recent history.

Metabolic differences
One literature review attempted to understand higher levels of obesity among African Americans by analyzing RMRs and total daily energy expenditure (TDEE) differences between Caucasians and African Americans. The authors concluded that for African-American participants, two-thirds of reviewed studies demonstrated lower RMR values, whereas one-third found lower TDEE values. Such studies begin to build a case that genuine metabolic differences seem to exist between different racial and ethnic groups, perhaps owing to the forces of natural selection as influenced by differential exposure to prehistoric famines.

Fat deposition
In response to similar evolutionary pressures, different patterns of fat deposition may have developed among racial and ethnic populations. Body fat, especially abdominal fat, is the true risk factor in relation to body size, and the usefulness of BMI as a health indicator depends in part on its consistent relationship to specific levels of body fat. A recent meta-analysis evaluated the relationship between percent body fat and BMI among different racial/ethnic groups and concluded that equivalent body fat levels produced significantly different BMI values when compared between racial/ethnic groups. Obesity, as measured by percent body fat, was reached at much lower BMI levels in some populations than the recommended cutoff value of 30. Likewise, it was concluded that obesity cutoff levels higher than a BMI of 30 might be justified for other racial/ethnic groups.

Not surprisingly, additional research has confirmed a wide range of ideal BMI values (associated with lowest mortality) for different racial/ethnic groups. For example, the ideal BMI for African-American women is 26.8, which is well above the established overweight BMI cutoff of 25.0. On the other hand, the ideal BMI for Caucasian women is 24.3. Although specific BMI guidelines have been established for the US population in general, there may also be considerable variation in ideal BMI based on age and gender, either within or among racial/ethnic groups. Accordingly, blanket assumptions about the health consequences associated with a specific range of BMI values may be inappropriate when dealing with diverse populations.

Race and the cultural determinants of obesity
In addition to biologic predispositions for obesity, powerful cultural influences have evolved that may favor larger body sizes. In societies where food is scarce (the case for much of human history), obesity may be socially preferred as an indication of wealth, social status, and good health. In support of this hypothesis, one study found that in 80 percent of developing countries (where food resources are more likely to be scarce), the social ideal for both male and female beauty was overweight.

It has only been a recent development, most often in cultures that have an abundance of food, that
socioeconomic status and attractiveness have come to be associated with thinness for women. In the US, middle- and upper-class Caucasian females exhibit a strong preference for thinness and engage in behaviors (many of them unhealthy) that are expected to result in a slender figure. The cultural emphasis on thinness may be diminished or completely lacking for many racial/ethnic groups in the US who refute thinness as a norm limited to upper-class Caucasian women. As has been found in other cultures, the deprivations of poverty experienced by many racial/ethnic groups in the US may further support a cultural preference for large bodies as a symbol of health and power. The prevalence of obesity among African-American women may be explained in part by a cultural preference for overweight bodies.13

It has been hypothesized that racial/ethnic women may have higher BMIs owing to lower activity levels and higher consumption of energy-dense foods. Such behaviors may be biologically driven, as discussed above, or may merely represent the challenges of poverty (limited opportunities for activity and healthy diets because of low income or unsafe environments). A third alternative, however, is that these behaviors may represent the different cultural roles that food and activity can play within racial/ethnic communities.

Beyond health values, diet composition and activity levels within a society are intimately connected to a variety of social meanings and relationships. An ethnographic study of diet and activity practices among Australian Aborigines identified wider social meanings that made personal behavior change in these areas very difficult.14 For example, fat and salt were seen as key ingredients for meals that fostered closeness with families and friends, whereas meals that met dietary guidelines were seen as cold and clinical. Different categories of physical activity were also identified, each with its own cultural meaning.

As argued by the authors of the study, it is difficult to change behaviors by appealing to health benefits without understanding and considering the larger social and cultural contexts in which the behaviors occur.14 As with Australian Aborigines, diet composition and activity levels among racial/ethnic groups in the US are undoubtedly influenced by powerful social variables that have little to do with concerns for personal health.

Implications for healthy weight management

The foregoing discussion raises several issues that have implications for how the health professions should address racial/ethnic disparities in obesity. First, racial/ethnic disparities in the prevalence of obesity are generally limited to women. According to NHANES III, rates of obesity among men remain surprisingly consistent across racial groups. Second, the health impact of a larger body size (BMI) may not be significant for women from some racial/ethnic groups (eg, the ideal BMI for African-American women is 26.8, well into the established overweight range). This may be attributable to biologic differences in RMR, energy expenditure, and fat deposition that make standardized BMI categories unreliable indicators of health status among diverse populations. Third, whereas most women seem to experience some negative socioeconomic consequences in relation to a large body size, women from some racial/ethnic groups may be protected against size-related loss of self-esteem owing to a broader, multidimensional definition of beauty that may tolerate or even promote larger body shapes. Finally, there are a variety of cultural values that influence food and activity choices that may transcend personal health values.

As we design a plan of action for reducing racial/ethnic disparities in obesity, the following points are worthy of consideration:

1. The actual degree of racial/ethnic disparity in obesity, as reflected in the NHANES data, may not be accurate or meaningful. The research literature is consistent in demonstrating a wide variety of ideal BMI values among different racial/ethnic groups. Disparities that are measured using a single BMI standard are therefore misleading. Unless these differences are properly considered, the goal of reducing racial/ethnic disparities in BMI begins with an unknown gap.
2. Disparities in body size may not represent the most salient health threat to racial/ethnic groups. Rather, disparities in health status are far more likely to be a function of society-wide inequalities in income, education, and environment, as well as genetic diversity—not body size.
3. The morbidity and mortality associated with obesity are primarily a function of biologic factors (unique to each racial/ethnic group) interacting with new social environments, as in the case of the Pima Indians of Northern Arizona. But drawing general conclusions about the relationship between obesity and illness and then applying them to all racial/ethnic groups is unwarranted given the unique evolutionary history and biologic adaptation of each group.
4. Personal weight loss programs that target members of racial/ethnic groups are not likely to have a meaningful impact on obesity at the popul-
tion level but may serve to undermine the self-esteem of women who are made to feel that their body size is unacceptable.

5. Community-level interventions should focus on improved nutrition and opportunities for activity in school, community, and worksite settings. Programs should involve broad-based participation from the affected populations and should be presented in culturally sensitive ways that support traditional values associated with food and activity without stigmatizing large body shapes.

6. Many in the health field are now arguing forcefully that obesity is a problem caused by an “obesogenic” social environment that includes rampant junk-food advertising, an overabundance of fast-food establishments, and limited opportunities for activity. A national policy approach that alters the most negative aspects of the social environment will potentially benefit all citizens, including racial/ethnic groups.

7. It may be far more meaningful to prevent the development of obesity among racial/ethnic groups by targeting the determinants of obesity among their youth rather than attempting to significantly alter adult body size once established.

Conclusion

Although the national goal to reduce racial/ethnic disparities in health outcomes is appropriate, it must be pursued with caution in the area of obesity. Obesity disparities are largely limited to women who, in some cases, may experience minimal threats to their health and who may have a cultural preference (or at least tolerance) for larger body sizes. Focused efforts that promote weight reduction among these women may offer little chance for health improvement but may be a potent factor in lowering self-esteem, distorting body image, and increasing diet obsessions and eating disorders. Rather than supporting cultural diversity and the well-being of minority women, such efforts may merely represent a repressive form of acculturation into the pervasive “culture of thinness” that characterizes the majority population.

It would be much better to proceed slowly with culturally sensitive, community-based interventions and changes in national policy while remembering the Hippocratic maxim to “first do no harm” as we strive to reduce racial/ethnic disparities in obesity. One way to do this is to target behaviors that are known to improve health status rather than focus on changing body size. For example, one recent study concluded that high levels of physical activity were associated with lower odds of non–insulin-dependent diabetes mellitus among all racial and ethnic groups and that the relationship may be even stronger in Hispanic subjects. Community infrastructures and national policies that promote increased activity will likely go further in the promotion of ethnic health than will efforts to alter body size.

References


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Body Image Distortion and Eating Disorders: No Longer a “Culture-Bound” Topic
by Ann V. Jacob, MS, NCC, LPC

Health professionals today face many challenges with regard to adolescents and eating disorders. Eating disorders, once thought to be typically a Caucasian, upper-to-middle-class disorder of young women, are now showing a staggering increase among all social classes and ethnic groups in the United States.1–3 All health professionals should strive to understand the role that culture plays in the development and maintenance of body image distortion and eating disorders. This article outlines current studies looking at body image distortion and eating disorders across cultures and ethnicities within the United States and offers practical suggestions to the health practitioner for how to handle potential problems in a culturally sensitive manner.

The eating disorders of anorexia nervosa and bulimia nervosa have long been associated with persons of middle-to-high socioeconomic status and achievement-oriented young Caucasian females. This association has actually led researchers in the field to term eating disorders as a “culture-bound syndrome.” Culture-bound syndromes are defined as constellations of symptoms that are restricted to a particular culture or group of cultures.4 In Western culture, being thin has come to symbolize self-discipline, control, sexual liberation, assertiveness, and competitiveness, as well as affiliation to higher socioeconomic classes.5

Traditionally, it was believed that eating disorders and related body image distortion were confined to Caucasian, upper-middle-class women. However, over the past several years, researchers have begun to explore behaviors that are related to the development and maintenance of eating disorders (body dissatisfaction, dieting, binge eating) in females of ethnic diversity within the United States.

Most of these studies revealed that African-American women tend to report less dieting behavior and pressure to be thin and show a significantly more positive body image than Caucasian women.4–6 It can be argued that, overall, African Americans have a strong sense of racial identity that serves as a protective factor against Western weight ideals and are not as affected by exposure to the dominant cultures.5,7,8 In addition, African-American girls have been found to have a more flexible and less rigid perception of beauty than that of Caucasian girls, allowing more variability for what is considered attractive.9

However, the past few years have seen a significant increase in African-American adolescents, with few or no African-American peers, who are enrolled in highly competitive, predominantly Caucasian schools.1 African-American individuals with eating disorders who were brought up in the dominant Caucasian culture reported a strong desire to please others and held the view that they were responsible for “correcting the image of blacks.”1 Perhaps it can be argued that those middle-class African Americans who strive to participate in the dominant culture are, in fact, placing themselves at risk for body image disparagement and/or developing an eating disorder. Abrams et al. studied the eating attitudes, behaviors, and psychological adjustment of African-American and Caucasian female college students.10 These researchers found that African-American women who reject their African-American identity and idealize Caucasian culture are likely to endorse attitudes about body image and dietary behaviors in a manner similar to Caucasian women.10

Latino-American women have not been shown to have the same “protective factor” as African-American women. Several studies have shown that Latino-American women show similar body image and weight concerns to European Americans in all measures of weight and body satisfaction.6,11 Other studies looking at eating disorders in recently immigrated Latino-American women indicate that the incidence of eating disorders in this population may be
associated with the process of acculturation, low self-esteem, and a powerful need for societal acceptance.\textsuperscript{1} Smith and Krejci conducted a study looking at attitudes and behaviors associated with eating disorders, such as body dissatisfaction, excessive dieting, and fasting and binge eating in Hispanic and Native American females.\textsuperscript{11} These authors concluded that although there were fewer females who met the complete criteria for eating disorders, over one half of the females reported excessive dieting or fasting. Forty-nine percent of the total sample reported episodes of binge eating, and one-third reported a significant fear of gaining weight.\textsuperscript{11} Despite recent research that has shown Hispanic females to closely match Caucasian females in eating disorders, the Native American population reported more behaviors related to bulimia (14.2\%) than both the Hispanic sample (13.1\%) and the sample of Caucasian females (10.1\%).

Robinson et al. conducted a study looking at ethnicity and risk for eating disorders among Caucasian, Latino-American, and Asian-American girls.\textsuperscript{12} This study focused specifically on the relationship between desired body shape, socioeconomic status, body satisfaction, and body mass index. The researchers found that the Latino-American girls scored the highest in body dissatisfaction, with Asian girls following close behind. Ironically, Caucasian girls in this sample showed the least amount of body dissatisfaction.

In a study looking at Chinese students living in the United States, increased acculturation was associated with heightened scores on the Eating Disorders Inventory, particularly the variables of bulimia, drive for thinness, and maturity fears.\textsuperscript{13} Highly acculturated students also reported significantly greater perfectionism scores, specifically body perfectionism. Those women who did not report high acculturation tended to report less of the symptoms associated with eating disorders, as well as less depression. Davis and Katzman suggested that in an effort to assimilate, immigrants may overcorrect real or imagined deficits, and that in this effort, females may focus specifically on their body owing to cultural norms.\textsuperscript{13} The authors also describe an individual’s cultural alliance as a protective factor, similar to the studies focusing on African-American females.\textsuperscript{13}

Thus, it appears that there is an increase in the prevalence of body dissatisfaction and eating disorders among diverse ethnic groups, who were previously assumed to be immune to these disorders. The data suggest that as individuals are acculturated into Western society, an identity conflict occurs between assimilation and acculturation to the new society and cultural alliances to ethnic standards and beliefs.

### Three rules for the culturally sensitive practitioner

There are three important rules to remember when working with females of other cultures in the area of weight, body image, or dieting: (1) Always ask; do not assume that the female does not have a problem because of her outward appearance, culture, or ethnicity. (2) Be careful with your questions. Try to refrain from asking questions in an offensive manner. (3) Find out more information about her culture before making any suggestions or recommendations.

**Always ask**

When working with a female from another culture, it may be natural to assume that because a female presents a normal body weight or what seems to be “culturally appropriate” that she must have a healthy body image. Recent research indicates that this may not always be the case. If you work with a female from another culture, it is important to still ask those diagnostic questions that may reveal problems with body image and potentially an eating disorder. If you are working with a female who recently immigrated to the United States, ask questions about how she is “fitting in” with the other American females.

Based on what information is known about women of different ethnicities, most health professionals may make assumptions regarding a female’s ethnicity, culture, and presenting appearance. Remember, females with bulimia nervosa usually present at a weight that is within a normal range. Look for the typical signs that can indicate body image distortion or eating-disordered behavior (ie, marks on the back of the hand; baggy clothing; obsessive thinking about food, exercise, or body size). Furthermore, depending
on the ethnicity or culture of the female with whom you are working, do not assume that it is culturally normal for a female to be extremely thin or overweight. Again, it is important to ask her how she views her body or weight in general.

**Be careful with your questions**

When interviewing a female of another culture, ask questions that are appropriate, refraining from questions that might be viewed as judgmental or value laden. As the recent research has shown, females of all cultures are now suffering with eating disorders, so do not assume that you know the person’s beliefs or values regarding food, diet, or weight simply because you can identify their ethnicity.

First ask questions about her culture in general if you do not have any prior experience working with women of her ethnicity or culture. This will give you baseline information, and it is not offensive to ask a question such as, “In your culture, how do women view their bodies?” This will give you a general sense of her culture. You can then ask a follow-up question based on her answer, which will reveal more about her specific situation, such as, “Do you view your body in the same way as the women in your culture?”

**Find out more information about her culture**

Before making any suggestions or recommendations that may affect a young female’s weight, body image, or diet, it is first important to have an understanding of her culture. Prior to problem solving, a practitioner should have a general knowledge about that female’s current lifestyle and cultural background. Particularly if you are working with one culture or ethnicity, it is imperative to do prior research to understand values, spiritual beliefs, and how women are viewed in that particular culture. You may find it helpful to attend some social or cultural events, which will expose you to the food, music, and culture of that group.

It is always dangerous to make suggestions without first understanding the person and the things that influence and affect her behavior. Again, do not be afraid to ask questions of your client or patient. In fact, you may find that the female with whom you are working is delighted in your interest!

**References**


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Physical Love
by Susan Stinson

I love my body. I love it with the force of a basic 
impulse toward self-preservation, with an animal 
appreciation for what my bones, joints, tendons, 
muscles, organs, veins, skin, and fat can do. There 
are neglected sym-
phonies of meaning in 
in all my belly does for 
supporting and sustain-
ing breath, for yielding 
pleasure in sex, and for 
facilitating the transform-
ation of food into the 
energy needed for every human action. Mouth, 
tongue, eyes, wrists, fingertips: every element of the 
body could be a poem and a treatise. Fat has its 
place among them.

I love my body as a political act, a daily affirm-
ation of the idea that the world can change to include 
things as difficult to envision as more equitable 
distribution of power and resources and appreciation for a 
wide range of bodies, including mine. Each time I move with 
pleasure, dress myself comfortably, or offer my physical self a 
moment of praise, it is an act of 
homage to people all over the world who have faced 
difficult circumstances and taken steps to change 
them. My small, personal acts of resistance are not in 
themselves full expressions of my support for others 
whose bodies and lives are treated with disrespect, 
but they help keep me awake to how difficult and 
how important those struggles are.

I love my body as a spiritual discipline, a way of 
knowing myself and my surroundings. I try to experi-
ence my physical sensations as directly as I can and to 
otice when distractions are getting in the way. Fear of 
death is, I find, a large 
distraction, and so is a 
longing to be accepted 
by a culture that rejects 
me as an unworthy par-
ticipant because I am a 
fat woman. It is very dif-
ficult for me to accept 
changes in my body, to face pain, illness, and imperfec-
tion. There is a temptation to believe that these things 
are my fate because I am a fat woman, but it appears 
to me that they are the human condition.

It is difficult to resist the fat hatred that the cul-
ture directs at me in terms of economic and social 
discrimination, limited accessibility, and biased 
health care. It is hard to be joyful, tender, and 
healthy under the stress of all 
that. The strength of other fat 
people who resist these pres-
sures sustains me. The struggle 
to love my body is worth the 
risk and effort it takes. And I do. I love my lush, 
soft, fat body as it swells every space I enter with its 
undeniable, vibrant presence.

Susan Stinson is author of three novels: Fat Girl Dances with 
Rocks, Martha Moody, and Venus of Chalk. Susan will be a 
keynote speaker at the WomanLivingLarge gathering in Seattle, 

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