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What persons with physical disabilities can teach us about obesity

Kaley M Roosen and Jennifer S Mills

Abstract

In response to Dr Marks' paper titled 'Homeostatic theory of obesity', we discuss how research on persons with physical disabilities, who exist on the margins of traditional notions of beauty and health, can inform theories of obesity. The impact of sociocultural messages related to undesirability and abnormality is explored, and parallels are discussed between obese and disabled bodies. We argue that to reduce rates of obesity, there is a need not only to reduce thin valorization but also to promote social acceptance of diverse bodies, including bodies that are traditionally understood as unattractive, unhealthy and unproductive (i.e. disabled and/or obese). There is further need to reevaluate definitions of health and wellness in order to be inclusive of diverse bodies as well as encourage equitable access to health-promoting practices and social programming.

Keywords

body image, disability, eating disorders, health promotion, obesity

Dr Marks' paper outlining the homeostatic theory of obesity offers a comprehensive summary of the literature related to the aetiology of obesity. In particular, the proposed Circle of Discontent synthesizes a large body of literature on the biological, psychological and social factors that lead to disordered eating and body dissatisfaction. As researchers who study disordered eating among women with physical disabilities, we reflected on how the proposed aetiological mechanism captures the experiences of such persons who are rarely considered in eating disorder and obesity literature. Specifically, we explore here how the experience of body shaming in physically disabled women assists us in understanding how a societal intolerance for different and unfit bodies further promotes discontent and obesity, beyond a preference for thin bodies. We argue that there is a need for a cultural shift that expands the definition of health and well-being to include diverse body types, including persons with disabilities and obese individuals.

Women with physical disabilities are an often overlooked population within the obesity and eating disorder literature. Emerging research has demonstrated that women with physical disabilities can experience higher rates of body dissatisfaction and mental health issues, such as anxiety and depression, as well as increased risk for both disordered eating and obesity (for review, see Roosen, 2016). Our research with these women has uncovered complex interactions between social, psychological and physical factors that can help us to understand the reasons why these women are at increased risk for obesity. Furthermore, our research has explored how the relationships between *ableism* (a societal preference for fit/healthy bodies) and *sizeism* (a societal preference for thin bodies) can contribute to internalized shame about one's body. Taken together, research related to women with physical disabilities, who lie on the margins of both ideal beauty and health standards, offers a unique opportunity to understand how sociocultural messages impact an individual's body image and the associated emotional distress.

Marks proposes that one intervention target to reduce the rates of obesity within the obeseogenic environment would be to shift the cultural preference for thin bodies, which can promote unhealthy dieting and body dissatisfaction.

York University, Canada

Corresponding author:
Kaley M Roosen, Department of Psychology, York University, 297 Behavioural Sciences Building, 4700 Keele Street, Toronto, ON M3J 1P3, Canada.
Email: kaley@yorku.ca

However, our research has uncovered another powerful factor influencing people's feelings about their body: a widespread societal preference for fit and healthy bodies. Both disabled and obese persons experience widespread discrimination as well as insidious societal messages regarding the need fix, cure, rehabilitate, lose weight and/or improve mobility. For both groups of people, their bodies are assumed by others to represent permanent poor health and low quality of life, or in other words, a burden on an already stretched healthcare system. Society's tendency to problematize disabled, obese or physically different bodies, due to assumptions regarding burden of cost and reduced productivity, can have a long-standing negative impact on self- and body esteem. Furthermore, stigma around disability and/or obesity can be the catalyst for mental distress, disordered eating and body dissatisfaction.

In our research, women with physical disabilities revealed how their efforts to lose weight were often fuelled by the motivation to fit in, improve their physical attractiveness and 'pass as normal' (i.e. less disabled). At the same time, these women attempted to avoid weight gain due to fears of losing mobility, independence and productivity, in addition to fears that other people will judge them for somehow 'causing' their disability by gaining so much weight. Furthermore, our clinical observations of nondisabled individuals with eating disorders reveal that the fear of physical disability due to obesity is a frequent catastrophic fear that can perpetuate disordered attitudes and behaviours. The commonly assumed connection between obesity and disability/illness may represent one of the underlying factors driving societal body shaming. We argue that the current societal intolerance for physically different and unfit bodies would continue to fuel to Circle of Discontent proposed by Marks, even if there is a shift away from the promotion of thin bodies.

Indeed, recent research suggests that there may be a cultural shift underway, away from the promotion of a thin ideal body and towards a 'fit' ideal body (Musolino et al., 2015). Fitness describes the body's ability to function efficiently and effectively in work and leisure activities, which is usually tied to health as well as good nutrition and physical activity. Being fit is largely presumed to be evidence of good general health and quality of life. Fitness, in its traditional definition, is antithetical to obesity and disability. Although the promotion of health and wellness might, at first glance, seem like a worthwhile societal goal, a valuation of fit, healthy bodies (and the devaluation of 'unfit' bodies) can also fuel body dissatisfaction and psychological distress. Instead of pining for thin bodies, many people are now focused on becoming fit and healthy, yet paradoxically, often to an unhealthy degree. Some have even called for the recognition of a new type of eating disorder (so-called 'orthorexia'), where individuals attempt to follow rigid healthy eating rules and exercise routines to the point of emotional distress and impairment of functioning (Koven and Abry, 2015).

In an increasingly obeseogenic environment where calorically dense food is readily available without much needed energy output, control over food intake and activity levels will continue to be admired, particularly in a society that values independence, productivity, health and physical attractiveness. For women with physical disabilities, attempts at controlling their dietary intake and weight can be related to feelings of self-agency and the belief that they may be reducing the burden of their body on other people. Relatedly, as Marks highlights, obese individuals are largely presumed to be at fault for their 'excess' weight. However, these inaccurate and damaging assumptions of control and causality over one's health, fitness and weight can lead to increased social stigma and internalized body shame. Both disabled and obese individuals are especially at risk of dieting and other disordered eating behaviours. For both groups, attempts to restrict their food intake is a coping mechanism that, in the short term, can enhance feelings that they are doing something good for their health, but in the longer term, can erode at self-esteem and body acceptance, as well as disrupt normal eating behaviours leading to obesity or, in some cases, clinically disordered eating. It is no coincidence that as high fat/sugar foods become increasingly available and convenient in addition to the greater promotion of healthism (i.e. the belief that persons can control their health and fitness), obesity, body dissatisfaction and disordered eating will continue to rise.

Another important finding from our research on women with physical disabilities that, in our view, expands the list of intervention targets covered by Marks is the promising role of coping as a protective factor. In the face of sociocultural messages of the unattractiveness, abnormality, asexuality and undesirability of their bodies, many women with physical disabilities maintain quite positive views of themselves and their bodies. Furthermore, these same women do not demonstrate increased risk for mental health issues or rate their quality of life as any lower than do women without disabilities. The term disability paradox has been used in previous literature to describe the unexpected findings that most disabled people report a quality of life and well-being equal or above that of their able-bodied counterparts (Albrecht and Devlieger, 1999). These findings also highlight how traditional assumptions regarding health, fitness and quality of life can be misleading. One explanation of this paradox, uncovered in our research, was that the women used their psychological and social resources to ameliorate any stressful events stemming from living with a disability in a largely inaccessible environment. Women spoke of the increased resiliency, psychological growth and self-acceptance that grew out of living a life with a disability. In addition, our results from surveying a large sample of participants confirmed that the longer a woman has lived with a physical disability, the less likely she is to develop body dissatisfaction, disordered eating, mental health stress and poor self-esteem. Many women with disabilities had

found alternate ways to tolerate and accept their bodies, despite societal messages of undesirability and presumed poor health and fitness.

Understanding the development of coping strategies and psychological resiliency in woman with disabilities may be helpful in translating these findings to any person struggling with body dissatisfaction and mental health stress. But for persons struggling with obesity in particular, facilitating a similar development of self-acceptance and increased empowerment for health-promoting behaviours would be an essential first step within a culture that stigmatizes and blames individuals for their weight gain. Although not as effective for broad social change, psychological treatment aimed at increasing body acceptance, social supports and coping capacity, as well as replacing learned food-based emotion regulation to alternate, healthy and skills-based strategies, could aid in breaking the Circle of Discontent proposed in the development of obesity. Our research has revealed that women with disabilities often discuss the utility of both individual psychotherapy and seeking healthy and inclusive social supports in learning to accept themselves and their bodies, in addition to ending unhealthy and ineffective weight-loss strategies.

The Health at Every Size (HAES: Bacon, 2008) movement represents a potential framework for preventing and treating disordered eating and body dissatisfaction. However, the movement needs to be expanded to include not only issues around accepting obese bodies but also other marginalized bodies. As Marks discussed, within efforts to reduce obesity epidemic, there has been push to encourage healthy eating and increased physical activity in order to reduce the burden of chronic illness and disability, which has unintentionally stigmatized both obese and disabled bodies. Furthermore, these efforts do little to address the sociocultural factors related to obesity. We believe that eliminating the societal assumption that persons are largely in control of their health, weight and fitness, as Marks described, also requires the acknowledgement and a better understanding of the role of poverty and inequitable access to health-promoting initiatives that impact certain at-risk populations. There is a need to reimagine the idea of health and fitness to include diverse bodies. Studies of women with physical disabilities suggest that encouraging a narrow definition of what bodies can be considered healthy and valuable leads to psychological distress, low body esteem and disordered eating. These narrow parameters of health serve to further marginalize and exclude both persons with disabilities and obese persons from equitable access to preventative healthcare and programming that targets healthy living.

The experiences of persons with physical disabilities parallel the experiences of obese persons in many ways. Social and psychological factors such as stigma, exclusion, poverty, body dissatisfaction, body shaming and perceived pressure to modify one's body impact persons with disabilities, as well as obese individuals, often exacerbating disordered eating and contributing to decreased self-esteem. Taken together, we propose that there is not only a need to shift cultural preferences away from thin valorization but also to expand the definition of who can be considered healthy and fit. Furthermore, there is a need to encourage acceptance and ascribe value to diverse body types, including those who would be viewed as traditionally non-healthy, non-normative and, in some cases, socially costly or burdensome. The belief that all bodies can achieve health and well-being would promote a cultural shift towards acceptance and inclusion of diverse bodies. Specifically, this societal attitude would facilitate equitable access to healthcare and health-promoting behaviours (e.g. nutritious foods, inclusive physical activity programmes and technologies, stress management and social support) for people with all body types.

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References

Albrecht GL and Devlieger PJ (1999) The disability paradox: High quality of life against all odds. *Social Science & Medicine* 48(8): 977–988.

Roosen KM (2016) *Women with physical disabilities and disordered eating: A mixed methods approach*. Unpublished Dissertation.

Bacon L (2008) *Health at Every Size*. Dallas, TX: Benbella Books.

Koven NS and Abry AW (2015) The clinical basis of orthorexia nervosa: Emerging perspectives. *Neuropsychiatric Disease and Treatment* 11: 385–394.

Musolino C, Warin M, Wade T, et al. (2015) 'Healthy anorexia': The complexity of care in disordered eating. *Social Science & Medicine* 139: 18–25.