A NEW PERSPECTIVE ON WOMEN, WEIGHT AND CULTURE: THE HUBERT HEALTH EDUCATION MODULE FOR NURSE PRACTITIONERS

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By

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ABSTRACT

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Many women feel dissatisfied with their bodies and diet in an attempt to conform to the cultural ideal. An alternative weight management paradigm is emerging which asserts that women can improve the quality of their lives regardless of weight and body size. Transition from the traditional model based on personal transformation to the new model of health based on health and self-acceptance, requires that health professionals challenge previous values and treatment modalities. The Hubert Health Education module, (HHEM) guided by Malcolm Knowles adult learning principles is designed to encourage the nurse practitioner (NP) to explore personal values and cultural influences regarding weight and body size. This three hour module introduces basic components of an alternative paradigm to weight management. The NP is in a perfect position by virtue of education and experience in weight management to incorporate this information as a new practice and perspective.

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INTRODUCTION

Western culture has an obsession with body size, weight and the ideal of thinness. The media, fashion industry and entertainment industry have barraged women with models of thinness unattainable for most women (Garner & Wooley, 1991). Thinness and small body size are equated with fitness, beauty, power and control, attractiveness and happiness (Fontaine, 1994). This anti-fat mentality leads to body dissatisfaction and decreased self-esteem in women who try to live up to the Western cultural standards. Self-esteem becomes deeply connected to body size and shape, and women incur profound health problems as a result of internal and external pressures to change their bodies (Brown & Jasper, 1993; Low Beeching, 1993). Women learn to focus on appearance when body size and shape are crucial to social values.

An alternative weight management paradigm is emerging which focuses on wellness solutions, i.e., feeling good about oneself, eating well and being active (Berg, 1995). This paradigm asserts that thin is not intrinsically healthy and beautiful nor is fat intrinsically unhealthy or unappealing (Robison, 1997). Accepting people with

different body sizes and shapes and emphasizing that people have different body sizes by nature are central themes (Robison, 1997). This shifting paradigm compels the nurse practitioner (NP) to evaluate and challenge cultural and personal values regarding weight and body size. Presently, nurse practitioners may not have an awareness of the alternative weight management paradigm and may need additional education to explore alternate weight management modalities.

Statement of the Problem

Western culture has very stringent ideals of acceptable body weight and body size for women. As a result, many women feel dissatisfied with their bodies and diet in an attempt to fit the cultural ideal. Current weight control practices and restrictive dieting have detrimental psychological effects including weight preoccupation, depression, decreased self esteem, and an increased risk for disordered eating and weight gain (Robison, 1997; Kratrina, King, & Hayes, 1996). An alternative weight management paradigm is emerging which promotes a holistic view of wellness. This paradigm asserts that women can improve the quality of their lives regardless of weight and body size. NPs need further educational preparation to become familiar with this emerging paradigm in order to provide care to women with weight and body size concerns.

Purpose of the Project

Given the importance of the need for NPs to provide care to women with body weight and body size concerns, the purpose of this project is to develop a health educational module to assist the NP to recognize and explore personal and cultural influences regarding weight and body size. In addition, the HHEM will introduce basic components of an alternate paradigm to weight management. The goals of the HHEM are to: (1) recognize and challenge the cultural ideals and values that promote disordered eating for women, (2) evaluate current weight control practices and recognize the harmful effects of dieting, and (3) develop an awareness of an alternative approach to weight management.

Definition of Terms

The significant terms for this project include weight, body size, culture, perspectives, self-esteem, health education module, and nurse practitioner. The conceptual definition of each is explored and an operational definition is stated.

Weight

Goodman (1995) states that weight is a framework for issues like control, entitlement, conformity, power, the way a society grants or withholds approval, opportunities and social status. In the general literature, the term weight is not defined although methods to measure weight are discussed. Weight, as defined by the Riverside Webster's II dictionary (1996), refers to the heaviness or mass of an

object as determined by weighing. Body weight then refers to the measurement of the heaviness of the body. In isolation, the term body weight is neutral and has no associated negative or positive connotation. It is only in reference to cultural value that these measurements have significance. Body weight is determined by a multitude of cultural, socioeconomic, and behavioral factors and genetics (Gaesser, 1997).

Several measures of body fat/weight are available. The concept of the "ideal" or the "desirable" weight is derived from insurance actuarial tables, or height and weight tables. These height and weight tables have a range of ideal weights corresponding to height and body frame sizes. These tables are used to indicate weights at which insurance policy holders are expected to attain the greatest longevity (Garner & Wooley, 1991). Ranges outside these "ideal" ranges are designated as either underweight or overweight. Criticisms of these tables include arbitrary grouping of the data, lack of anthropometric measurements for frame sizes, lack of consideration for aging, differences in lean body mass and regional fat distribution (Garner & Wooley, 1991). Despite these criticisms, individuals and health care professionals use these charts to determine success with traditional weight loss strategies, the attainment of "ideal" weight, and as predictors of mortality (Gaesser, 1996).

More recently, body mass index (BMI) has been used as a measurement for determining ideal body weight and tendency toward obesity. BMI is calculated by weight in pounds multipled by 700 and divided by height in inches squared (Gaesser, 1997). Recommended BMIs are generally within the range of 20-26 for both men and women.

For this project, weight refers to the heaviness or mass of the body measured in pounds on scales with comparison to the "ideal" weight which appears on height and weight tables. Typically women refer to weight in numbers on a scale as opposed to BMIs.

Body size

The concept of body size is important as the pursuit for thinness and "ideal" body size is culturally driven (Cliska, 1990). Western culture has an intense preoccupation with weight and body size (Rodin, 1993). Women in particular are imprinted with a cultural ideal body size and struggle throughout their lives as this social norm becomes the yardstick for self-evaluation (Cliska, 1990). Many women in western society experience significant dissatisfaction with their body size and shape and perceive themselves as overweight (Tiggeman & Wilson-Barrett, 1998). Body size is a term used frequently in the literature although no concrete definition is given. Body is defined by the Riverside Webster's II dictionary (1996) as the physical part of a person and size is defined as a physical dimension, bulk or magnitude. There is a diversity of body

sizes which may be determined by age, fat deposition, gender and genetics (Hirschmann & Munter, 1995). For this project, body size refers to the physical size and shape of a woman's body.

Culture

According to Lorig (1996) culture refers to a shared set of beliefs, assumptions, values and practices. Cultural rules, norms, values and ideals are transmitted by individuals and groups of people (Fontaine, 1994). Aesthetic preferences for body size and shape vary from culture to culture and at different times in history (Fontaine, 1994).

Western culture has an intense preoccupation with weight and small body size as powerful symbols of health and beauty (Lopez, 1997). In the last few decades, there has been a marked trend toward the increasingly thin ideal in women's beauty (Rodin, 1993). Values are the result of individually formed attitudes and culturally learned beliefs (Raines, 1993).

For the purpose of this project, culture refers to socially transmitted values, behavior patterns, beliefs and practices particular to Western culture. Western culture is defined as North American culture.

Perspectives

According to the Riverside Webster's II dictionary (1996), perspectives are a mental view, an outlook, or the relationship of aspects of a subject to each other and to

the whole. Reutter and Ford (1996) define perspectives as changing views. For the purpose of this project, perspectives refer to a new view or a changing view of the inter-relationship between women and weight and the impact of the media and the culture in perpetuating those views. In addition, the introduction of an alternative approach to health, despite weight or body size, provides a new and changing view of weight management.

Self esteem

Self-esteem is an important concept to consider when managing clients with weight and body size concerns. Body size and shape are crucial to social value, while self-esteem is affected by social identity (Brown & Jasper, 1993; Cliska, 1990). In the social context, diminishing self-esteem ensues when people compare themselves to the very thin cultural ideal (Cliska, 1990). Self-esteem is developed by interactions with significant others and diminished by reinforcement of these interactions. According to Pender (1996) self esteem is the value attributed to self. This valuation is based on a person's achievements, desirable and undesirable traits, strengths and weaknesses, and success in interpersonal relationships. Self-esteem is developed over time and is amenable to change; it can be enhanced by positive expression. Identifying positive attributes of self can focus attention on characteristics which are admired by others (Pender, 1996). Enhanced self-awareness of positive characteristics

and their presence in conscious thought will produce behavior reflecting positive responses from significant others. Self-esteem is an essential part of the foundation for building a healthy lifestyle (Cliska, 1990; Pender, 1996).

Self-esteem for this project is defined as a person's view of self which is amenable to change. This concept includes positive and negative attributes which are affected by external influences such as social norms and internal influences such as growth.

Health Education Module

The literature suggests that the terms patient education, health instruction and health education module have commonalities. In general, each includes a group process, a plan or organized activities which are implemented to improve health behaviors and enhance health promotion.

Rankin and Duffy-Stallings (1990) define patient education as a process of influencing behavior and generating changes in attitudes, knowledge, and skills required to maintain or improve health. Health instruction as defined by Fodor and Dalis (1989) refers to a plan prepared for a sequential arrangement of learning which is designed to positively influence health, values, practice, attitudes and cognitive capabilities conducive to the optimum development of the individual, the family, and the community. However, Lorig (1996) defines health education

module as any set of organized activities designed to improve health behaviors and/or health status.

For this project, health education module refers to a set of organized, sequentially prepared learning plans. These learning plans are designed to have a positive influence on health, values, practice and attitudes which will improve health behaviors.

Nurse Practitioner

Advanced practice nursing is an umbrella term used to describe various roles in nursing, particularly the clinical nurse specialist, the nurse practitioner, the nurse midwife, and the nurse anesthetist (Davies & Hughes, 1995). According to Rankin and Duffy- Stallings (1990), a nurse practitioner (NP) is a registered nurse with additional specialized academic and clinical training whose practice includes physical assessment, diagnosis, and the management of common health problems. The NP provides a full realm of primary healthcare services with a holistic patient and family focus. Educational programs for NPs emphasize physical assessment and history taking, pharmacology, nutrition, primary care and health promotion (Page & Arena, 1994). Historically, NP practice has been associated with primary care (Cronenwett, 1995). For the purpose of this project, NP refers to a registered nurse with a master's degree in nursing who is practicing in a primary care setting.

Chapter 2

CONCEPTUAL FRAMEWORK

Given the importance of the need for the nurse practitioner (NP) to manage women with body weight and body size concerns, the development of the Hubert Health Educational Module (HHEM) enables the NP to recognize and explore personal and cultural influences regarding body weight and body size. In addition, this health education module introduces basic components of an alternative paradigm to weight management. The goals of this module are to: (1) recognize and challenge the cultural ideals and values that promote disordered eating for women, (2) evaluate current weight control practices and recognize the harmful effects of dieting and (3) develop an awareness of an alternative approach to weight management.

The educational process should enhance learning. Learning is a process that involves change and considers the characteristics of the learner. The NP is an adult with responsibilities for health promotion and accumulated experience in nutrition and weight management. For this health education module, the adult nurse practitioner is the learner and the targeted audience. Thus, Malcolm Knowles' (1990) andragogical model of learning provides the framework

for the module. Knowles defines andragogy as the art and science of helping adults learn.

Although Knowles (1990) did not illustrate his principles in a conceptual format, Zylstra (1998), created a conceptual visualization of these principles. This visual model presents the basic principles of adult learning which enhance comprehension of adult learning principles (Figure 1). An adaptation of this model, specific to this project, appears in Figure 2, Adult Learning Principles Applied to New Perspectives on Women, Weight and Culture. It illustrates the application of Knowles' adult learning principles in formulating a health educational module for the NP. The descriptions in Figure 2 are based upon the literature review and expanded upon in Chapter 3, the literature review. Each principle is stated and is followed by a description of its relevance to this project.

Knowles' principles of adult learning assert that:

1) <u>Adults "need to know" the importance of why they need to learn something before undertaking to learn it.</u>

Adults have strong beliefs about what educational offerings are needed to enhance clinical practice. In addition, adults may also weigh the value of participating in a learning experience before committing their time. An educational module directed toward the NP needs to include information that identifies the importance of the information to the learner. The `need to know' provides the ideal opportunity to use educational materials with NPs to

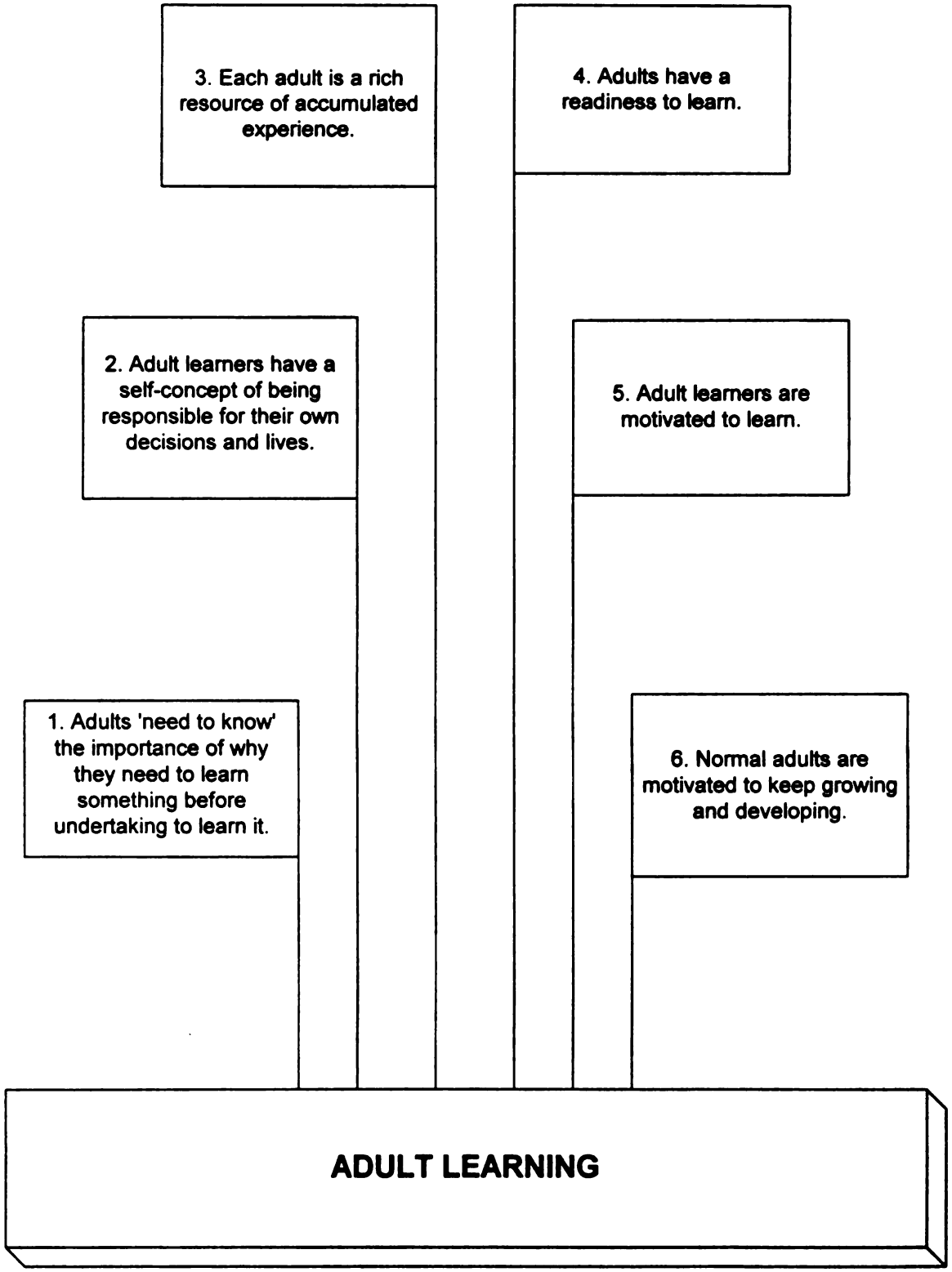

Figure 1 - Knowles' (1990) Priniciples of adult learning as visualized by L. Zylstra (1997)

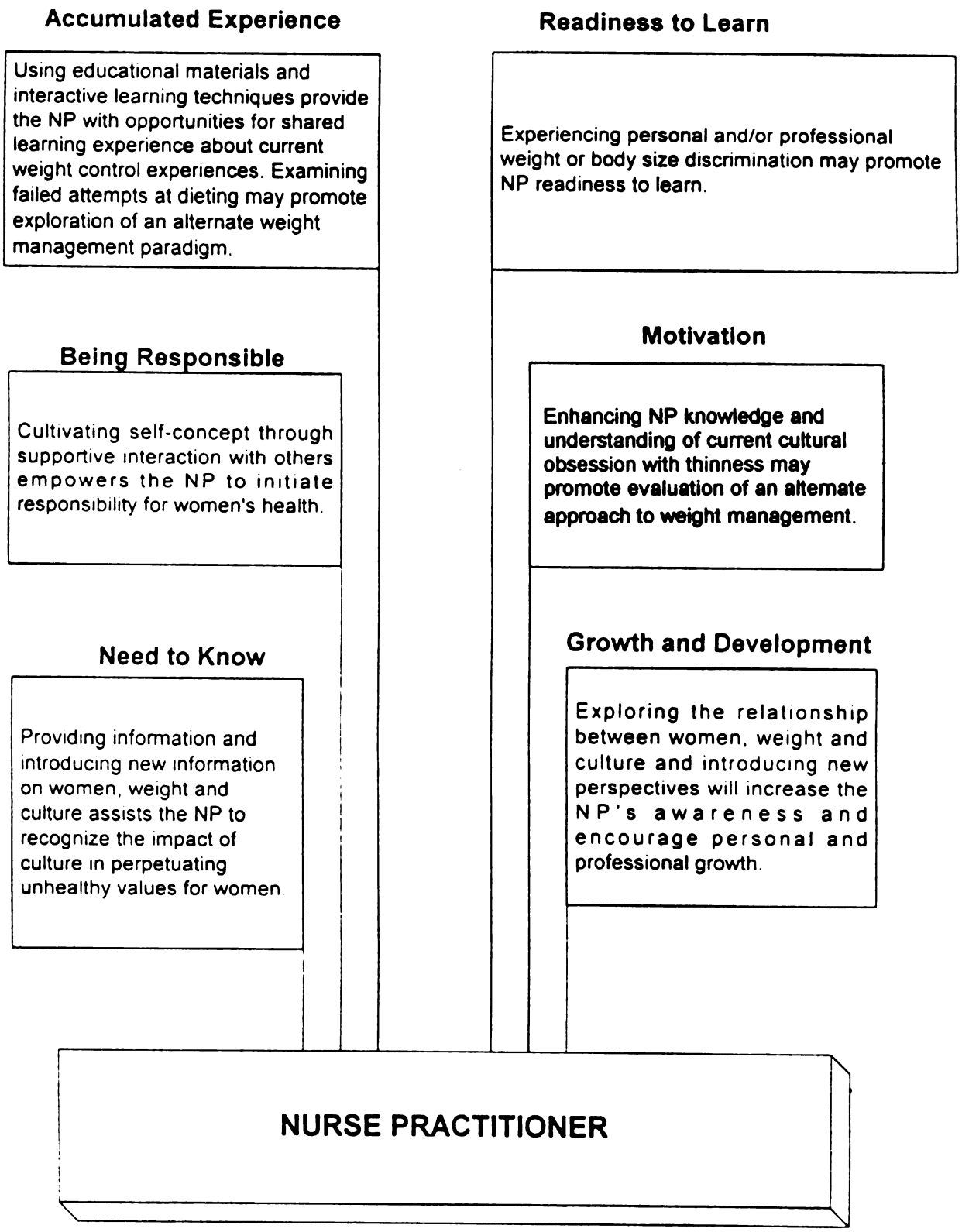

Figure 2 - Knowles' (1990) Principles of Adult Learning Applied to New Perspectives on Women, Weight and Culture

assist them to recognize the impact of Western culture on women and the drive for thinness. Additionally, exploring the failure of current weight control practices to maintain weight loss may be the perfect opportunity to introduce an alternative weight management paradigm.

2) Adult learners have a self-concept of being responsible for their own decisions and lives.

Adults are individuals who have accepted the responsibility for their own lives. Adults are self-directed in decision making and in facing the consequences of those decisions. Taking responsibility for learning and being accountable for their own professional development are characteristics of the adult learner. The NP has the responsibility to promote health for women. Introducing information regarding a new health perspective may improve the NP's self-concept and meet the learner's objective toward professional growth and development. Supportive interactions with others in a respectful, supportive environment enhances self-directed learning (Knowles, 1990).

3) Each adult is a rich resource of accumulated experience.

Adults in educational programs have diverse backgrounds and a variety of personal and professional experiences. The richest resources for learning resides within adult learners (Knowles, 1990). Past experience helps adults view their world differently and interpret accumulated experience in meaningful ways; for example, the NP has accumulated

experience in weight control practices (Knowles). Experiential learning, such as group discussions and problem-solving techniques draws upon the experience of the NP and can assist with formulating new perspectives.

There are some negative effects of accumulated adult experiences (Knowles, 1990). These experiences may predispose learners to acquire biases which impair the ability to form different perceptions, new ideas or alternate ways of thinking. Exploring and sharing one's personal experiences and attitudes toward women of size with those of other health care providers may enable the NP to provide more compassionate care. Recognizing the failure of traditional weight management of women may provide the impetus to evaluate alternate weight management strategies for women.

4) Adults have a `readiness to learn'.

Adults are ready to learn those things they need to know and thus increase their ability to cope effectively with their real-life situations (Knowles, 1990). The NP who has encountered personal and/or professional experience with failed weight management or has experienced weight discrimination may be ready to learn to explore an alternate weight management paradigm.

5) Adults are motivated to learn.

Adults are life centered learners. Values, attitudes, knowledge, skills and understanding are learned more effectively when they are presented in real-life situations

(Knowles, 1990). A health educational module presenting an alternative weight management paradigm could provide the NP with new perspectives on women, weight and culture and enhance the NP's innate motivation to learn.

6) Normal adults are motivated to keep growing and developing.

Adults are motivated to keep growing and developing. Internal pressures of self-esteem and quality of life are potent motivators (Knowles, 1990). Professional people are more likely to seek learning because of intrinsic motivation, such as responsibility for clients, self-fulfilment, achievement or a desire to improve task performance (Abruzzese, 1996). A health education module for the NP which focuses on an alternative approach to weight management may provide impetus and a resource for personal and professional growth.

Chapter 3

LITERATURE REVIEW

Aesthetic preference for body shape and size varies from culture to culture (Fontaine, 1994). Historically, women's social value has been inseparable from their bodies and conflicting social values have been the catalyst for change (Brown & Jasper, 1993). Fraser (1997) cites current morality, medicine, the value of body size as an economic status symbol, modernism, consumerism and changing women's roles as factors which promote thinness in today's society. In order to understand this current obsession with weight and body size in Western culture, it is important to examine the historical and cultural evolution of these concepts.

Cultural Perspective

Prior to the nineteenth century, plump women with full breasts were the erotic ideal (Fontaine, 1994). A plump wife was a sign of fertility, wealth and evidence of her husband's economic success and the result of a righteous life. In the Victorian era, fat was sexual and affectionately referred to as the silken layer. After the Civil War, energy and vigor became fashionable and there was a shift to an active lifestyle.

Female preoccupation with thinness and dieting began when Western women received the ability to vote in the early 1920s (Wolf, 1991). The previous curvaceous form was rapidly replaced with the linear body form. After World War II, women's bodies became fuller as women were engrossed again in traditional domestic roles of raising children and caring for the household. Wolf views these weight shifts as a historical solution to the dangers proposed by the feminist movement which offered increased opportunities for women associated with increased economic and sexual freedom. As the women's movement began to give women a sense of effectiveness, power, courage and high self-esteem, the dominant culture created an emphasis on thinness. This counter force resulted in weight preoccupation and chronic dieting leading to anxiety, passivity and low self-esteem.

Cultural pressure for thinness has continued to evolve over the last forty years spanning the 1960's to the 1990's as changing gender roles in contemporary society influenced the way in which the sexes viewed their bodies (Garner & Wooley, 1991; Rodin, 1993). Several authors (Garner & Wooley, 1991; Shisslak & Crago, 1994; & Wolf, 1991) have observed an association between peak activity of women's efforts to gain power and diminishing body size. As women have moved into previously male-dominant roles, the traditional curvaceous female body shape is viewed negatively while the masculine shape continues to symbolize competency and self-discipline. Meeting cultural goals is

intrinsically rewarding as it satisfies personal needs for recognition, security and achievement. Failure to meet the cultural goals provokes anxiety (Emmons, 1994).

Cultural prejudice against fat and toward thinness is called weightism (Levine & Hill, 1991). The social stigma against obesity is widespread and has significant psychological and social implications. An aversion to obesity and negative stereotyping begins early in life. People consistently associate larger body type with such negative adjectives as stupid, lazy, sloppy, bad, ugly, self-indulgent, and undisciplined (Kassirer & Angell, 1998). Widespread prejudice and contempt against overweight people has emerged as the extremely thin woman represents the cultural norm. Public contempt against people, based solely on their weight, is one of the few remaining prejudices accepted in Western culture.

Role of the Media

Culture ascribes values to body shape, weight and size. Technology in contemporary Western society has enabled these concerns to reach new heights (Rodin, 1993). The rise of the media in the twentieth century functions as the primary stimulus for encouraging thinness and promoting the current obsession with weight control (Fontaine, 1994). Marketing strategies capitalize on women's fear of fat by promoting self-consciousness and personal discontent (Garner & Wooley, 1991). The impact of the media is associated with promoting socially acceptable norms of thinness. Advertisers promote

the thin body ideal to sell products based on a sense of inadequacy (Ogen & Evans, 1995). Comparison between the media and self creates shame and dissatisfaction. Media exposure has been linked to eating disorder symptomatology through gender role endorsement, body dissatisfaction and ideal stereotype internalization.

Advertising and the media are powerful educational forces. The current emphasis on excessive thinness for women is one of the most obvious examples of advertising's influence on individual behavior and cultural standards (Kilbourne, 1994). The current obsession with weight is enormously profitable for the media and numerous corporations. The diet industry has tripled over the last ten years, increasing from a $10 billion to a $30 billion a year industry with projections to $50 billion in the next five years (Kilbourne, 1994).

The visual and print media, including magazines, books, television and videos, serve as major catalysts for promoting thinness and obsession with weight control (Fontaine, 1994). Clothing retailers and fashion designers promote body dissatisfaction and propagate the cultural ideal by associating good looks and a thin body with a glamorous and stress-free life (Fontaine, 1994).

Mass media's representation of women during the last forty years also reflects changes in eating disorder epidemiology during the same time span. The weight of the female sex symbol decreased dramatically during this time as

popular publishing began marketing the thinness ideal (Harrison & Cantor, 1997). A significant increase of thin models in popular women's magazines was observed accompanied by a substantial increase in the number of diet and exercise articles. Garner and Wooley (1991) reported that 69% of *Playboy's* centerfolds and 60% of Miss America Pageant contestants weighed at least 15% below expected body weight; this is an indication of anorexia.

Current Weight Control Practices

The decision to restrict eating or to diet is generally made for self-improvement. The expectation is that dieting boosts feelings of well-being, improves appearance and enhances health (Polivy, 1996). Dieting to lose weight is a widespread practice among women (French, Perry, Leon, & Fulkerson, 1994). The strong societal emphasis on physical appearance and slimness has prompted intense body preoccupation and a willingness to attempt any weight-loss strategy (Rodin, 1993). Dieting has been implicated as a causal factor in the development of unhealthy behaviors and eating disorders specific to weight control, such as purging and binging. The failure of food restriction or dieting to make one's body more personally and socially appealing can create low self-esteem and self-worth (Brown & Jasper, 1993).

A classic study of the psychological impact of semi-starvation and food restriction was conducted by Keys, Brozek, Mickelson and Taylor (1950) during World War II.

Thirty six conscientious war objectors of normal weight were studied to detect the effects of starvation. Prior to conducting the experiment, all participants were screened to guarantee that they were physically healthy and psychologically adjusted. In measured time frames, food was reduced to half of the previous intake. Several psychological reactions, i.e., emotional disturbances, apathy, lethargy, irritability, decreased libido and social withdrawal, were observed during the phase of food restriction. Interestingly, after the study ended and the participants were restored to their normal weight, psychological problems remained. This research suggests that detrimental psychological effects are associated with semi-starvation in previously healthy men.

The psychological effects of semi starvation observed by Keys et al. (1950) can be seen in a variety of current weight loss programs such as Weight Watchers, Optifast and Nutri-Slim that promote restrained eating. Participants restrict calories and initially lose weight, become hungry, lethargic, irritable, sedentary and socially isolated. Weight gain ensues as participants begin binging on restricted foods. Restrained eating and chronic dieting produces symptoms of chronic hunger and semi-starvation (Fraser, 1997).

Restrained eating results in a multitude of psychological disorders. Compared to unrestrained eaters, restrained eaters have scored as more emotionally labile on

personality measures such as self-esteem, anxiety measures, narcissism scales and general measures evidenced by the California Personality Inventory Test (Polivy, 1996). The high prevalence of dieting has also led to weight fluctuations. Weight fluctuations over time appear to result in high stress levels and diminished well-being. Studies have found a strong correlation between weight fluctuation and death from all causes (Brown, & Jasper, 1993).

French et al. (1994) studied 852 adolescent females to evaluate psychological variables and health behaviors over a three-year period. Participants were divided into frequent dieters, intermittent dieters, and non-dieters. Although a higher body mass index (BMI) was predictive of dieting behavior, this group also found that dieters of normal weight outnumbered overweight dieters. The results of this study showed that frequent dieters had higher BMI, and were more likely to report weight fluctuations compared to intermittent or non-dieters. Frequent dieters were more likely than intermittent or non-dieters to use diet pills, laxatives, self-induced vomiting or enemas to lose weight. Dieters in this study scored more negatively on psychological scores such as maturity, fears, ineffectiveness, friendship and self concept than did non-dieters. These authors concluded that frequent dieting behavior in adolescents may be indicative of disordered

eating behavior. Other suggestions included prevention programs for frequent dieters.

The traditional weight management and weight control paradigm focuses on weight loss as a measurable outcome. As a result, 15-35% of Americans are trying to lose weight (Kassirer & Angell, 1998). Unsafe weight control practices include commercial weight loss groups, very low calorie diets, fasting, diet pills, binging and purging, yo-yo dieting, laxatives, liposuction and excessive exercise (French et al., 1994; Serdula et al., 1993). Pharmaceutical agents recently prescribed for rapid weight loss have been detrimental to health. Dexfenfluramine is associated with potentially fatal pulmonary hypertension; olestra causes a loss of essential vitamins, and fen-phen may be associated with serious and occasionally fatal valvular diseases of the heart (Kassirer & Angell). Studies have shown that despite the cultural weight obsession, weight loss is not sustained by many dieters. People who diet regain one to two thirds of the lost weight within one year, almost all weight is regained within five years, and many gain back more than they have lost (Robison, 1997; Kratina, King, & Hayes, 1996).

Weight and Body Size

The current pervasive incidence of body dissatisfaction has been termed `normative discontent' and has been linked to social norms of thinness and appearance (Ogden & Evans, 1995). Shape dissatisfaction is endemic in adolescents and

young women even when their weight falls within the normal range. Culturally acceptable body size is ingrained early in life and these social norms become the criterion for self-evaluation (Fontaine, 1994).

The "ideal" body shape in Western culture is unattainable for most women. In a normal weight distribution, only five percent of women approximate this ideal (Steiner-Adair, 1994). In the recent Nurses Study, a body mass index (BMI) between 20 and 27 was not associated with increased health risks. However, the message emerged that a BMI of 19 or less was the "ideal" number to which women should aspire (Robison, 1997). A BMI at this level is an indicator of anorexia nervosa (Robison, 1997).

Cultures tend to stigmatize behaviors and traits believed to be within an individual's control. Prejudice against overweight individuals in Western culture is accepted as it is believed to be the individual's "fault" (Segal-Isaacson, 1996). As a result, overweight individuals are viewed as failures, lacking will power and looked upon with contempt. Body size is seen as a reflection of an individual's ability to engage in self-corrective behavior (Rodin, 1993). Weight becomes a moral issue, a social hindrance and a character flaw (Fontaine, 1994).

The glamorization of thinness is a critical factor in the development of eating disorders and self-image distortions. Anorexia and bulemia are at epidemic proportions in adolescents and young people who develop

dangerous and bizarre eating behaviors (Kassirer & Angell, 1998). Women spend an excessive amount of time, energy and money on external appearances deflecting attention and energy from that which might empower them (Zerbe, 1993; Kilbourne, 1994).

Examining the value placed on weight and body size means challenging the beauty myth that propagates low self-esteem in women unable to live up to the cultural ideal. Shisslak and Cargo (1994) identify four benefits of challenging the beauty myth: 1) freedom from habitual appearance anxiety, 2) gains in money, time and energy, 3) increased sense of validity, and 4) an increase in health and physical comfort (p.420).

Attitudes of Health Care Providers

Culture encompasses learned patterns of behavior and beliefs characteristic of a particular society. Individuals and groups of people transmit cultural rules, norms and ideals (Fontaine, 1994). Health care providers are products of their culture and are not immune to the cultural beliefs and attitudes held by society (Peternelj-Taylor, 1989).

Health care providers have a responsibility to promote the health of individuals, the community and society. Providers of health care have a challenging task of evaluating their own beliefs and values regarding body weight and shape (Fontaine, 1994). Educating health care providers about fat prejudice is vital to improving health (Burgard, & Lyons, 1994). Compassionate health care and

separating body weight and size from self-worth is critical to improving health outcomes.

One of the most common health promotion activities for nurse practitioners in the primary care setting is weight management. Research has shown that past behavior may predict future behavior when habitually performed (Hoppe & Ogden, 1997). These authors used a cross-sectional questionnaire to examine practicing nurses' beliefs about obesity, their current weight management practices, and the context in which the advice is given. This study also explored the relationship between the nurses' beliefs and behavior in relation to their own body mass index (BMI). Overall, the nurses rated lifestyle factors as more important causes of obesity than biological factors. Additionally, the nurses' own BMIs appeared to influence their beliefs and behaviors regarding obesity prevention.

Sansone, Sansone and Wiederman (1998) conducted a study to explore the use of health care resources comparing obese and non-obese patients in a health maintenance organization *(HMO)* primary care setting. Results revealed that an increasing BMI was predictive of a greater number of contacts with the facility, increased number of prescriptions, greater number of physicians seen and a greater number of diagnoses. To account for the increased number of physicians seen, these authors concluded that obese individuals may have legitimate concerns about negative attitudes from health care professionals. Obese

patients may be hesitant to continue with a single physician due to embarrassment around weight and body issues and may be hesitant to return to the same physician who prescribed a weight loss program if they have not met the prescribed weight loss goal. A limitation of this study was the absence of psychosocial or psychological measures which may have contributed to the medical distress.

Health professionals must recognize the harmful consequences of comparing individuals with social norms of thinness. Treatment interventions based on weight comparisons provide negative reinforcement and can have harmful effects on patient self-esteem (Ogden & Evans, 1995). These authors investigated the effect of weighing and the manipulation of social norms on body dissatisfaction, mood and self-esteem. Seventy-four participants were categorized as underweight, normal weight and overweight according to a fictional height and weight chart. Results of this study suggested that weighing an individual and comparing these weights to the social norms resulted in decreased mood and self-esteem in participants who were assessed as overweight. While weighing patients is viewed as a neutral activity, it may be detrimental to the psychological and physical health of the individual. These authors suggested considering other measures to evaluate the success of obesity treatment.

To investigate attitudes of nurses regarding weight and sex, Peternelj-Taylor (1989) conducted an investigation

using a volunteer sample of 100 nurses to study the phenomenon of mutual withdrawal. The purpose of the study was to investigate the impact of obesity on the nurse-patient relationship and to determine if patients were perceived differently based on weight and sex. Nurses evaluated obese patients more negatively and as less socially attractive in comparison to the non-obese patient. There was a negative bias toward obese men and the authors contended that previous studies revealed female health professionals attributed more favorable attributes to females than males. The results of this study suggest that nurses are not immune to learned stereotypes and biases regarding obesity. These authors recommended further research to explore reciprocal withdrawal of patients from obese nurses and the effect on the nurse-patient relationship.

The cultural prejudice against fat has a significant impact on self-esteem and self-acceptance (Fontaine, 1994). Cross-sectional studies have shown that young women who are chronic dieters have greater depression, negative affect, body dissatisfaction and lower self-esteem when compared to non-dieters (French et al., 1994).

The traditional standard practice of weight management has a high failure rate in maintaining and sustaining weight loss (Murphree, 1994). Health care providers, physicians and nurses frequently encounter women with weight and body size concerns particularly between the ages of twenty-four

and forty-four as this age range has the highest occurrence of major weight gain. Murphree used a focus group of twenty-six women with a mean BMI of 39.5 to discuss why their experiences with traditional weight management regimens had been unsuccessful. Participants were asked to name problems they attributed to their weight, previous diet modifications and exercise involvement. None of the participants found diet sheets, low calorie recipes, dietary referral or behavior modification helpful. Several participants thought that food deprivation and dieting failure led to feelings of low self-esteem and anger. They also suggested that alternative approaches might include group therapy, group exercise, instruction in modification of currently used recipes, dietary modification that addressed food texture and taste, and consideration of transportation and childcare issues.

In 1992, the National Institute of Health Consensus Conference concluded that current treatment for obesity had failed abysmally and future efforts should focus on approaches that produce health benefits independent of weight loss. Transition from the traditional model which is based on personal transformation to the new model of health which is based on health and self-acceptance, requires health professionals to challenge previous values and treatment modalities. Values, personally held attitudes or beliefs about the beauty and truth or worth of another

individual, object or action are used to guide daily behavior or action (Raines, 1993).

Alternate Weight Management Paradigm

An alternative paradigm for weight management is emerging. The focus is on total health and wellness solutions. Health promotion and self-acceptance are the goals of this new paradigm (Burgard & Lyons, 1994). Health encompasses integration and balance of spiritual, emotional, mental and physical aspects of life. Weight is merely one measurement of physical health and physical health is only one component of total health (Robison, 1997). The new paradigm is opposed to dieting; it's fundamental premise is that people can improve the quality of their lives despite body size (Berg, 1995; Robison, 1997).

The alternate paradigm proposes three major foci for people with health concerns and the health professionals working with them. The goal is for health professionals to integrate these approaches in their practices and thus empower clients to live healthier, more fulfilled lives in the bodies they presently have. The major foci are: 1) self-acceptance: provide affirmation and reinforcement of human worth irrespective of differences in physical size and shape, 2) physical activity: provide skills and support for increasing social, pleasure-based movement for enjoyment and enhanced quality of life; and 3) normalized eating: provide skills and support for discarding externally imposed rules and regimens for eating and attaining a more peaceful

relationship with food by relearning to regulate intake in response to physiological and satiety cues (Robison, 1997 p. 31).

The new weight management paradigm is a new philosophy; therefore, emerging research and program evaluations are only beginning to be published. Presently, limited published results from research studies implementing this approach are available.

Steinhardt and Nagel (1995) examined the effectiveness of a non-diet approach on the problem of compulsive overeating. Their subjects who were readers of *Overcoming Overeating* reported decreases in eating preoccupation, body preoccupation and emotional eating over a two-year period. Limitations of the study included a convenience sample and lack of physiological measures.

Cliska (1990) studied the effects of a 12-week educational and experiential group program on chronically obese women. Improvements in restrained eating and self-esteem were reported with short term improvements in drive for thinness, depression, body dissatisfaction and social adjustment. During the intervention and at the six-month posttest, no observed changes in weight, fasting glucose, serum cholesterol, lipids or blood pressure were reported.

Carrier, Steinhardt and Bowman (1994) conducted a worksite wellness program using the alternative approach over a three-year period. These authors reported a significant improvement in the level of physical activity,

self-nourishment, restrained eating, self acceptance and self-esteem. These authors chose not to measure body weight but recommended further studies assessing physiological measures.

One respected insurance agency in the United States, Kaiser Permanente, has implemented a major revision of its approach to weight management which acknowledges dieting failure and the myth that thin must be healthy (Robison, 1997). This organization promotes size acceptance, recognizes body diversity and recognizes the connection between physical health and emotional well being. In addition to improving eating and exercise behavior, a stable weight is endorsed, even if this weight is higher than what the culture accepts.

Canada's nationwide health program, *Vitality*, combines three components of the new health based model, i.e., feeling good about one's self, eating well, and being active (Berg, 1995). The preventive efforts focus on young adults ages twenty-four to forty-four. Individuals in this age group have been identified as being influential in helping others change as well as being high risk candidates for developing diabetes, cancer and heart disease. This nationwide health program de-emphasizes weight loss and fosters self-empowerment within the social system.

Health Education Module

Adults learn differently than children although the process is related. Knowles (1990) maintains that adults

are task or problem-oriented learners rather than subject centered learners and are self-directed regarding intentions, choices, initiative, energy, freedom and responsibility. Adults draw from past life experience and life-stage developments. The adult is released from the teacher as the source of knowledge and becomes competent by assuming responsibility for learning (Schlomer, Anderson, & Shaw, 1997).

Preparing and implementing a health education module involves the same problem solving approach as the nursing process. Assessment, planning, implementation and evaluation need specific consideration for participant involvement and evaluation of the module.

In assessing the content of health education, data should be based on health problems, interests and needs (Fodor & Dalis, 1989). A learning assessment should include the level of health knowledge, health practices, kinds of health interests, and growth and development characteristics within specific age groups (Fodor & Dalis, 1989).

The planning process involves identifying goals and learning objectives. Goals are broad-statements of the direction or intent of the educational module and are more general than objectives. Learning objectives are important in planning, teaching and evaluating educational sessions. Objectives are statements of desired, teachable, observable and learnable behaviors which learners can exhibit after the learning situation (Ferguson, 1998). In health instruction,

objectives should relate to skill development, idea development, information acquisition, opinion expression and development, and values awareness (Fodor & Dalis, 1989).

Implementation is the process of planning and using learning activities formulated to meet the learning objectives. For learning to be effective, facilitators must adapt to a variety of learning styles. Learning styles vary from gender to gender and from person to person. Thirty to forty percent of learners are visual, twenty to thirty percent are auditory , twenty to twenty-five percent are tactual and twenty to twenty-five percent are kinesthetic (Dunn & Dunn, 1993). Using a variety of learning styles will stimulate a variety of senses and facilitate learning.

Instructional strategies are a series of critical steps used to attain an objective. The teaching strategy about values awareness encourages exploration of personal values. Values instruction may be used to motivate and arouse interest. Implementing this strategy for a value laden health topic permits the participants to analyze existing values and examine values that may impair actions, decisions or judgements (Fodor & Dalis, 1989). In addition, new or other values may be introduced for examination.

To implement a health education module, a series approach is more conducive to learning than a singular approach. A series approach allows the participant, i.e., NP, to evaluate the material introduced, apply new

knowledge and discuss the impact of this learning experience with other group members (Fodor & Dalis, 1989).

Regardless of time available for instruction, sequencing of information can considerably affect the learner's ability to understand, integrate, retain and transfer learning (Alspach, 1995). When sequencing is well planned, facts, concepts, and principles are gradually introduced and interrelated (Alspach, 1995). Time is a valuable resource for adults and educators must use this resource in the most effective and efficient way possible.

Using videotapes as a method of instruction has become an appealing teaching and learning activity as a variety of senses are stimulated (Abruzzese, 1996; Rankin & Duffy-Stallings, 1990). Seventy percent of learning occurs through listening, observing and discussing (Abruzzese). Videotapes present places, experiences and situations that can recreate life situations, thus encouraging participants to explore understandings and attitudes. In addition, videotapes can facilitate discussion. The videotape chosen should be suited to meet the learning objectives.

Using printed media in the form of magazines or handouts is a familiar medium for learning (Alspach, 1995). Most handouts are easy to obtain and learners may refer to them as often as necessary for clarification and reinforcement (Alspach, 1995).

Brainstorming is another creative learning strategy utilized; it is a creative idea generating technique

(Alspach, 1995). Incorporating this strategy encourages spontaneity, involvement in the learning process and can leave the participants feeling energized (Abruzzese, 1996).

In the learning environment, adults often learn more by taking an active role (Carkhuff, 1996). Traditionally, lecture format has been a teaching strategy used to help the interaction between the student and the curricula presented. In this linear format, the teacher controls the information being presented and the student is a passive recipient. Lecturing conflicts with adult learning theory and is incongruent with autonomous decision-making used by nurses in clinical practice (Schlomer et al., 1997).

Group discussions help the learning process as they provide opportunities for adults to share ideas, literature, research and experience in practice (Wilkinson & Wilkinson, 1996). Such groups provide `real world' learning by solving real life problems (Carkhuff, 1996). Peer interaction in group discussions may prompt questioning to explore perspectives or alternative ideas.

Evaluation is a necessary component of an educational program. There are several purposes for conducting program evaluations. First, evaluation assesses the content and may assist in program expansion. Second, evaluations become the foundation for improving the educational program. The strengths and weaknesses of the facilitator, the effectiveness of educational strategies and instructional techniques, material resources and the organization of

health instruction reflect the impact of the instructional process. Third, an evaluation assesses the extent to which the participants attain specific outcomes (Fodor & Dalis, 1989; Rankin & Duffy-Stallings, 1990).

The NP must realize that the transition from a dieting and weight loss approach to health, wellness and enhancement of quality of life approach may be difficult. It is essential that the NP create a respectful, safe, nurturing environment free of weight and body size bias to examine health issues. Barriers to respectful care must be recognized and eliminated to affect change in current practice. A health education module which assists the NP to evaluate personal values and cultural influence that propagate continued unhealthy weight management is essential in order to realize the desired transition. An introduction to an alternate weight management paradigm may provide the impetus for the NP to evaluate current weight management practices and to promote optimal wellness by including alternative weight management modalities.

In summary, this literature review examined selected concepts which are the foundation for new perspectives on women, weight and culture; it identified the basic components required in order to develop a health education module for the NP.

CHAPTER 4

THE DEVELOPMENT OF THE HUBERT HEALTH EDUCATION MODULE

The Hubert Health Education Module (HHEM) for NPs addresses new perspectives on women, weight and culture and is based upon an extensive literature review, Knowles' (1990) principles of adult learners and selected operational definitions. This chapter includes a discussion of the module's a) learning objectives, b) major content areas, c) implementation and organizational issues, d) instructional strategies, and e) evaluation. The format is similar to that of the sample product, Appendix A. However, the product's layout has been designed for easy use by the NP facilitator; e.g., an outline form with brief bullet descriptions rather than full sentences and an agenda with suggested time frames for individual sessions.

The HHEM is designed to increase the NP's awareness of the impact of culture in encouraging body dissatisfaction and unhealthy eating practices in women. It also provides an approach to enable the NP to evaluate this information and to recognize alternate approaches to health despite weight or body size. This module is not intended as an in-depth exploration of the alternate paradigm, but rather a brief introduction to this paradigm with suggestions and

resources for further investigation. Thus, the specific goals of this module are to: (1) recognize and challenge the cultural ideals and values that promote disordered eating of women, (2) evaluate current weight control practices and recognize the harmful effects of dieting, and (3) develop an awareness of an alternative approach to weight management.

Permission to implement the HHEM will be given by the author. In accordance with this agreement, facilitators will be asked to provide verbal or written feedback to the author regarding content and outcome evaluation.

Target Group

The HHEM is targeted at the individual NP within the context of groups of NPs. An alternate approach might be a self-study module although this method of implementation was not selected as Knowles' (1990) asserts that interactive learning and sharing accumulated experience are consistent with adult learning and often adults learn more by taking an active role in learning (Carkhuff, 1996). A group size of twenty-five to thirty-five participants is proposed to promote group cohesiveness and encourage interaction among participants.

The facilitator for the HHEM will be a NP with experience in the primary care setting and a focus on health for women. The NP should be knowledgeable about the topic and be able to answer a wide variety of questions.

Setting

The setting for this program should be a comfortable well-lit room. A conference room in a hospital or a primary care clinic would be suitable. If the HHEM is presented as a break-out session in conjunction with a one or two day seminar, a smaller room would be conducive to learning. Since interactive learning and round table discussion are appropriate educational approaches to utilize, a large table or circular formation of chairs would be ideal to promote group cohesiveness and participation (Wilkinson & Wilkinson, 1996).

Cost

It is anticipated that this program would be provided at no cost or minimal cost to NP participants. Some educational materials may need to be purchased. Frequently rooms are available in hospital and primary care settings at no cost for educational purposes. However, if the HHEM is sponsored by and presented in conjunction with an educational program, the cost of the room may be incorporated into the conference fee.

Time Frame

Although a series approach is supported by the literature (Fodor & Dalis, 1989), there may be conflicts with time commitments and ability of the adult NP to attend several hour long sessions. A three hour time frame, divided into three one hour sessions and sequentially presented information would meet the goals of the HHEM and

would allow for continuity of learning (Alspach, 1995). As adults place high value on their time, this time frame might be the window of opportunity to introduce the NP to this new perspective related to women, weight and culture.

Instructional Materials

The literature supports the use of a variety of instructional strategies in order to adapt to a variety of individual learning styles (Dunn & Dunn, 1993). As presentation of information is important for promoting adult interest, a variety of available materials and videos were reviewed. One video, Slim Hopes, was selected because it presented experiences and situations that recreated life situations and could facilitate discussion (Rankin & Duffy-Stallings, 1990). The videotape, **Slim Hopes: Advertising and the Obsession with Thinness** (Kilbourne, 1995) is a thirty two minute video which depicts how the media and culture influence an individual's self image and promotes eating disorders. This video may be obtained by contacting the Media Education Foundation at (800) 897-0089.

Several handouts have been reviewed and selected for the HHEM. They will be provided to participants for reference, clarification and reinforcement of presented information (Alspach, 1995). These handouts include: 1) **Ten Top Reasons To Give Up Dieting** which may be obtained free by contacting the Council on Size and Weight Discrimination at (914) 679-1209, 2) **Weight Management: Traditional vs. The Nondiet Approach,** a comparison table which lists components

of the traditional approach to weight management with components of the new weight management paradigm. This handout may be used with permission of the co-author, Nancy King, from the book *Moving Away from Diets*, at [818-957-8588], 3) **Basic Tenents of Health at Every Size** which promotes self-esteem and acceptance of people regardless of body size and may be obtained from the book *Moving Away from Diets* or by contacting jikeda@garnet.berkley.edu., 4) **Loving Your Body** which encourages self respect and self-acceptance. This handout was also selected from the book *Moving Away from Diets* and may be reproduced for educational purposes, and 5) **Fat Acceptance Behavior Assessment**, also obtained from the book *Moving Away From Diets* written by the National Association to Advance Fat Acceptance (NAAFA). This selection may be used for educational purposes with permission by contacting NAAFA at (800)-442-1214. This self-evaluation form encourages the NP participant to examine personal values related to dieting and body size and should encourage values exploration. The relevance of each instructional strategy will be discussed as it is integrated into each session. The printed media can be easily duplicated at a nominal fee.

Supportive equipment for the HHEM is consistent with the objectives of the module (Rankin & Dully-Stallings, 1990). A television with a video cassette recorder (VCR) is needed in order to view the selected video, Slim Hopes: Advertising and the Obsession with Thinness. Many hospitals

and primary care settings have a VCR available as an instructional tool as it is frequently used by health educators. In addition a chalkboard or a marker board may be used to assist with visualizing ideas suggested by the NP participants.

Instructional Assumptions for Adult Learners

As the audience consists of adult NPs, the teaching/learning process needs to accommodate the needs of adult learners. Adults command respect as mature individuals who bring into a learning situation a large reservoir of life and work experiences (Knowles, 1990). As problem centered learners, adult readiness for learning is dependent on the demands and problems that confront them daily with the intention of applying this learning to solve problems in their present roles and responsibilities. Adults are self-directed in their learning and need to be provided with opportunities to evaluate the effectiveness of instruction in relation to their own goals and experience. As voluntary and knowledgeable learners, adults often engage in learning activities for a variety of personal and professional reasons (Abruzzese, 1996). Adults work best with instructors and colleagues who interact with them and who are also subject to the same imperfections (Abruzzese, 1996). Negative past learning experiences may prohibit adults from fully participating in a learning environment. Instructors must provide a learning environment conducive to a positive learning experience. Adults may be less flexible

with learning if habits, attitudes and perspectives differ significantly from what they are accustomed to or from what they have personally experienced. Adults also have multiple responsibilities and place high value on their time (Abruzzese, 1996).

Outline for the Module

The following sections reflect the structure selected for this three hour health education module. Each section is organized with background information for the NP facilitator, objectives for each session, instructional media specific to each session, and educational methods to meet the learning objectives.

Introduction to the Hubert Health Education Module

This section introduces the HHEM to the NP participants. It reflects the key aspects of the HHEM and encourages NP participants to synthesize the information on a personal level. The HHEM focuses on the impact of Western culture and the media in promoting stringent body size ideals, the dieting strategies implemented in an effort to live up to the cultural "ideal", and an introduction to the alternative weight management paradigm.

Session I.

In order for the NP to recognize and begin to challenge the cultural ideals and values that promote body dissatisfaction for women, an increased awareness of the issue needs to occur. Thus the objective of Session I is to heighten the NP's awareness of culture and the role of the

media in perpetuating body dissatisfaction and low self-esteem for women.

Instructional Methods. A variety of instructional methods are proposed to meet this learning objective as each NP reflects on personal and cultural value placed on body size. Group discussion about value awareness permits all participants to analyze existing values and examine values that may impair actions, decisions or judgements (Fodor & Dalis, 1989). Peer interactions in group discussions may prompt questioning to explore new perspectives (Wilkinson & Wilkinson, 1996). Using videotapes for instruction serves to facilitate discussion and encourage participants to explore values. The videotape, **Slim Hopes: Advertising and the obsession with thinness** (Kilbourne, 1995) was selected. This is a thirty- two minute video which depicts how the media and culture influence an individual's self-image and promotes eating disorders. Recognizing and discussing how women are portrayed via this medium should provide the learner with new perspectives on women and weight. After viewing the video, interactive discussion is planned.

Background Information for the NP Facilitator. The NP facilitator needs to have knowledge about the topic of interest. This section describes the significant information from the literature review and assists the NP facilitator for preparation of Session I.

Attitudes of Health Care Providers. Culture encompasses learned patterns of behavior and beliefs

characteristic of a particular society. Individuals and groups of people transmit cultural rules, norms and ideals (Fontaine, 1994). Literature has shown that health care providers are products of their culture and not immune to the cultural beliefs and attitudes shared by society (Peternelj-Taylor, 1989). Studies have shown that health care providers share the same societal prejudice and negatively stereotype clients who don't or can't live up to the social norms of thinness (Fontaine, 1994).

The NP has a responsibility to promote the health of individuals, the community and society. Providers of health care have a challenging task of evaluating their own beliefs and values regarding body weight and shape (Fontaine, 1994). Educating health care providers about fat prejudice is vital to improving health (Burgard & Lyons, 1994). Compassionate health care and separating body weight and size from self-worth is critical to improving health outcomes.

Weight and Body Size. Shape dissatisfaction is endemic in adolescents and young women even when their weight falls into the normal range. Culturally acceptable body size is ingrained early in life and these social norms become the criterion for self-evaluation (Fontaine, 1994). The "ideal" body shape in Western culture is unobtainable for most women. In a normal weight distribution, only five percent of women approximate this ideal (Steiner-Adair, 1994). Body size becomes a moral issue, a character flaw and a social hindrance (Fontaine, 1994).

Cultural Perspective. Cultures ascribe value to weight and body size and these values vary from one culture to another (Fontaine, 1994). In Western culture, the obsession with thinness for women has evolved over the past forty years as changing gender roles influenced the way women viewed their bodies (Garner & Wooley, 1991; Rodin, 1993). Cultural prejudice against fat is called weightism. Public contempt against people, based strictly on their size, is one of the few remaining prejudices accepted in Western culture. The social stigma against obesity is widespread and has significant psychological and social implications (Levine & Hill, 1991).

Role of the Media. The rise of the media in Western culture has been implicated in encouraging thinness and promoting the current obsession with weight control (Fontaine, 1994). The visual and printed media, including magazines, television, movies, books and videos. They perpetuate the thin ideal and capitalize on women's fear of fat by promoting self-consciousness and personal discontent (Garner & Wooley, 1991; Fontaine, 1994). Comparison between the media's thin ideal and the self creates shame and dissatisfaction. Media exposure has been linked to eating disorders symptomatology through gender role endorsement, body dissatisfaction and ideal stereotype internalization.

Session II.

In order for the NP to recognize the variety of current weight control practices employed by women to live up to the

cultural "ideal" and the harmful effects of these practices, an increased awareness of weight control methods will be examined. Thus, the specific focus of this session is to enable the NP participants to evaluate current weight control practices and recognize the harmful effects of dieting.

Instructional Methods. A variety of instructional methods have been selected to meet the objectives of this session. Brainstorming is a creative learning strategy utilized as an idea generating technique (Alspach, 1995). Incorporating this strategy encourages spontaneity, involvement in the learning process and can leave the participants feeling energized (Abruzzese, 1996). Group discussions facilitate the learning process as they provide opportunities for adults to share ideas, literature, research and experience in practice (Wilkinson & Wilkinson, 1996). Such groups provide `real world' learning by solving real life problems (Carkhuff, 1996). Peer interaction in group discussions may prompt questioning to explore perspectives or alternative ideas. The handout, **Ten Top Reasons To Give Up Dieting** was selected to provide participants with a reference and to generate discussion. Using the printed media, in the form of magazines or handouts is a familiar medium of learning (Alspach, 1995). This approach was selected because the printed media is easy to obtain and learners may refer to them as often as necessary for clarification and reinforcement (Alspach).

Background Information for the NP Facilitator. The NP facilitator needs to have knowledge about the topic of interest. This section describes the significant information from the literature review and assists the NP facilitator for preparation of Session II.

Current Weight Control Practices. The strong cultural emphasis on womens' bodies has prompted intense body preoccupation and a willingness to attempt any weight loss strategy (Rodin, 1993). Dieting to loose weight is a widespread practice among women and studies have shown that 15-35% of women are dieting (French et al., 1994). The diet industry has tripled over the past ten years and is now a $30 billion dollar industry (Kilbourne, 1994). Despite many weight loss strategies, weight loss is not sustained for many dieters; almost all lost weight is regained within five years and many gain back more than they loose (Robison, 1997; Kratina, King, & Hayes, 1996). The drive to become thinner has been implicated as a causal factor in the development of unhealthy behaviors and eating disorders as women strive to become thinner rather than healthier.

Chronic dieting, food restriction, restrained eating and weight fluctuation have detrimental physical, psycho-social and psychological consequences (Fraser, 1997). Among these are decreased self-esteem when failing to maintain weight loss, inability to recognize internal cues of hunger, altered mood states causing fatigue, social withdrawal and decreased libido, physical symptoms including loss of muscle

mass and weight loss with rebound weight gain and weight preoccupation (Keys et al., 1950; Graser, 1997; Robison, 1997; Kratina, Kind, & Hayes, 1996). Weight fluctuations over time appear to result in diminished well-being and death from all causes (Brown & Jasper, 1993).

Session III.

The last session addresses an alternate approach to weight management. It is designed to enhance the NP's awareness of the components of an alternative approach to weight management and evaluate approaches to incorporate the components of the alternative approach into the NP's personal life and/or professional practice.

Instructional Methods. Once again, a variety of instructional methods are utilized to meet the learning objectives of this session. Peer interactions in group discussions may prompt questioning to explore new perspectives (Wilkinson & Wilkinson, 1996). As this information is relatively new and somewhat unfamiliar, several printed handouts have been selected. Using the printed media, in the form of magazines or handouts, is also a familiar medium of learning (Alspach, 1995). Most handouts are easy to obtain and learners may refer to them as often as necessary for clarification and reinforcement (Alspach). The selected handouts were obtained from the book *Moving Away From Diets,* by Kratina, King and Hayes (1996) and include: **Weight Management: Traditional vs. The Nondiet Approach,** a comparison table which introduces

components in the new weight management paradigm and should stimulate discussion; **Basic Tenents of Health at Every Size**, which promotes self-esteem and acceptance of people regardless of body size; and **Loving Your Body** which encourages self respect and self-acceptance.

The last portion of the third session focuses on evaluation. The evaluation consists of two parts; the first is a self-administered assessment form, the **Fat Acceptance Behavior Assessment**, also obtained from the book *Moving Away From Diets*. This self-evaluation form consists of thirty-four questions on a Likert scale. Fat acceptance behaviors are scored and broken down to either harmful behaviors or behaviors that are consistent with body size acceptance, a component of the new paradigm. This form is intended for personal use as a values exploration exercise and should encourage the NP participants to evaluate personal behavior, recognize harmful behaviors and reveal behaviors that will encourage body size acceptance. The second part of the evaluation consists of a written evaluation form to be turned in at the commencement of the three hour health education module; it requests evaluation of the program by the NP participant.

Background Information for the NP Facilitator. The NP facilitator needs to have knowledge about the topic of interest. This section describes the significant information from the literature review and assists the NP facilitator for preparation of Session III.

Alternate Weight Management Paradigm. An alternative paradigm for weight management is emerging. The new paradigm is opposed to dieting and the fundamental premise is that people can improve the quality of their lives despite body size (Berg, 1995; Robison, 1997). Weight is merely one measurement of physical health and physical health is only one component of total health The focus is on total health and wellness solutions.

The alternate paradigm proposes three major foci for people with health concerns and the health professionals working with them. The goal is for health professionals to integrate these approaches into their practices and thus empower clients to live healthier, more fulfilled lives in the bodies they presently have. The major foci are: 1) self-acceptance; provide affirmation and reinforcement of human worth irrespective of differences in physical size and shape, 2) physical activity; provide skills and support for increasing social, pleasure-based movement for enjoyment and enhanced quality of life, and 3) normalized eating; provide skills and support for discarding externally imposed rules and regimens for eating and attaining a more peaceful relationship with food by relearning to regulate intake in response to physiological and satiety cues (Robison, 1997 p. 31).

Evaluation. Evaluation is a necessary component of an educational program. There are several purposes for conducting program evaluation. First, evaluation assesses

the content and may assist in program expansion. Second, evaluation becomes the foundation for improving educational programs. The strengths and weakness of the facilitator, the effectiveness of educational strategies and instructional techniques, material resources and the organization of health instruction all impact the instructional process. Third, evaluation assesses the extent to which the participants attain specific outcomes (Fodor & Dalis, 1989; Rankin & Duffy-Stallings, 1990). This information about evaluation was used to develop a written evaluation form for the HHEM.

The evaluation form for the HHEM was created by this author and is specific for this module. The questions were chosen to evaluate the impact of the HHEM from a program perspective. This is critical for content development and improvement as well as overall program evaluation. Information obtained on the evaluation form may be utilized to adjust content format, reallocate time or implement different instructional strategies.

While content evaluation is important, outcome evaluation assesses the extent to which the participants attain specific outcomes. For the three hour consecutive HHEM, this author chose to measure attainment of objectives from each of the three sessions for a variety of reasons. Affective behaviors, such as newly-acquired beliefs, attitudes or values, cannot be evaluated as readily as other types of learning; it is not possible to their schedule

integration within a specific time period or to appraise them objectively. In order for affective behaviors to be evaluated, learners must have an opportunity to experience a value-related issue, re-examine their beliefs about values and select an appropriate course of action.

Chapter 5

IMPLICATIONS FOR NURSE PRACTITIONERS

The primary health care system serves as an entry point, screening area, and education arena for women with health concerns. The NP is in an excellent position to implement health education to women of all ages. An introduction to different perspectives on women, weight and culture may alter the approach used as the NP reflects upon recent learning experiences and establishes new personal goals. Three major areas of implications arise as a result of the Hubert Health Education Module (HHEM). They are related to practice, education and research.

Practice

The NP assumes various roles in promoting health for women. The role of assessor, client advocate, change agent, collaborator and role model are discussed as they apply to women via this new perspective.

In the role of the assessor, the NP needs to evaluate and screen current health and lifestyle practices. Included in the assessment are the components of the client's well-being and self-esteem, current nutritional practices and physical activity. Of particular importance is the value the NP places on weight and body size and the various weight

control methods proposed to women. Information regarding the client's past or present weight control methods is vital for the NP in determining learning needs and education.

Role modeling a positive body image to women may be a challenging task for the NP. As products of the same culture, the NP often struggles with the same weight and body size issues. When the NP develops personal body comfort and a healthy lifestyle, a positive image is projected. Positive strategies include refusing to participate in discriminatory comments and practices which denigrate women and to accept women as individuals regardless of weight or body size.

The NP acting as change agent in the primary care setting and in the community can have a positive impact by challenging the cultural values that promote body dissatisfaction for women. Consciousness raising is needed regarding the damaging effect of culture and the overemphasis on women's appearance. The NP can accomplish this through public speaking, publications and political activism. The change agent role is utilized when the NP introduces alternate weight management strategies which initiates positive alterations in the individual's values as well as in the health care system.

As a patient advocate, the NP needs to be supportive and not impose personal values on others. Negative attitudes from the NP can affect continuity of care for women unable to live up to the cultural ideal. In being

supportive, the NP assists women to exercise their rights in improving self-care abilities. Furthermore, as a patient advocate, the NP needs to be aware that weight discrimination is unacceptable and needs to be identified and named as a political problem and a form of prejudice.

In collaborative practice, the NP exchanges information and participates in womens' health with other members of the health-care team. To successfully implement a new approach to weight management, the NP may need to collaborate with a variety of health care professionals with similar philosophies. Registered dietitians, occupational therapists, physical therapists and support groups may collaborate to provide comprehensive health services.

The NP who implements this new weight management philosophy may share this approach with other health-care providers. Disseminating information may result in values exploration and enlighten other providers in humane approaches to health care for women.

Education

Education is a key aspect in promoting health. An educational module which heightens the NP's awareness about women, weight and culture may also transform the NP's perspectives. Values exploration may encourage the examination of goals for women's health. Integrating healthy eating, physical activity and compassionate care are congruent with promoting healthy lifestyles.

The suggested three hour time frame for the HHEM should be flexible with the needs of the learner, the allotted time for implementation and the environment in which the information is presented. While one one hour session time frame is appropriate for presentation of the proposed information, the NP facilitator may choose to alter the outline and time format. This author suggests utilizing the proposed outline and time frames as a pilot approach while evaluating alternate time sequencing strategies. Establishing flexibility with each session and adapting alternate methods of organization may evolve after evaluating the pilot program.

Implementing the HHEM as a series approach, for example, an hourly session at three different pre-determined intervals over time may have a different impact on the participants' learning and affective behavior. The benefit to the learner might be opportunities to apply the new information between sessions, examination of beliefs and values as a result of the learning experience and discussion regarding the impact of the learning experience with peers at subsequent sessions.

Continuing education is essential with the changing health-care trends. The NP is responsible for remaining competent, providing quality patient care and maintaining high standards of care. The American Nurses Credentialing Center (ANCC) is a national group which provides several options for staff development departments to become

accredited or approved (Abruzzese, 1996). Accreditation of nursing staff development programs for continuing education credits may vary from state to state according to mandatory education requirements. Many states have additional regulations determined through their state boards of nursing. To encourage attendance, the NP facilitator could contact the American Nurses Credentialing Center for information about awarding contact hours to participants (Abruzzese, 1996).

To alleviate the process of obtaining contact hours for the individual NP facilitator, the HHEM could be sponsored by and be integrated into an organized one or two day NP seminar. There are several advantages to this proposal. The aggregate cost of instructional materials, photocopying fees, administrative fees, electronically scored evaluation forms and contact hours would be incorporated into the cost of the conference. Program coordinators would facilitate the process and provide information regarding available time frames. Education programs frequently have break-out sessions. Presenting the HHEM as a break-out session would assure a population interested in the chosen topic.

NPs from local areas are frequently involved in setting up educational opportunities on topics of shared interest and flyers are circulated for topics under discussion. To elicit participation for the HHEM and provide incentive for attendance, the NP facilitator could contact local groups or

advertise in local hospital newsletters or primary care centers.

Many health-care organizations, public-school systems and business organizations integrate diversity into their curriculum. Public contempt against people based solely on their weight is one of the few remaining prejudices allowed in Western culture. If people can be educated that it is wrong to discriminate against people based on cultural heritage, race, age, sex and physical challenges then they can be also educated to recognize that discrimination based solely on weight is equally harmful. The NP needs to be an educator and lead by example by refusing to participate in perpetuating the cultural stereotype. This means educating people to love, respect and celebrate their bodies and to appreciate the qualities of humor, empathy, warmth and compassion toward people of all sizes.

Although the HHEM has been developed to be utilized specifically by the NP, it can also be adapted for use with other organizations whose interests lie in women's health, thus it could be presented at a variety of locations. For example women's workgroups, local YWCA's and groups which promote wellness and holistic approaches to health.

Incorporating the HHEM into undergraduate and graduate nursing curriculum should be addressed. Many programs address nutrition and exercise but fail to address the cultural component that promotes body dissatisfaction and low self-esteem for women. This module could be presented

to curriculum committees for content evaluation or incorporated into classes on women's health.

Research

NPs are often involved in research as research helps guide practice. In order to evaluate the long term effectiveness of implementing a health education module on women, weight and culture, measurable outcomes are necessary.

To evaluate the impact of the HHEM over time, an outcome evaluation in the form of a mailed self-reporting questionnaire could assist with evaluating beliefs or value changes that persisted after the learning experience. Typically, these evaluations occur three to six months after the learning intervention.

Longitudinal studies would be helpful in determining if the impact of the HHEM has long-term effects on changes or improvements in the client and NP therapeutic relationship. Focusing on health and wellness rather than weight loss may positively influence client acceptance of their body size, improve self care, and increase self-esteem.

Summary

In summary, a health education module for the NP which introduces a new perspective related to health for women presents an opportunity for the NP to explore personal values, evaluate current clinical practice and introduce alternate management modalities into personal practice. Providing new information on the interrelationship between

women, weight and culture should assist the NP in recognizing the impact of culture in perpetuating unhealthy values for women. The HHEM should provide the NP with the "need to know", encourage participation, and foster personal and professional growth and development. Knowles' adult learning principles provide an appropriate framework for the HHEM; it treats adult learners intelligently and respects their knowledge gained from previous learning.

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APPENDICES

APPENDIX A

A NEW PERSPECTIVE ON WOMEN, WEIGHT, AND CULTURE:

THE HUBERT HEALTH EDUCATION MODULE FOR NURSE PRACTITIONERS

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1999

IMPLEMENTING THE HUBERT HEALTH EDUCATION MODULE

The Hubert Health Educational Module (HHEM) is designed to increase the NP's awareness of the impact of culture in encouraging body dissatisfaction and unhealthy eating practices in women. It also provides an approach to enable the NP to evaluate this information and recognize alternate approaches to health despite weight or body size. This module is not intended as an in-depth exploration of the alternate paradigm, but rather a brief introduction to this paradigm with suggestions and resources for further investigation.

Permission to implement the HHEM will be given by the author. In accordance with this agreement, facilitators will provide verbal or written feedback to the author regarding content and outcome evaluation.

Goals
- Recognize and challenge the cultural ideals and values that promote body dissatisfaction for women
- Evaluate current weight control practices and recognize the harmful effects of dieting
- Develop an awareness of alternative approaches to weight management

Target Group
- The individual NP within a group context
- Proposed total group size @25-35 to promote group cohesiveness

Facilitator
- NP with experience in primary care settings with a focus on health for women
- Knowledgeable about topic and able to answer a wide variety of questions

Setting
- Comfortable well-lit room
- Large table or circular formation of chairs

Cost
- Provide at no cost or minimal cost to NP participants
- If sponsored by conference; cost could be included in conference fee

Time Frame
- Three hour presentation which is divided into three one-hour sessions
- May adjust according to format
- Sequentially presented information

Instructional materials

- VCR
- Chalkboard or marker board
- Video tape **Slim Hopes: Advertising and the obsession with thinness**
  (May be obtained by contacting the Media Education Foundation (800) 897-0089).
- Handouts
  - **Ten Top Reasons To Give Up Dieting**
    (May be obtained by contacting the Council on Size and Weight Discrimination (914) 679-1209. May be copied with copyright intact.)
  - **Weight Management: Traditional vs. The Nondiet Approach**
    (May be obtained from the book, *Moving Away from Diets* with permission from the author, Nancy King, at (818) 957-8588)
  - **Basic Tenents of Health at Every Size**
    (May be obtained from the book, *Moving Away from Diets* or by contacting jikeda@garnet.berkley.edu)
  - **Loving Your Body**
    (May be obtained from *Moving Away from Diets* book and may be reproduced for educational purposes)

Evaluation

- Course evaluation
- Self evaluation-**Fat Acceptance Behavior Assessment**
  (May be obtained from the book, *Moving Away from Diets* or for education purposes by contacting NAAFA at (800) 422-1214

Instructional Assumptions for Adult Learners

- Adults need to know the importance of why they need to learn something before undertaking to learn it
- Adult learners have a self-concept of being responsible for their own decisions and lives
- Each adult is a rich resource of accumulated experience
- Adults have a readiness to learn
- Adult learners are motivated to learn
- Normal adults are motivated to keep growing and learning
- *References*: Abruzzese, 1996 and Knowles, 1990.

Outline for the Module

The following sections reflect the structure selected for this three hour health education module. Each section includes background information for the NP facilitator, instructional methods specific to each session's objectives, the goals and objectives, an agenda, and learning strategies to meet the learning objectives.

INTRODUCTION

You may introduce the HHEM content in a manner that best suits your personal and educational style. The following introduction may be used to provide background information for your use or employed as a script.

Many women feel dissatisfied with their bodies and diet in an attempt to conform to the cultural ideal. An alternative weight management paradigm is emerging which asserts that women can improve the quality of their lives regardless of weight and body size. Transition from the traditional model which is based on personal transformation to the new model of health which is based on health and self-acceptance, requires that health professionals challenge previous values and treatment modalities. This experience, guided by Malcolm Knowles adult learning principles, will encourage you to explore your personal values and cultural influences regarding weight and body size and will introduce basic components of an alternate paradigm to weight management. You are in a perfect position by virtue of your education and experience in weight management to incorporate this information and form new perspectives.

SESSION I

Background Information for the NP Facilitator

Instructional Methods

- Group discussion about value awareness permits the participants to analyze existing values and examine values that may impair actions, decisions or judgements
- Peer interactions in group discussions may prompt questioning to explore new perspectives
- Videotapes for instruction can serve to facilitate discussion and encourage participants to explore values
- *References*: Fodor & Dalis, 1989,; Kilbourne, 1995 and Wilkinson & Wilkinson, 1996.

Attitudes of Health Care Providers

- Culture encompasses learned patterns of behavior and beliefs characteristic of a particular society
- Individuals and groups of people transmit cultural rules, norms and ideals
- Health care providers are products of their culture and not immune to the cultural beliefs and attitudes shared by society
- Educating health care providers about fat prejudice is vital to improving health
- Compassionate health care and separating body weight and size from self-worth is critical to improving health outcomes
- *References:* Burgard & Lyons, 1994,; Fontaine, 1994 and Peternelj-Taylor, 1989.

Weight and Body Size

- Shape dissatisfaction is endemic in adolescents and young women even when their weight falls into the normal range
- The "ideal" body shape in Western culture is unobtainable for most women
- In a normal weight distribution, only five percent of women approximate this ideal
- Body size becomes a moral issue, a character flaw and a social hindrance
- *References:* Fontaine, 1994 and Steiner-Adair, 1994.

Cultural Perspective

- **Cultures ascribe value to weight and body size**
- **In Western culture, the obsession with thinness for women has evolved over the past forty years as changing gender roles influenced womens' views of their bodies**
- **Public contempt against people, based strictly on their size is currently an acceptable form of prejudice in Western culture**
- **The social stigma against obesity is widespread and has significant psychological and social implications**
- ***References*: Fontaine, 1994,; Garner & Wooley, 1991,; Levine & Hill, 1991,; Rodin, 1993, and Wolf, 1991.**

Role of the Media

- **The rise of the media in Western culture has been implicated in encouraging thinness and promoted the current obsession with weight control**
- **Visual and print media, including magazines, television, movies, books and videos market the thin ideal and capitalize on women's fear of fat by promoting self-consciousness and personal discontent**
- **Comparison between the media and the self creates shame and dissatisfaction**
- ***References*: Fontaine, 1994 and Garner & Wooley, 1991.**

OUTLINE FOR SESSION I (APPROXIMATELY 1 HOUR)

Goal

- **The NP will recognize and challenge the cultural ideals and values that promote body dissatisfaction for women**

Objectives

Upon completion of this session the NP will be able to:

- **Describe the impact of culture and the media in promoting the "ideal" body shape for women**
- **Discuss how women are stereotyped based on weight and body size**

Agenda

I. Introduction (approximately 10 minutes)

A. Introduction of the NP facilitator
B. Introduction of the NP participants
C. Brief overview of the three hour learning module
D. Review of the objectives for Part 1

II. Culture and the media: Activities and group discussion (approximately 50 minutes)

A. Using interactive discussion, have the audience brainstorm and list adjectives/characteristics of the "ideal" woman. May give examples from popular television shows, movies, fashion models or entertainers. List them on one side of the chalkboard. On the other side of the chalkboard, list the adjectives/characteristics of women who fail to live up to the cultural "ideal". May give examples from popular television shows, movies, fashion models or entertainers. Compare the lists.

B. If time permits, other questions to ask could include:

1) What do the "ideal" women in Western culture have in common?
2) What is the "ideal" body shape for women.
3) What are various body sizes and shapes of women.
4) How do you feel when you compare yourself with the "ideal"?
5) What do you value in women?

C. View the video *Slim Hopes: Advertising and the Obsession with Thinness*.

1) Discuss the impact of this video on the group's perception of the influence of the media and culture on women's self image and the promotion of unhealthy weight control practices.
2) Break between Session I and Session II (approximately 10 minutes)

SESSION II

Background Information for the NP Facilitator

Instructional Methods

- Brainstorming is a creative learning strategy utilized as an idea generating technique
- This strategy encourages spontaneity, involvement in the learning process and can leave the participants feeling energized
- Group discussions facilitate the learning process as they provide opportunities for adults to share ideas, literature, research and experience in practice
- Peer interaction in group discussions may prompt questioning to explore perspectives or alternative ideas
- **Ten Top Reasons To Give Up Dieting** provides a reference for discussion
- Using the printed media, in the form of magazines or handouts is a familiar medium of learning
- Most handouts are easy to obtain and learners may refer to them as often as necessary for clarification and reinforcement
- *References*: Alspach, 1995,; Fodor & Dalis, 1989,; Wilkinson & Wilkinson, 1996.

Current Weight Control Practices

- The strong cultural emphasis on women's bodies has prompted intense body preoccupation and a willingness to attempt any weight loss strategy
- Dieting to loose weight is a widespread practice among women
- The diet industry has tripled over the past ten years and is now a $30 billion dollar industry
- Despite many weight loss strategies, weight loss is not sustained for many dieters as almost all lost weight is regained within five years and many gain back more than they loose
- The drive to become thinner has been implicated as a causal factor in the development of unhealthy behaviors and eating disorders as women strive to become thinner rather than healthier
- Chronic dieting, food restriction, restrained eating and weight fluctuation have detrimental physical, psycho-social and psychological consequences
- Consequences are decreased self-esteem in when failing to maintain weight loss, inability to recognize internal cues of hunger, altered mood states causing fatigue, social withdrawal and decreased libido, physical symptoms including loss of muscle mass and weight loss with rebound weight gain and weight preoccupation

- **Weight fluctuations over time appear to result in diminished well-being and death from all causes**
- ***References*: French, et., al, 1994,; Kratina, King & Hayes, 1996.; Robison, 1997 and Rodin, 1993.**

OUTLINE FOR SESSION II (APPROXIMATELY 1 HOUR)

Goal

- **Evaluate current weight control practices and recognize the harmful effects of dieting**

Objectives

- **1.Describe several current weight control practices**
- **2.Identify the detrimental effects of dieting**

Agenda

I. Review of the objectives for session II (approximately 5 minutes)
II. Current weight control practices: Activities and group discussions(approximately 15 minutes)

A) Depending on the size of the group, have NP participants break up into small groups or have the NP facilitator implement an interactive group dialogue. Ask participants to make a list of all of the diets or weight loss strategies they have heard of, have personally tried or have suggested to clients. If necessary prime the group with suggestions, i.e., slim fast, grapefruit and egg, cabbage soup, diuretics, laxatives etc. and have each group share the list. The facilitator may use the chalkboard to make the list visible to participants. Discuss the variety of weight control practices women use to live up the cultural "ideal". Discuss whether weight loss has been maintained.

III. The harmful effects of dieting: Activities and group discussion (approximately 30 minutes)

A) How do you feel or how do other women feel when dieting?

1) **Discuss the psychological effects and consequences of dieting**
   a) **inability to recognize internal cues of hunger**
   b) **food obsession**
   c) **binging and purging behavior**
   d) **weight fluctuation and failure to maintain weight loss**
   e) **decreased self-esteem**
   f) **altered mood states (lethargy, fatigue)**
   g) **social withdrawal**
   h) **decreased libido**
   i) **weight preoccupation**

B) Refer to and discuss the handout Ten Top Reasons to Give Up Dieting

Break between Session II and session III (approximately 10 minutes)

SESSION III

Background Information for the NP Facilitator

Instructional Methods

- Peer interactions in group discussions may prompt questioning to explore new perspectives
- As this information is relatively new and somewhat unfamiliar, several printed handouts can be provided
- Using the printed media, in the form of magazines or handouts is a familiar medium of learning; most handouts are easy to obtain and learners may refer to them as often as necessary for clarification and reinforcement
- *References:* Alspach, 1995 and Wilkinson & Wilkinson, 1996.

Alternate Weight Management Paradigm

- The new paradigm is opposed to dieting and the fundamental premise is that people can improve the quality of their lives despite body size
- Weight is merely one measurement of physical health and physical health is only one component of total health
- The focus is on total health and wellness solutions
- Health professionals need to integrate this new approach into their practices and thus empower clients to live healthier, more fulfilled lives in the bodies they presently have
- The major interventions to use are:
  1) Self-acceptance;.provide affirmation and reinforcement of human worth irrespective of differences in physical size and shape
  2) Physical activity; provide skills and support for increasing social, pleasure-based movement for enjoyment and enhanced quality of life
  3) Normalized eating; provide skills and support for discarding externally imposed rules and regimens for eating and attaining a more peaceful relationship with food by relearning to regulate intake in response to physiological and satiety cues
- *References:* Berg, 1995 and Robison, 1997.

Evaluation

- Part I- The participants submit the written evaluation at the conclusion of the Session III
  1) Assesses the content and may assist in program expansion/revision
  2) Assess the extent to which the participants attain specific outcomes

- **Part II- Fat Acceptance Behavior Assessment, a self administered assessment form intended for values exploration and the NP's personal use**
- ***References:* Alspach, 1995, Fodor & Dalis, 1989 and Rankin & Duffy-Stallings, 1990).**

OUTLINE FOR SESSION III (APPROXIMATELY 1 HOUR)

Goal

- Develop an awareness of an alternate approach to weight management

Objectives

- Identify the components of the new weight management paradigm
- Discuss ways the alternate approach could be incorporated into personal life and/or professional practice

Agenda

I. Review the objectives for session III (approximately 5 minutes)
II. New weight management paradigm: Activities and group discussion (approximately 30 minutes)
   A) Refer to the hendout **Weight Management: Traditional vs. The Nondiet Approach**
      1) Generate interactive discussion comparing and contrasting each component of the traditional (dieting) paradigm with the new weight management or nondiet paradigm. The components are:
         a) self-acceptance;.provide affirmation and reinforcement of human worth irrespective of differences in physical size and shape
         b) physical activity
         c) normalized eating
   B) Refer to the handout **Basic Tenents of Health at Every Size**
      1) Generate a discussion based on the tenents listed
      2) Discuss the concept of appearance stereotyping and body size acceptance
   C) Refer to the handout **Loving Your Body**
      1) Generate a discussion on self-respect and self-acceptance
      2) Reflect on methods to integrate body size acceptance into your personal and professional lives
III. Summarize the learning module and refer participants to the resource list
IV. Evaluation (approximately 10 minutes)
   A) Administer and collect the course evaluation form.
   B) Distribute the handout **Fat Acceptance Behavior Assessment** form.

APPENDIX B

HHEM EVALUATION FORM

Please complete this evaluation form. The information you provide is important and will be used to assess the content of this educational offering and will assist the facilitator in future presentations.

	Strongly Agree				Strongly Disagree
1) Were the facilities comfortable?	1	2	3	4	5
2) Was the facilitator knowledgeable about the content and prepared to answer questions?	1	2	3	4	5
3) Was the information clearly presented?	1	2	3	4	5
4) Were the objectives written clearly and relevant to each session?	1	2	3	4	5
5) Were the handouts helpful?	1	2	3	4	5
6) Were the instructional methods effective?	1	2	3	4	5
Objectives					
Based on my participation in this educational offering, I am able to:					
1) Describe the impact of culture and the media in promoting the "ideal" body shape for women	1	2	3	4	5
2) Discuss how women are stereotyped based on weight and body size.	1	2	3	4	5
3) Describe several current weight control practices	1	2	3	4	5
4) Identify the detrimental effects of dieting	1	2	3	4	5
5) Identify the components of the new weight management paradigm	1	2	3	4	5
6) Discuss ways the alternate approach could be incorporated into my personal life and/or professional practice.	1	2	3	4	5

Comments?

How did you learn about the program?

APPENDIX C

Reference List for Nurse Practitioner Facilitators

Video

Slim hopes: Advertising and the Obsession with Thinness by Kilbourne, J. (Creator).[Videotape]. (Available from the Media Education Foundation, 26 Center Street, North Hampton, MA 01060 or (800) 897-0089. Cost: $75.00.

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APPENDIX D

Resources for Nurse Practitioner Participants

Books

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Organizations

International No Diet Coalition
Council on Size & Weight Discrimination
P.O. Box 305
Mt. Marion, NY 12456
(914) 679-1209

National Association to Advance Fat Acceptance, Inc. (NAAFA)
P.O. Box 188620
Sacramento, California 95818
(916) 558-6880
(800) 442-1214
Internet address: http://naafa.org

APPENDIX E

Top Ten Reasons To Give Up Dieting

#10: Diets don't work. Even if you lose weight, you will probably gain it all back, and you might gain back more than you lost.

#9: Diets are expensive. If you didn't buy special diet products, you could save enough to get new clothes, which would improve your outlook right now.

#8: Diets are boring. People on diets talk and think about food and practically nothing else. There's a lot more to life.

#7: Diets don't necessarily improve your health. Like the weight loss, health improvement is temporary. Dieting can actually cause health problems.

#6: Diets don't make you beautiful. Very few people will ever look like models. Glamour is a look, not a size. You don't have to be thin to be attractive.

#5: Diets are not sexy. If you want to be more attractive, take care of your body and your appearance. Feeling healthy makes you look your best.

#4: Diets can turn into eating disorders. The obsession to be thin can lead to anorexia, bulimia, bingeing, and compulsive exercising.

#3: Diets can make you afraid of food. Food nourishes and comforts us, and gives us pleasure. Dieting can make food seem like your enemy, and can deprive you of all the positive things about food.

#2: Diets can rob you of energy. If you want to lead a full and active life, you need good nutrition, and enough food to meet your body's needs.

And the number one reason to give up dieting:

#1: Learning to love and accept yourself just as you are will give you self-confidence, better health, and a sense of well-being that will last a lifetime.

Weight Management: Traditional vs. The Nondiet Approach

	Diet Paradigm	Nondiet Approach
WEIGHT	Achieving and maintaining ideal weight as close as possible, used as measure of success.	Body will seek its natural weight as individual eats in response to physical cues of hunger and fullness, as well as a sense of well-being and pleasure.
HUNGER	Attempt to suppress or ignore hunger. Transgressions associated with lack of will power or "giving in." Physical and emotional hunger confused.	Physical cues to eat are valued and relied upon. Responding to physical hunger and fullness (with occasional emotional eating) will bring about natural weight.
EXERCISE	Reaching and maintaining goal weight is dependent on exercise, which is often dropped when individual falls off diet. It is seen as a "have to" or "should," which commonly produces exercise resistance.	Physical activity, listening to body, seeking play, and natural movement are explored. Not connected to weight loss or change of body size or shape.
FOOD	Moralized as good/bad, legal/ illegal, should/shouldn't, on/off diet. Variety, quantity, calories, fat grams, etc., determined by external source, i. e. the diet, health care provider, the parent, etc.	Neutralized. All food is acceptable. Quantity, quality, and frequency are determined by individual exploring and responding to physical cues, sense of well-being, taste, and medical values (such as blood glucose levels). It is self-regulated, internally cued, and nonrestrained.
SELF-ESTEEM and SIZE ACCEPTANCE	Individual typically gains a false sense of power and control with weight loss, adherence to diet, and exercise plan. Self-esteem and body acceptance rarely improve. This goal is elusive as one can get thinner, more toned, or both.	Increase in self-esteem and personal power from self-determined eating style and movement. Bodies come in all sizes and are naturally beautiful. Cultural norms are recognized as hazardous; pursuit of these standards can interfere with quality of life.
TRUST/ DISTRUST of SELF and BODY	Individual may come to distrust body and sense of judgment, especially with history of failure. Trust is placed primarily in diet or provider.	Trust develops in self and body by discerning physical cues and freely responding to them without judgment or criticism.

BASIC TENETS OF HEALTH AT EVERY SIZE

- Human beings come in a variety of sizes and shapes. We celebrate this diversity as a positive characteristic of the human race.
- There is no ideal body size, shape, or weight that every individual should strive to achieve.
- Every body is a good body.
- Self-esteem and body image are strongly linked. Helping people feel good about their bodies and about who they are, can help motivate and maintain healthy behaviors.
- Appearance stereotyping (beauty-is-good, homely-is-bad) is inherently unfair to the individual because it is based on superficial factors that the individual has little or no control over.
- We respect the bodies of others even though they might be quite different from our own.
- Each person is responsible for taking care of his or her body.
- Good health is not defined by body size; it is a state of physical, mental, and social well-being.
- People of all sizes and shapes can reduce their risk of poor health by adopting a healthy lifestyle.

Conclusion

Health promotion programs should celebrate the benefits of a healthy lifestyle. Programs should be sensitive to size diversity. They should promote body satisfaction, and the achievement of realistic and attainable health goals without regard to weight change.

Developed by Dietitians and Nutritionists who are advocates of size acceptance; their efforts coordinated by Joanne P. Ikeda, MA, RD, Nutrition Education Specialist, Department of Nutritional Sciences, University of California, CA 94720-3104. Comments regarding these tenets may be sent to <jikeda@garnet.berkeley.edu>.

Fat Acceptance Behavior Assessment

1= never 2= rarely 3= occasionally 4= frequently 5= daily

How often do you:

1. make negative comments about your fatness _____
2. make negative comments about someone else's fatness _____
3. directly or indirectly support the assumption that no one should be fat _____
4. say something that presumes being fat is unhealthy _____
5. say something that presumes being thin is healthy _____
6. say or assume that someone is "looking good" because she or he lost weight _____
7. say something that presumes that a fat person wants to lose weight _____
8. say something that presumes that a fat person should lose weight _____
9. say something that presumes that fat people eat too much or "the wrong things" _____
10. disapprove of someone for gaining weight _____
11. assume something is "wrong" when someone gains weight _____
12. admire weight loss dieting or rigidly controlled eating _____
13. admire compulsive or excessive exercising _____
14. tease someone about his or her eating (habits or choices) _____
15. criticize someone's eating to a third person ("so-and-so eats way too much junk") _____
16. discuss food in terms of "good or bad" _____
17. talk about "being good" and "being bad" in reference to eating behavior _____
18. say something that presumes being thin is better (or more attractive) than being fat _____
19. comment that you don't wear a certain style because "it makes you look fat" _____
20. comment that you love certain clothing because it "makes you look thin" _____
21. participate in a "fat joke" by telling one, or laughing, or smiling at one _____
22. support the diet industry by buying their services or products _____
23. undereat or exercise obsessively to maintain an unnaturally low weight _____
24. encourage someone to let go of guilt _____
25. encourage or admire self acceptance and self-appreciation or love _____
26. encourage someone to feel good about his or her body as is _____
27. openly admire a fat person's appearance _____
28. openly admire a fat person's character, personality, or actions _____
29. oppose or challenge fatism verbally _____
30. oppose or challenge fatism in writing _____
31. challenge or voice disapproval of a "fat joke" _____
32. challenge myths about fatness and eating _____
33. compliment ideas, behavior, character, etc. more often than appearance _____
34. support organizations which advance fat acceptance (with your time or money) _____

Behaviors # 1-23 are not helpful or downright harmful to a heavy person's mental health. Look over your 3-4-5 answers to isolate areas that need improvement. Strive to avoid these and similar behaviors in the future.

Behaviors # 24-34 show fat acceptance and are consistent with the size acceptance movement. Reread items where you marked 1 or 2; make a list of realistic goals for increasing supportive behavior.

Adapted from survey by Susan Kano for National Association to Advance Fat Acceptance
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