# “I HATE MY BODY”

# TAKING A WEIGHT INCLUSIVE APPROACH WITH ADOLESCENTS

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# DISCLOSURE OF CONFLICT OF INTEREST & FUNDING

- The authors whose names are listed immediately below disclosed that:
  - no financial relationship, in **any amount**, exists between the authors in control of content and an ineligible company
  - are both employed full-time by the Eating Recovery Center

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# LEARNING OBJECTIVES

1

Participants will be able to identify signs of "diet culture" messages in popular culture and personal beliefs and contrast these with a weight-inclusive approach.

2

Participants will be able to articulate at least one negative impact of "diet culture" on eating disorder development.

3

Participants will be able to know how to apply at least two benefits of a weight-inclusive care approach in their practice.

# Weight Inclusive Approach

# WEIGHT INCLUSIVITY

- Approach to health and well-being that recognizes and respects that bodies naturally come in a wide range of shapes and sizes

- Instead of focusing on weight as a measure of health, a weight-inclusive approach prioritizes supportive behaviors, individualized care, and the reduction of weight stigma

- Began appearing in clinical discussions in the late 1990s and early 2000s and has become more widely recognized in clinical settings throughout the 2010s and 2020s

# HEALTH AT EVERY SIZE ®

## A Weight Inclusive Approach to Health

### The goal of HAES is to accept and respect the natural diversity of body sizes and shapes

- Teaches people to eat in a flexible manner that focuses on enjoyment while honoring internal hunger and fullness cues
- Removes the focus from weight and treats the whole person, including physical, psychological, and emotional well-being

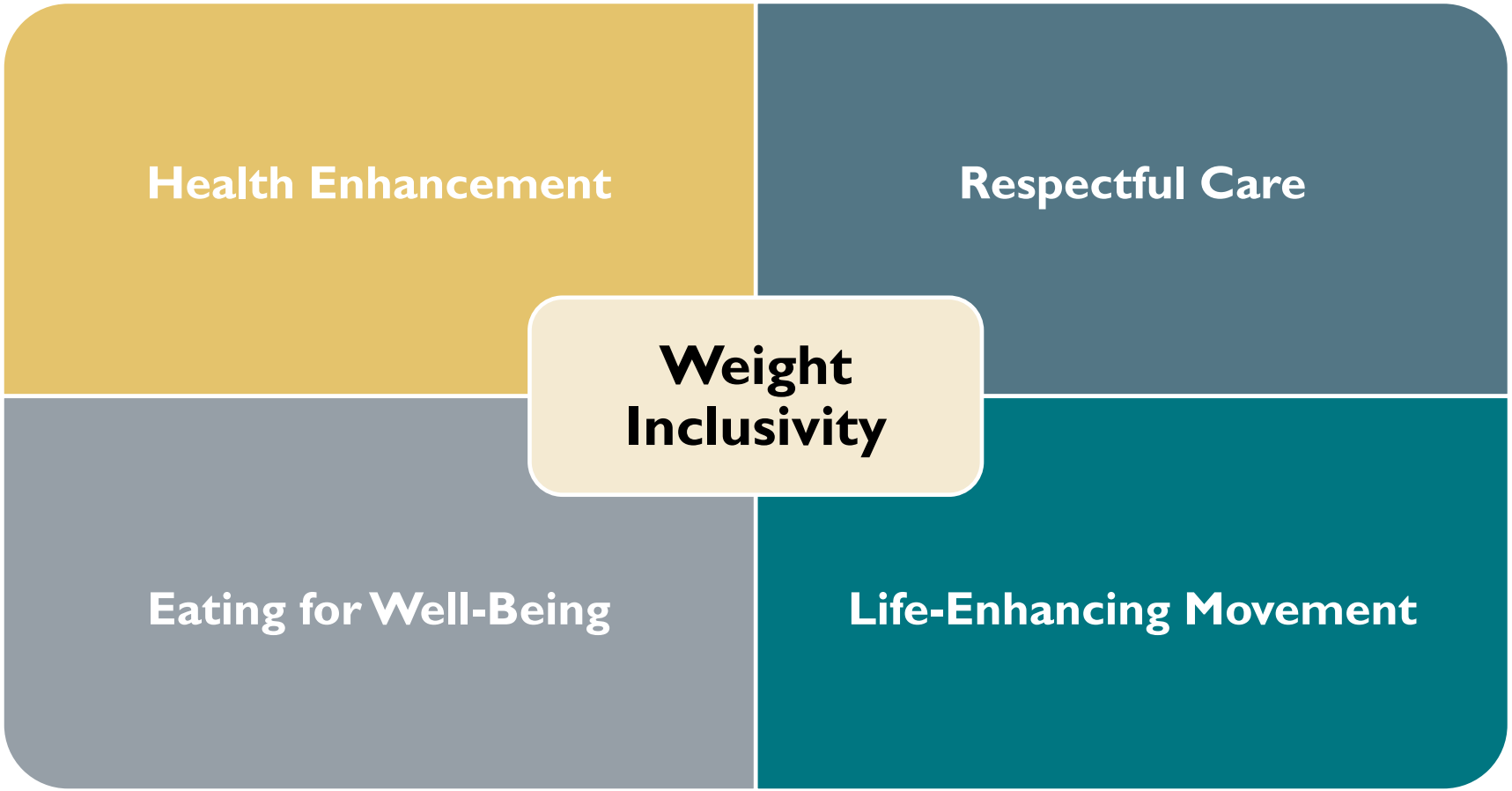
### HAES seeks to show the divide between health and body weight and size

- Backed by research and is not just about being more compassionate
- Supports improved healthy behaviors for people of all sizes without using weight as a mediator

# HEALTH AT EVERY SIZE ® MISCONCEPTIONS


- Anti-weight loss
- Anti-health
- Anti-science and medical nutrition therapy
- Exercise and nutrition doesn't impact health
- HAES practitioners can't work with people who desire weight loss
- It's just for people in larger bodies

# HEALTH AT EVERY SIZE ® PRINCIPLES



# HEALTH ENHANCEMENT

- Focuses on expanding access to evidence-based care, supportive environments, and health-promoting behaviors for everyone—without tying health to body size.
- Shifts the focus from "fixing weight" to improving health resources, opportunities, and behaviors.

| Traditional Weight Loss Paradigm | Health at Every Size |
|---|---|
| Everyone can be thin, happy, and healthy by dieting. | Dieting usually leads to weight gain, decreased self-esteem and increased risk for disordered eating. |
| To be healthy you must be thin. | • Health is shaped by:<br>  • access to safe spaces<br>  • income and food access<br>  • discrimination<br>  • stress<br>  • community support<br>  • environmental conditions<br>• Improving these factors often has a greater impact on health than weight-focused interventions. |


# EATING FOR WELL BEING

- Means supporting people in developing a positive, sustainable and enjoyable relationship with food that honors hunger, fullness, satisfaction, and cultural traditions.
- Focuses on how we eat, why we eat, and how food supports our lives—not about controlling body size
- Promotes intuitive eating & food neutrality
- Avoids demonization or glorification of food

# RESPECTFUL CARE

- Emphasizes providing compassionate healthcare and support that is free from weight bias, stigma, and discrimination.
- Calls for creating healthcare experiences where people of all body sizes are treated with dignity, listened to fully, and offered evidence-based care that does not assume weight is the cause—or the solution—to every health concern.
- It's about creating a clinical environment where people feel safe, valued, and understood regardless of their body size.

# LIFE ENHANCING MOVEMENT

- Encourages people of all sizes to engage in physical activity that feels enjoyable, accessible, and supportive of overall well-being.
- Rejects the idea that movement must be tied to weight loss, punishment, or "earning food," and instead reframes movement as a source of pleasure, connection, and vitality.
- Means supporting people in finding ways to move their bodies that bring joy, comfort, and energy—regardless of their size, ability, or fitness level.
- It's about expanding possibilities, not enforcing prescriptions – joyful vs. compulsive movement.

# Why Take a Weight Inclusive Approach?

# TERMINOLOGY ALERT

"Obesity," "Overweight," and "Severe Obesity" are HIGHLY stigmatizing and pathologizing terms

We believe that weight is not a behavior, and size is not a disease, and do not condone the use of these terms in our clinical practice

# POSSIBLE OUTCOMES

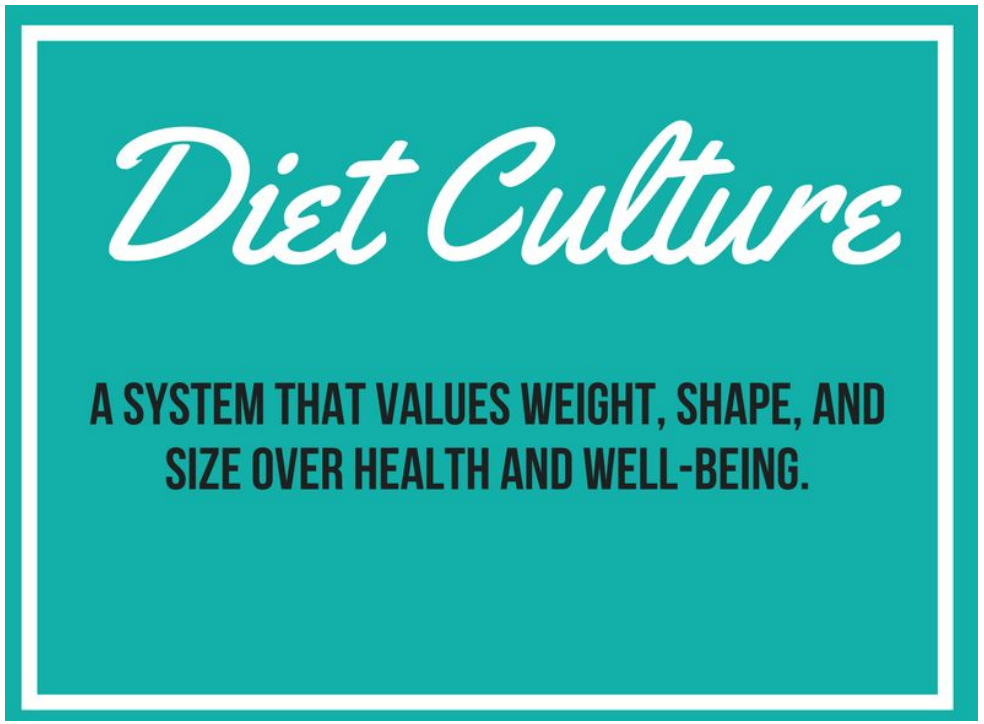
## Weight-Centric

- Healthcare provider avoidance
- Disordered eating patterns
- Increased shame/guilt
- Abandon new behaviors due to "failure"
- Reduced attunement with body cues

## Weight-Inclusive

- Appreciation for body diversity
- Reduced disordered eating patterns
- Increased self-compassion
- Choose sustainable behaviors
- Increased attunement with body cues

# SURROUNDED BY DIET CULTURE




- Places importance on caloric/food restriction
- Promotes ignoring body cues
- Normalizes negative self-talk
- Labels foods as good and bad
- Fat shaming & food shaming
- Toxic fitness culture
- Photo editing apps
- Associates worth with food intake, exercise and appearance
- Promotion of weight loss
- Promotes orthorexic, "clean-eating" behaviors
- Plenty more examples……all in the name of "health"

# REALITY OF DIETS

They don't work long-term

They can set you up for binging and eating disorder behaviors

They teach you to be out of touch with your hunger cues

They are often nutritionally inadequate or even dangerous

They don't teach you how to feed yourself for the long run

Often based on self-disgust and punishment

It can be harmful to lose and regain

Encourage you to think of food as "good" or "bad"

Try to convince you that being deprived makes you better than others

Can lead you to put your life on hold

# WHY THIS MATTERS

Children are causalities of diet culture and ever-changing messages of 'health.'

- At age 6 to 10, girls start to worry about their weight, and by 14, 60-70% are trying to lose weight. (Anderson 2022)
- Over 1 million children and adolescents in the U.S. (or ~3%) are suffering with an eating disorder. (nimh.nih.gov/health/statistics/eating-disorders)
- 37.6% of all U.S. adolescents ages 16-19 are trying to lose weight. (cdc.gov/nchs/data/databriefs/db340-h.pdf)
- Up to 46% of U.S. adolescents dislike their bodies. (Wang et. al, 2019)
- 22% of children and adolescents worldwide have eating behaviors that could lead to or indicate an eating disorder. (Lopez et. al, 2023)
- A 2023 study revealed a 93% increase in eating disorder-related medical visits by youth. (Jain 2023)
- Just 20% of adolescents with eating disorders seek treatment. (Forest et. al, 2017)

# SIZE DISCRIMINATION IS A COMPLEX TRAUMA

Complex trauma: trauma that continues or repeats for months or years at a time…[resulting in] severe psychological harm (Herman, 1988)

Living in a larger body in a society steeped in diet culture, weight stigma, and fatphobia is a complex trauma

Complex trauma leads to worsened health outcomes

# WHAT IS WEIGHT BIAS & ITS IMPACT?

Negative attitudes & beliefs about people with larger bodies that occur internally, interpersonally, or systemically

Children in larger bodies are at an increased risk for weight bias.

A healthcare appointment can become a negative and shameful experience for kids in larger bodies.

Providers may not even be aware that they are adding to the stigma patients are already dealing with from peers, family members, and others.

# WEIGHT STIGMA

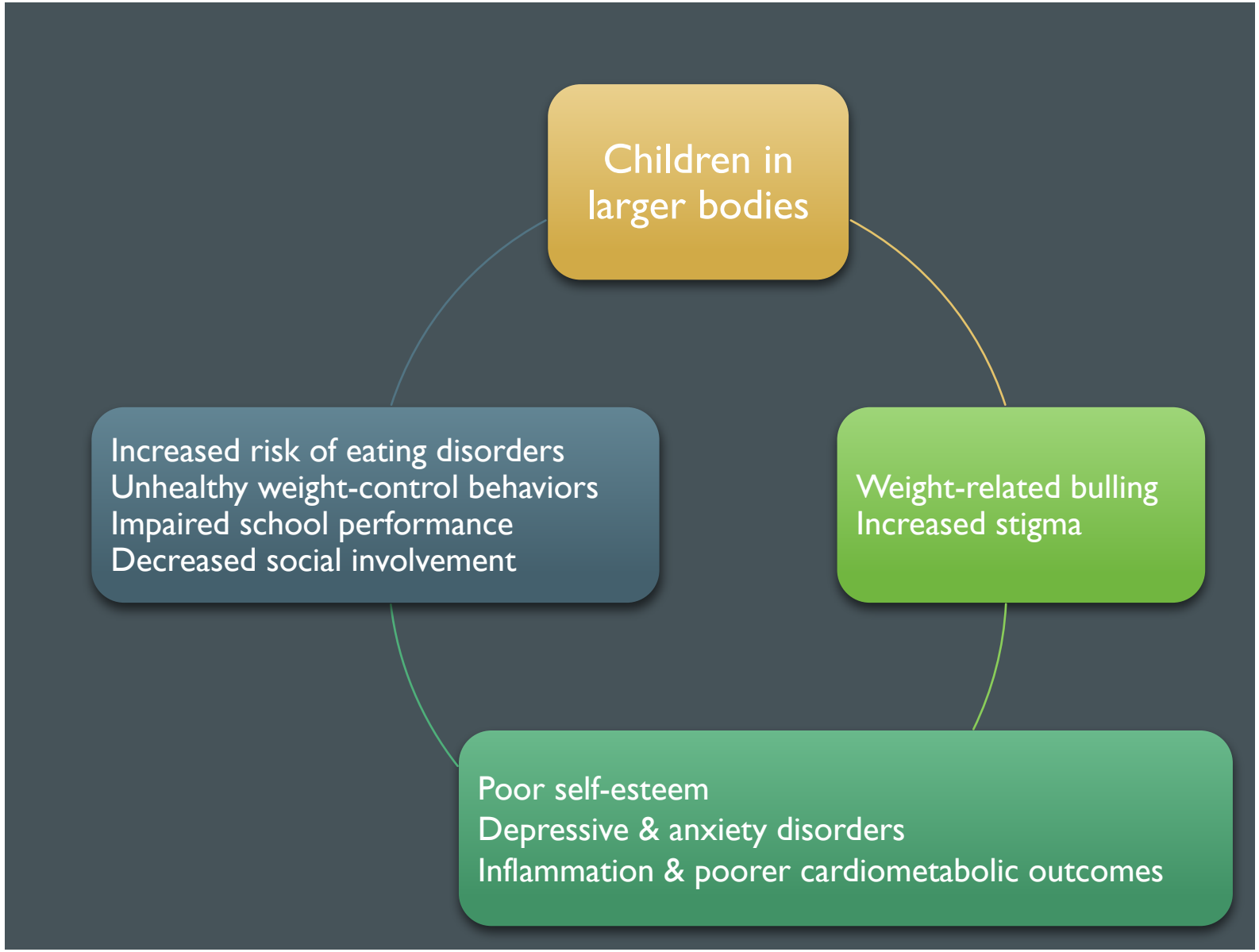
- Refers to the social devaluation, mistreatment, and stereotypes directed at people because of their weight
- Most often targets people in larger bodies, but it can affect people of any size
- Can appear as verbal comments, teasing, exclusion, unequal treatment, or subtle behavioral slights
- Rooted in the idea that weight is a personal failing, rather than the result of complex biological, social, and environmental factors.
- Shows up in interpersonal interactions, media, workplaces, schools, and healthcare settings
- More than a social issue—it has harmful impacts on mental & physical health, healthcare access, and risk for eating disorders

# CONSEQUENCES OF WEIGHT BIAS & STIGMA

- Both physiologic and psychologic negative outcomes
- Low self-esteem
- Binge eating
- Social isolation, depression, anxiety, interpersonal trauma
- Avoidance of healthcare services
- Decreased physical activity

- Physiologic stress responses
- Increased weight gain
- Provider weight bias can result in:
  - Poor patient satisfaction
  - Poor patient engagement/less patient rapport
  - Lower quality of care
  - Blaming or judging patients
  - Less time spent in discussion of health-related problems

# WEIGHT STIGMA CYCLE FOR KIDS IN LARGER BODIES



# POLICY STATEMENT:

# Stigma Experienced By Children & Adolescents With Obesity (2017)

# American Academy Of Pediatrics

- Goal: raise awareness regarding the prevalence and negative effects of weight stigma on pediatric patients and their families
- Provided clinical practice and advocacy recommendations regarding the role of providers in addressing weight stigma
- Improve care by:
  - modeling best practices for nonbiased behaviors and language
  - using empathetic and empowering counseling techniques, such as motivational interviewing
  - addressing weight stigma and bullying in clinical visits
  - advocating for inclusion of training and education about weight stigma in medical schools, residency programs, and continuing medical education programs

# BUT WAIT…ISN'T THERE EVIDENCE LINKING HIGHER BODY WEIGHT TO DISEASE & EARLY DEATH?

- This statement is likely to come up in your practices when addressing adolescent body weight, so it is important to understand what the science actually says outside of the weight bias of diet culture.

# BUT WAIT…ISN'T THERE EVIDENCE LINKING HIGHER BODY WEIGHT TO DISEASE & EARLY DEATH?

## There is strong evidence of association, and some evidence consistent with causality

- Many studies show higher BMI correlates with increased risk of certain diseases and mortality
- Higher adiposity is associated with and in some cases causally contributes to diseases including:
  - Increased inflammation
  - Insulin resistance
  - Dysregulated lipid metabolism
  - Higher blood pressure
  - Adverse cardiovascular biomarkers

## But several factors complicate causal claims

- Confounding variables: SES, fitness level, nutrition quality, stress, and healthcare access influence health independently of weight
- Weight cycling (repeated dieting) is associated with higher mortality and disease risk, making it hard to isolate the effect of weight alone
- The obesity paradox: in some populations (e.g., older adults, certain chronic illnesses), higher weight is associated with *lower* mortality risk
- BMI limitations: does not distinguish fat from muscle or reflect metabolic health

# IN SUMMARY

There is some evidence consistent with causality, but it is not definitive.

The relationship is multifactorial, influenced by genetics, environment, mental health, behaviors, sleep patterns, and social factors.

Weight alone is not a reliable or complete predictor of health or longevity.

Health is thoroughly assessed through a combination of behaviors, metabolic markers, mental health, and overall well-being.

We need to stay curious. There is a lot we don't yet know.

# CASE PRESENTATION

- 15 yo female  Height: 5' 4"
- Historically trended on/around the 90th percentile for weight-for-age with no known health conditions
- A year ago, she weighed 145# at her previous wellness check
- Since then has been demonstrating dieting behaviors & significant caloric restriction
- Recently had her 15 yo wellness check and weighed 130#
- Over the past year, her weight loss has been praised as "healthy" by loved ones, social circles, and her pediatrician
- Passed out at soccer practice and soccer coach recommended seeing a dietitian
- By the time she came to my office she was -
  - Amenorrheic
  - Bradycardic
  - Experiencing osteopenia
  - Entrenched in ED behaviors….

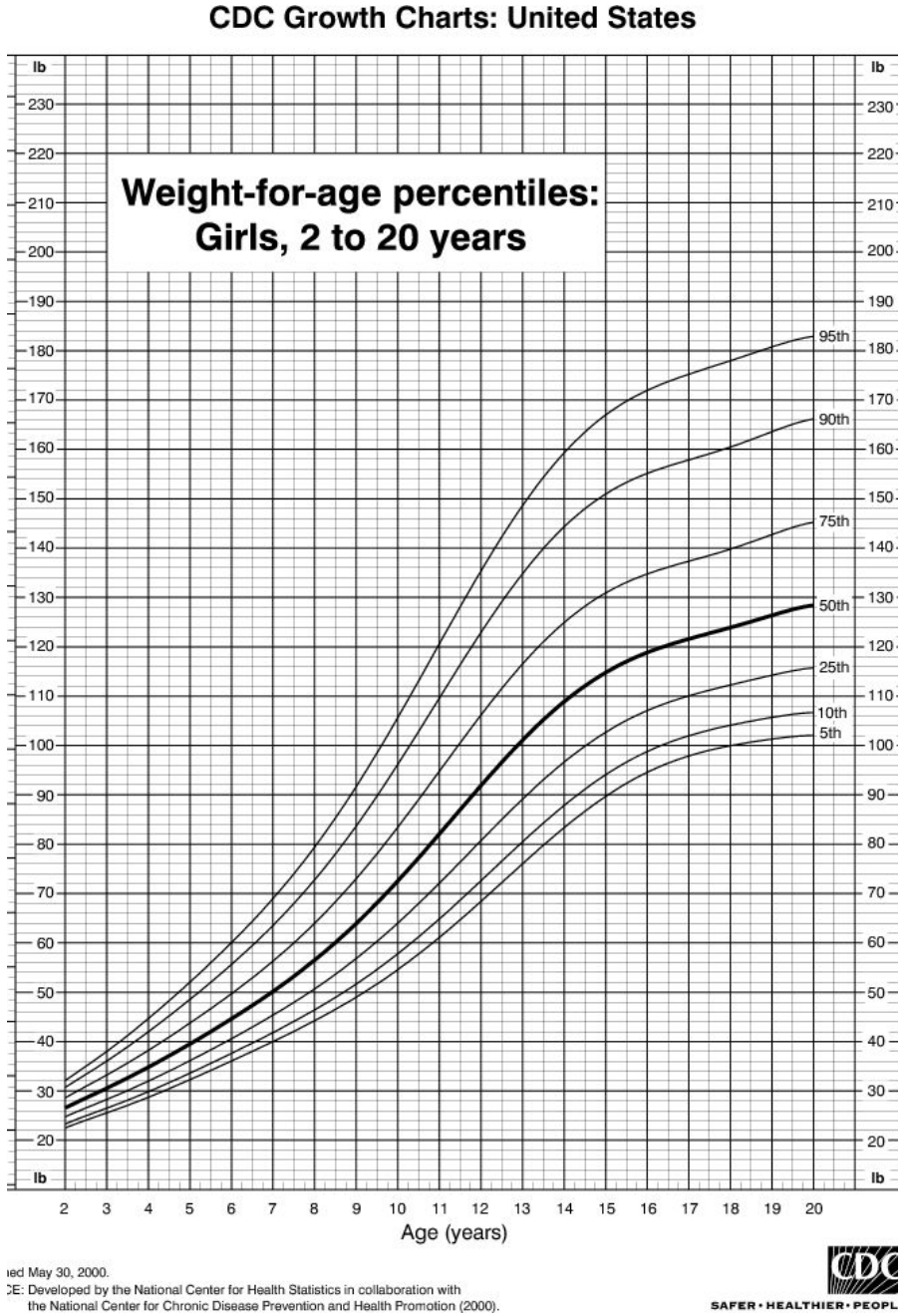
# 5 QUESTIONS TO CONSIDER

- Is recommending weight-loss ethical given the risks and when so few can maintain it long-term?
- Is it acceptable to allow a person to remain in a larger-body without trying to correct it?
- Am I making diagnostic or behavioral assumptions based on an individual's size/weight?
- How can I help clients navigate accessing necessary care & treatment?
- How can I create an environment within my practice where people of all body sizes are treated with dignity, listened to fully, and offered individualized dietary recommendations?

# 10 Ways RDs Can Incorporate a Weight Inclusive Approach

# #1 NORMALIZE DIVERSITY & CHANGES IN BODY SIZE

- Puberty causes rapid, normal changes in weight and shape
- Weight changes are not failures—they're physiology
- Growth trajectories vary widely
- Set appropriate target weights based on the adolescent's history
- Ask about experiences with teasing, shame, or weight-focused comments
- Validate the harm of weight stigma



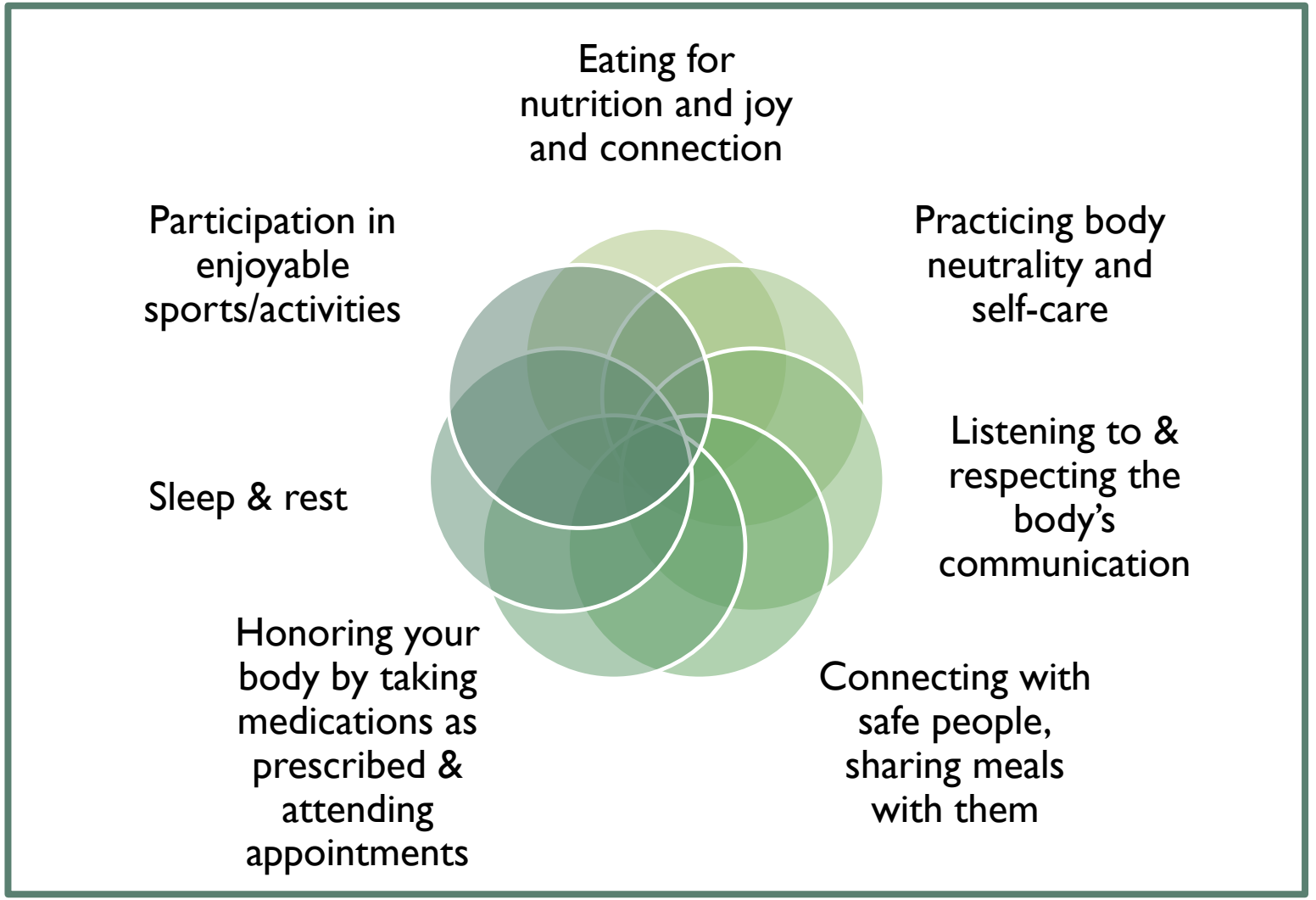
# #2 REFRAME HOW TO VIEW HEALTH

- Vital signs
- Lab work results
- How you feel
- Nutrition and hydration status
- Hormonal health
- Relationships
- Mental and emotional health
- Stress management
- Sleep patterns

| Weight-Centric Message | Weight-Inclusive, Growth-Supportive Reframe |
|---|---|
| "Your BMI is too high." | "Let's look at your overall health — sleep, stress, nutrition, movement, and how you're feeling." |
| "You're at risk because of your weight." | "Some of your health markers could use support — let's work together on habits that help your whole body." |
| "You need to lose weight to be healthy." | "Health is about many things. Let's focus on behaviors that support your growth and well-being." |

# #3 HELP CLIENTS SET GOALS UNRELATED TO WEIGHT/BODY IMAGE

Develop goals centered on energy, mood, & lifestyle



# #4 PROMOTE AN ALL FOODS CAN FIT APPROACH

Only foods off-limits are foods:

- You are allergic to
- That have spoiled
- You have never ever liked

Incorporate cultural sensitivity & inclusivity with food

Remove moral judgements from food

| Weight-Centric Message | Weight-Inclusive, Growth-Supportive Reframe |
|---|---|
| "That food is bad for you." | "All foods can fit — let's think about what helps your body feel energized and satisfied." |
| "You should eat less." | "Let's tune into your hunger and fullness cues so your body gets what it needs." |
| "Avoid junk food." | "How can we add foods that help you feel your best?" |

# #5 GUIDE FAMILIES TOWARD SUPPORTIVE HOME ENVIRONMENTS

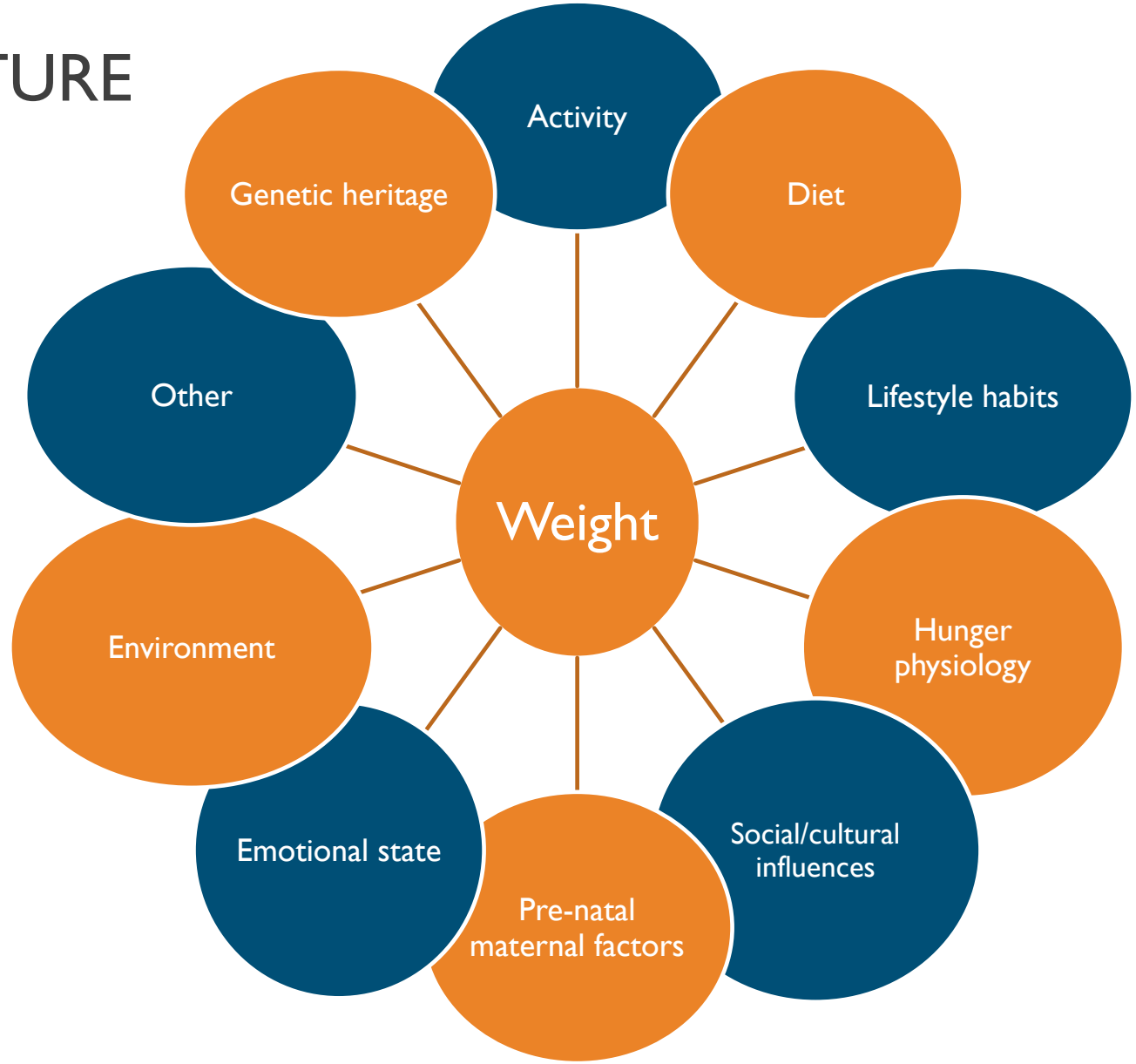
- Family culture is one of the strongest predictors of adolescent health behaviors.

- Coach caregivers on:
  - Avoiding comments on weight
  - Avoiding dieting talk
  - Eating meals together when possible
  - Providing regular, reliable meals and snacks
  - Modeling balanced & unrestrictive eating
  - Encouraging rest, play, and connection

| Weight-Centric Message | Weight-Inclusive, Growth-Supportive Reframe |
|---|---|
| "Our family needs to lose weight." | "Let's build routines that help everyone feel strong, rested, and supported." |
| "We don't keep fattening foods in this house." | "We keep foods that help us feel nourished, energized, and connected." |
| "You're eating too much." | "How is your body feeling — hungry, tired, stressed, bored? Let's check in together." |

# #6 CHALLENGE DIET CULTURE

Weight Is More Than Calories In vs. Calories Out – It Is Muti-factorial



# #6 CHALLENGE DIET CULTURE – EDUCATE ON CONSEQUENCES

## Physical Consequences

- Lower metabolism, digestive issues, constipation
- Lack of energy
- Difficulty sleeping
- Reduces amount of muscle tissue, including vital organs
- Lower body temperature, cold intolerance
- Decreased hormone production and immune system functioning
- Dry skin, brittle hair and nails
- Decreased bone density & missed/delayed growth spurts

## Psychological Consequences

- Feeling irritated, depressed, and/or agitated easily
- Increased obsessiveness about food and weight
- Increase in feelings of compulsion & pressure
- Body distortion thoughts, poor self-image
- Difficulty thinking, making decisions, concentrating
- Hyper-focused on food & increased food cravings
- Isolation—difficulties connecting with others & sharing in joyful experiences
- Feelings of guilt, shame and failure

# #7 PROMOTE JOYFUL MOVEMENT

Focus on movement that:

- Is fun
- Creates social connections
- Promotes stress relief
- Develops strength and confidence
- Helps improve sleep

Goal: builds a positive relationship with movement that lasts.

| Weight-Centric Message | Weight-Inclusive, Growth-Supportive Reframe |
|---|---|
| "You need to exercise to lose weight." | "Moving your body in ways you enjoy helps your heart, mood, and energy." |
| "Burn off those calories." | "Let's find activities that make your body feel strong and alive." |
| "You should be more active so you don't gain weight." | "Your body is growing — movement can help you sleep better, feel better, and build confidence." |

# #8 BUILD TRUST THROUGH INCLUSIVE LANGUAGE, SETTING & MATERIALS


| WEIGHT | |
|---|---|
| Instead of… | Try… |
| Overweight, obese | Larger body, higher weight |
| Ideal weight | Your weight is…. |

| FOOD | |
|---|---|
| HELPFUL | UNHELPFUL |
| Satisfying | Good |
| Delicious | Clean |
| Appetizing | Bad |
| Nourishing | Tempting |
| Filling | Addictive |
| Crunch | Dangerous |
| Crispy | Allowed |

## Nuance is important

Ask your clients what words feel supportive to them!

# #8 BUILD TRUST THROUGH INCLUSIVE LANGUAGE, SETTING & MATERIALS

- Language shapes self-perception, and adolescents internalize weight-based messages quickly
- Use Neutral, Non-Stigmatizing Language
  - "Your body is growing and changing, and that's normal."
  - "All bodies deserve care."
- Provide comfortable furniture for all body sizes
- Share inclusive materials that represent all body sizes

#9

# MONITOR FOR ANY WEIGHT BIASES

- What are my views about the causes of obesity? How does this impact my attitudes?
- How comfortable am I working with clients of different sizes?
- Do I make assumptions about a child and/or their caregiver's character, intelligence, abilities, health status, or behaviors based on their weight? Could my assumptions be impacting my ability to help my clients?
- For my patients in larger bodies, do I give caring, appropriate feedback to encourage healthful behavior change rather than encouraging weight loss?
- Do I consider all the client's presenting problems separate from their weight?

# #10 COLLABORATE WITH OTHER PROVIDERS WHEN NEEDED

Eating Disorder Professionals:

Therapists
Psychiatrists
Dietitians
Higher Levels of Care

- Important to remind clients that they can work on their internal world however, our world propagates ideals and we have a tendency to compare ourselves
- Therapists can help clients process how they feel towards their bodies and work towards:
  - Body Acceptance
  - Body Positivity
  - Appreciation of Body Functionality
  - Body Neutrality


- Not reaching 100% body acceptance, appreciation, love, neutrality does not mean failure
- Set realistic goals & help client take one step in the direction of the goal

# WEIGHT INCLUSIVITY DOESN'T STOP WITH INDIVIDUAL NUTRITION COUNSELING

## Community/School/Group Settings

- No matter your population, when doing group education consider that you do not know each person's individual challenges with food and body.
- Weight inclusive language and materials, pivoting weight bias statements, promotion of joyful movement, education regarding diet culture, promotion of all foods fit, and reframing the aspects of health can all aid in creating weight inclusive spaces in any nutrition setting.

## Example:

- Creating a handout on healthy eating for high school students for National Nutrition Month:
  - Avoid discussion of weight as a marker of health
    - Ex: "Shed your excess holiday weight by selecting healthy foods as we move into National Nutrition Month"
    - Instead: "Eating a wide variety of foods can help you feel your best as we move into springtime this year."
  - Refrain from villainizing certain foods
    - Ex: "Always skip the donut in favor of the apple to make the healthy choice."
    - Instead: "Fruits and vegetables offer vitamins, minerals, fiber, and water to support healthy digestion and the functions of your cells."

# THANK YOU

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# ADDITIONAL RESOURCES

# RESOURCES

## Books:

- Health At Every Size By: Linda Bacon
- Embody By: Connie Sobzack & Elizabeth Scott
- Body Kindness By Rebecca Scritchfield
- Intuitive eating By: Evelyn Tribole & Elyse Resch
- Ellyn Satter Institute
- Sick Enough By: Jennifer L Guadiani
- Fu*k It Diet By: Caroline Dooner
- Anti-Diet By: Christy Harrison
- The Body Is Not An Apology By: Sonya Renee Taylor

## Podcasts:

- Body Kindness
- Food Psych
- Every Body
- The Love, Food Podcast
- Phit for a Queen
- Body Image With Bri

## YouTube:

- Poodle Science
- Ted Talk: Why Diets Don't Work

## Instagram:

- @with_this_body
- @chr1styharrison
- @haes_studentdoctor
- @bodyimagewithbri
- @encouragingdietitian
- @murrarynutrition
- @your.latina.nutritionist
- @feelgooddietitian
- @kids.eat.in.color
- @yrfatfriend
- @heytiffanyroe
- @thenutritiontea

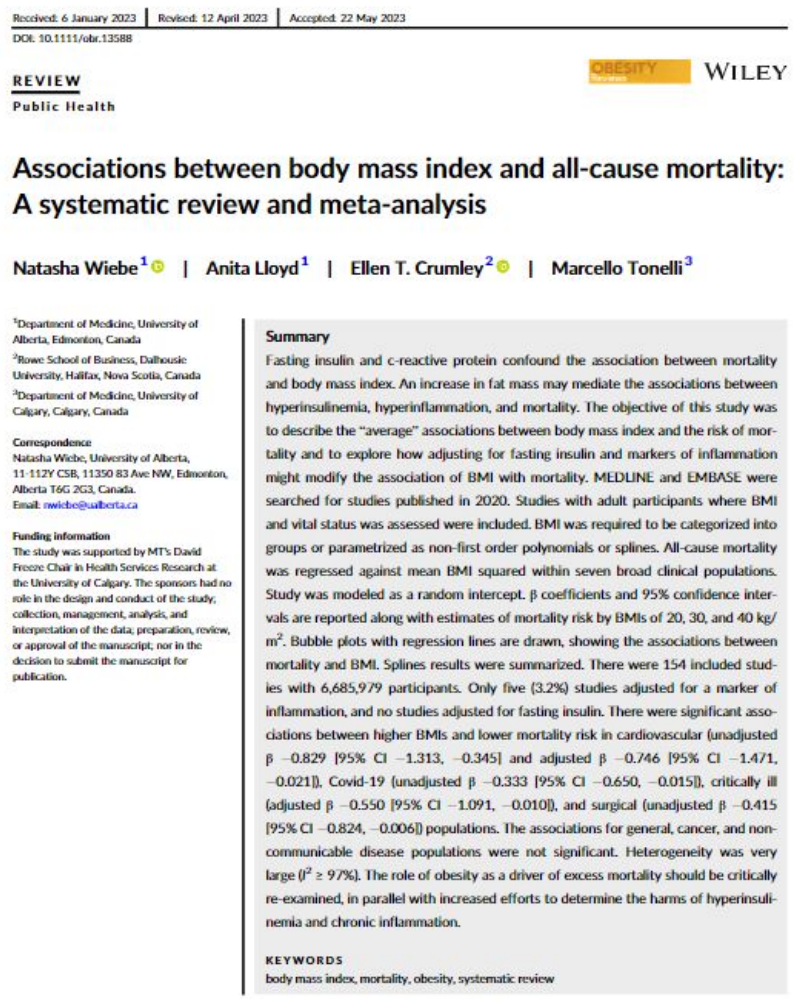
# HISTORY OF EXPLORING IMPACT OF WEIGHT BIAS

| | |
|---|---|
| Weight bias has existed for centuries | Began receiving formal academic and public attention in the early 2000s, when researchers started systematically studying it as a form of prejudice. |
| Early 2000s: The Start of Modern Research | Puhl & Brownell (2003), described it as stigmatization, bullying, and discrimination based on body weight. Their work helped establish weight bias as a legitimate area of psychological and public-health research. |
| Mid-2010s: Growing Recognition in Healthcare and Policy | Viewed more as a healthcare quality issue, articles highlighting its impact on patient care. A 2019 article in the *British Journal of General Practice* described weight bias as "the last acceptable form of prejudice" and emphasized its harmful effects in medical settings. |
| 2020s: Institutional and Global Attention | Major organizations (American Diabetes Association & World Obesity Federation) issued position statements & guidelines addressing weight bias, reflecting a shift toward formal policy action. Scholarly discussions continue to expand, with recent publications calling for clearer definitions and stronger interventions to reduce weight-based discrimination. |

# TIMELINE OF WEIGHT INCLUSIVITY

| | |
|---|---|
| 1960s–1980s: Early Roots in Body Liberation Movements | • The HAES framework traces its origins to 1960s body-liberation activism, which challenged cultural and medical assumptions about weight.<br>• These early movements weren't yet part of clinical practice, but they laid the philosophical groundwork. |
| 1990s–Early 2000s: First Clinical Discussions Begin | • By the late 1990s and early 2000s, clinicians and researchers began formally questioning weight-loss-focused care.<br>• This period saw the first academic critiques of weight-centric medicine and the early development of weight-inclusive models. |
| 2011: A Major Turning Point in Clinical Literature | • A widely cited paper, "Weight Science: Evaluating the Evidence for a Paradigm Shift" (Bacon & Aphramor, 2011), argued that weight-centric care lacked evidence.<br>• This publication is often considered a key moment when weight inclusivity entered mainstream clinical dialogue. |
| Mid-2010s: Growing Adoption in Healthcare Settings | • Clinical organizations and training programs began acknowledging weight stigma and exploring weight-inclusive care models.<br>• Research and provider education materials started framing weight-inclusive care as a legitimate alternative to weight-loss-focused treatment. |
| 2020s: Widespread Clinical Recognition | • Weight-inclusive care is now discussed across medical, mental-health, and nutrition fields.<br>• Recent clinical articles describe a "shift" away from weight-centric care toward weight-inclusive models, driven by patient advocacy and research on the harms of weight stigma. |

# WEIGHT IS NOT A BEHAVIOR AND SIZE IS NOT AN ILLNESS



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REVIEW
Public Health

OBESITY Reviews WILEY

**Associations between body mass index and all-cause mortality: A systematic review and meta-analysis**

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**Summary**

Fasting insulin and c-reactive protein confound the association between mortality and body mass index. An increase in fat mass may mediate the associations between hyperinsulinemia, hyperinflammation, and mortality. The objective of this study was to describe the "average" associations between body mass index and the risk of mortality and to explore how adjusting for fasting insulin and markers of inflammation might modify the association of BMI with mortality. MEDLINE and EMBASE were searched for studies published in 2020. Studies with adult participants where BMI and vital status was assessed were included. BMI was required to be categorized into groups or parametrized as non-first order polynomials or splines. All-cause mortality was regressed against mean BMI squared within seven broad clinical populations. Study was modeled as a random intercept. β coefficients and 95% confidence intervals are reported along with estimates of mortality risk by BMIs of 20, 30, and 40 kg/m$^2$. Bubble plots with regression lines are drawn, showing the associations between mortality and BMI. Splines results were summarized. There were 154 included studies with 6,685,979 participants. Only five (3.2%) studies adjusted for a marker of inflammation, and no studies adjusted for fasting insulin. There were significant associations between higher BMIs and lower mortality risk in cardiovascular (unadjusted β −0.829 [95% CI −1.313, −0.345] and adjusted β −0.746 [95% CI −1.471, −0.021]), Covid-19 (unadjusted β −0.333 [95% CI −0.650, −0.015]), critically ill (adjusted β −0.550 [95% CI −1.091, −0.010]), and surgical (unadjusted β −0.415 [95% CI −0.824, −0.006]) populations. The associations for general, cancer, and non-communicable disease populations were not significant. Heterogeneity was very large ($I^2 \geq 97\%$). The role of obesity as a driver of excess mortality should be critically re-examined, in parallel with increased efforts to determine the harms of hyperinsulinemia and chronic inflammation.

**KEYWORDS**
body mass index, mortality, obesity, systematic review


## CONCLUSION

2023 study found no evidence that higher BMI was associated with a higher mortality risk.

Rather, higher BMI was associated with lower mortality in several clinical populations.

These findings suggest that the role of inflammation and fasting insulin in mediating adverse outcomes that are typically attributed to obesity should be further considered, whereas the merits of public health interventions to treat obesity and/or promote weight loss should be critically re-examined.