Think Paper: Untangling health behaviours, respect, weight, wellbeing and social factors

This Think Paper is designed to help practitioners teach the Well Now way. The focus is on untangling the links between health behaviours, respect, weight, other social factors and health. As part of this you'll introduce the bigger picture of health, looking beyond 'personal choice' to the 'body politic'. This refers to the fact that wider social factors impact wellbeing. Respect, and the lack of it, is one such social factor that significantly impacts health. In other words, respect is a social determinant of health (SDH).

This activity also illustrates what I means when I say that Well Now is embodied, relational and intentionally political.

Weight Loss vs Health Gain and Respect

1. Ask why weight loss is traditionally suggested and write a list down the left hand side.
2. Make sure you include a metabolic condition, a musculoskeletal condition and reference to mental wellbeing.
3. Now invent an imaginary person. Explain that this person was recently diagnosed with the first condition on the list, say, type 2 diabetes. At the time of diagnosis they were doing shift work that they found very stressful for all sorts of reasons. It also meant they mainly ate sandwiches or 'something on toast' at meals and were only active for a short time each week. Fortunately, they've since managed to change their job to one they really enjoy. In addition, not only are they cycling to work every day but the shorter hours and regular schedule have enabled them to spend more time cooking, and they love experimenting with seasonal vegetables. They have more leisure time and enjoy being active outdoors. As they have got used to their routine they have started using a body scan (mindfulness practise) app for twenty minutes before work. They feel tons better. We don't know if their weight has changed.
4. Go along the 2nd column asking if, going by the evidence, we would expect health improvements due to food/activity/mindfulness in their diabetic control even if weight is unchanged. Emphasize the fact that weight might be unchanged each time you ask. The answer is yes, changes in eating for wellbeing, physical activity and mindfulness can all improve diabetic control independent of weight change, and hence weight loss. (We are not saying the changes will definitely improve health, but that they can.)
5. What about being treated with respect? One reason our person changed jobs was that they were being bullied. Do they think there is any link between how we are treated (bullying as a lack of respect for instance) and blood sugar control (or incidence of diabetes in a group)? The answer is yes, there is a link. So, ensuring people are treated with respect and dignity is important (as a human rights' issue and) for individual and population wellbeing. This link is usually talked about as 'stress'. On the one this is accurate, it is stressful to be relatively powerless. On

the other, stress gets used so much that if we use it it it can end up disappearing the power abuse. When this happens it is easy to hold the 'stressed' individual responsible for sorting the problem, say with with stress management. Of course, the problem is the bullying. Talking about respect instead of, or as well as, stress brings the power relationship into view.

6. Are we doing any harm by focusing on health-gain and respect?
7. Let's turn this last question back to the alternative, weight management. Are we doing any harm by focusing on weight management? The answer is yes. I use the example of weight fluctuation later on. As will become clear, there are also harms from advocating a non-diet focus on lifestyle and ignoring social determinants. The teaching style (pedagogy) used in Well Now advances criticality and one way it does this is by breaking silences. The harms of weight management are typically glossed over. Asking a question about harm brings hidden or repressed knowledge into view: there are very real costs to pursuing a weight-centred agenda. Asking about respect disrupts routine healthism and brings society, power and inequality into view. Healthism refers to a way of understanding health that, among other things, assumes lifestyle is the main determinant of health.
8. How then might you respond to the diabetes consultant who points out that her patient, Jay, went to see a dietitian, lost a significant amount of weight and has improved their health measures no end? The consultant is not a curious questioner who is inviting discussion on an apparent anomaly in order to deepen your mutual understanding. Instead, they suggest that Jay's weight loss disproves the belief that 'diets don't work'. They think that focusing on health-gain and body respect is sacrificing people who otherwise would lose weight with a conventional approach.

   Can you take time now to list the assumptions you identify in the consultant's concern. How would you address them?

   It's true, many people who attempt weight loss will end up heavier than they were before their diet. But the main point is not that diets don't work. This concern limits 'what matters' to discussions of health outcomes. The main point is that the drive to weight correction leads to shame and stigma. Shame and stigma diminish people's dignity. This is why it is a line I don't cross

   Holding up weight loss as proof that diets 'work' assumes weight loss leads to health improvement. Yet someone could lose weight by starting smoking, so this needs unpacking.

   To say many people end up putting weight on when they diet is not the same as saying no-one ever loses weight. Some people can and do lose weight. The examples that stand out most for me are anecdotes from clinic when one partner in a heterosexual couple gets diagnosed with diabetes and both partners alter their diet. What do you imagine happens? I have seen numerous instances where the man loses weight and the woman remains weight stable. Why do you think this is? Weight concerns have a strongly gendered dimension. This means that (cis) women are more likely to have a more complicated relationship with food and a history of dieting than are (cis) men. Take someone with an uncomplicated relationship with food who has not hitherto paid much attention to what they eat, provide a prompt for them to consider their diet, add opportunity to do so, and if this person is above their set-point weight it may be that they lose weight. On the

other hand, the set-point pathways of someone with a history of dieting will strongly resist weight loss.

In terms of abiding by evidence-based practise, the anecdotal observation that Jay lost weight may be interesting but one example does not capsize the boat of data from randomised controlled trials. To say the pursuit of weight loss is likely to do more harm than good is not disproved by one person losing weight. Either we are using an evidence based approach or we are not. If we are using an evidence based approach we will promote health-gain and body respect for all and speak up about the fall out from dieting, about thin privilege and size stigma.

How would you justify my use of anecdotes then? The consultant's concern carries the implicit suggestion that one person's weight loss proves others should try and lose weight. Quite aside from the fact that we don't know how long weight loss was sustained, or whether it was directly responsible for any health improvement, there is overwhelming evidence that dieting is not benign. First off there is shame and stigma. End of. There is still plenty of cause to ditch dieting even if we narrow 'what counts' to biomedical data. Most people who attempt weight loss end up yo-yo dieting and there is a robust association between yo-yo dieting, or weight fluctuation, and death from all causes, plus an association with death from heart disease in particular. Back in 1999 the British Nutrition Foundation stated that:

> *" a positive association has consistently been observed between body weight fluctuation and all-cause mortality and usually… with coronary mortality in particular.* ***This finding is very robust,*** *further confirmation is found in the British Regional Heart Study (Wannamethee & Shaper, 1990), in the Seven Nations Study (Peters et al., 1995) and in the Iowa Women's Health Study (French et al., 1997) (p 137)."*

Later Scottish guidelines (SIGN, 2010) read:

> *" Weight cycling is a common condition as only a minority of people who lose weight through weight management interventions are able to maintain their weight loss.. . . Weight cycling is a risk factor for all-cause mortality and cardiovascular mortality (hazard ratio (HR) approximately 1.8 for both)."*

An anecdote backed by evidence is a useful way of illustrating a concept and translating it to the real world. An anecdote contradicted by the evidence but cited as implicit, self-evidence 'proof' of a proposition (here, that diets do work) is at best misleading. There is something about the vocabulary of a normalised scientific etiquette for critique that dumbs down power abuse and disappears the dereliction of duty invested in us as healthcare practitioners, educators, researchers. Regardless of intent, the casual deployment of poor quality science is not merely misleading, surely it is downright fraudulent?

A final point: of course, anyone who is above their set-point who is going to lose weight with dieting will similarly lose weight with a Well Now approach. This is sort of beside the point really except to sharpen the consultant's critical acuity. A health-gain approach is not anti-weight loss, it is anti- the pursuit of weight loss.

9. What should we do though about any link between fatness and disease (even when weight-fluctuation is controlled for –see later) such as with type 2 diabetes? Fat and thin people get type 2 diabetes. People who get type 2 diabetes are

more often fat than thin. It is usually assumed that fatness causes diabetes. The pivotal metabolic dysregulation inn type 2 diabetes is insulin resistance. Someone who is insulin resistant is likely to store fat and gain weight. So you would expect people with type 2 diabetes to be fatter than the general population because the diabetes has caused weight gain. Another link between fatness and disease is osteoporosis. Fat people have a lower incidence of osteoporosis and this is directly linked to weight as weight bearing strengthens bone structure. Funny how infrequently messages like this about the health benefits of being fat get bandied about.

10. Returning to the initial question, 'what should we do about links between fatness and disease?' we are hit by the indelible hallmark belief that the something that should be done is about weight. Looked at from a holistic panorama I agree. We should be naming and tackling weight stigma and thin privilege, supporting people to heal from shame, naming and addressing power abuses in science and healthcare and turning the tide on the practise of ignoring social determinants of health. I am all for doing these somethings about weight.

    The practise of ignoring social determinants of health is especially relevant to type 2 diabetes. Traditionally, type 2 diabetes is taught as a disease of irresponsible lifestyle choices. It's true that diet and activity can influence self-management. It doesn't then follow that diet and activity habits caused diabetes. (Or that everyone has enough say in influencing their own diet and activity habits to be held as 'personally responsible' for any impact lifestyle might have). It is possible to get a nutrition-sensitive disease, like diabetes, or heart disease, even when meeting lifestyle recommendations. Plus, as I mentioned before, thin people get diabetes and heart disease. Type 2 diabetes is a disease of deprivation and disenfranchisement. This isn't saying that everyone who gets diabetes can be described as being marginalised or recognises themselves in this description. It means that on a population level diabetes is explained by high levels of chronic stress experienced as a result of powerlessness, adversity and material deprivation and that this link between low income and diabetes remains even when health behaviours and BMI are controlled for (Raphael et al, 2010).

    Put another way, stigma is a health hazard. Experiencing stigma is a source of chronic, or toxic, stress - it is stressful to be treated unfairly and put in a relatively powerless situation. Chronic stress is harmful for health and wellbeing as stress hormones affect our metabolism. This physiological pathway occurs regardless of health habits. In this way, our bodies and minds literally incorporate experiences of (dis)respect, (un)fairness and power(lessness). In other words, socially distributed pressures that arise because of 'the body politic' impact our health as they have embodied consequences. In short, respect is a social determinant of health (SDH*). Put more memorably: 'stigma - do the body count.'

    POINT ONE: The Well Now way is embodied: it recognises the embodied consequences of shame and inequity and theorises respect as a SDH.

11. We can go along the columns in the same way with heart disease. Eating for wellbeing, appropriate activity, mindfulness and respect can all impact heart health. (Just so you know, the belief that there is good evidence for reducing saturated fat intake isn't supported by the evidence.

". . ., increased risks for cardiovascular disease in early animal studies led to standard dietary guidance to restrict saturated fats (implying that red meats and butter are bad foods).1,27 But more recent evidence of a direct causal link is more ambiguous." (ADA, 2013)

Heart disease is also influenced by air pollution, insecure work and lack of control.

12. Yet, isn't it true that there is a link between BMI and heart disease? That people of a higher BMI have increased risk of heart disease than people of a lower BMI? Yes. Absolutely, there is a link. A link shows an association. It doesn't mean one variable is deterministic. When data from large scale studies, such as the Framingham study, were first analysed they showed this association. Initially it was assumed that fatness caused heart disease. What behaviour are fat people more likely to engage in than thin people? (Be prepared to respond to stereotypes in replies when you ask this question). Fat people are more likely to diet (and use toxic diet pills). When the results were re-analysed to allow for weight fluctuation the excess risk disappeared. This is explained by saying that high BMI was serving as proxy for weight fluctuation. This is saying that it became a smokescreen that obscured the real causal ink.
13. We can continue this line of criticality further. So, we have discovered that the link between high BMI and heart disease is caused by yo-yo dieting. This is useful to know. But whether or not there was a direct link between heart disease and high BMI may not be immediately relevant in the treatment room. Whatever someone's BMI, the ethical response is health-gain and body respect for all. That said, giving accurate and full information where it is requested, such as the impact of yo-yo dieting on health, can help people make sense of their experiences and so increase sense of coherence.
14. Joints: ask how a thin person might expect to be treated for knee pain. Now ask how a fat person with exactly the same knee problem might get treated. The difference highlights size bias in the medical pathway. A thin person would likely be asked about the pain and receive pain medication, strengthening exercises or further diagnostic intervention. A fat person would likely be told to lose weight. They would miss out on the medication, exercises and diagnosis. We need to ensure that everyone is taken seriously and receives equally appropriate treatment. This means assessing the fat person's needs for medication, exercises and diagnosis. If we stop here, we are offering a weight-neutral approach.
15. The term weight-neutral is used to describe an approach to wellness that focuses on health improvement rather than weight management, known as a non-diet approach. The term has long been synonymous with the HAES® movement.

    Both HAES and Well Now use an approach that does not promote diets to shift focus. HAES is non-diet, Well Now is health-gain. In Well Now, this shift is based on a paradigm approach that embraces the body politic from the outset. As a result, unlike HAES, the Well Now way seeks weight-equity and not weight-neutrality. The Well Now philosophy teaches that weight-neutral is a misnomer as there is no such thing as neutral, that everything has a situated standpoint and cannot be understood outside of relationship. A situated standpoint means we look at something in a certain way because of our particular beliefs, beliefs which are

influenced by our life experiences, education and so on. It highlights the fact that it is impossible to separate our ideas from who we are, and any claim to be 'value-free' or 'neutral' or 'objective' is redundant. It would be an audacious person who wanted to argue against this as they would be dismissing the foundational thesis of quantum science! The desire for objectivity can stem from a commitment to be fair. Here, the logic goes that in order to be fair we need to be free of bias and, often, that this also entails taking emotions out of the consideration. In fact, we are never free of bias and cognitive-emotional integration is a prerequisite for clarity. So, the best way to ensure we make decisions that have fair outcomes is first, to try and work out what our biases are and be transparent about them, and second, to take emotional literacy seriously.

Plus, as you can see, in this example to claim we were being 'weight-neutral' is misleading as we would be treating a fat person as if they were a thin person: I started off by saying "ask how a thin person might expect to be treated for knee pain." This is not neutral - this is an example of using thin people as the standard and as such it illustrates thin privilege in action.

I recognise that others will have their own reasons for choosing 'weight-neutral'. The reason I choose 'weight-equity' or 'weight-inclusiveness' for the Well Now way is that these terms are congruent with a paradigm that is relational and intentionally political. In this way, using them helps disrupt a narrative where bodies are seen as machines and health largely amounts to personal responsibility for lifestyle change.

16. Size equity, or inclusiveness, means recognising that the experience of seeking treatment and the meaning of knee pain are likely very different for fat and thin people. The thin person leaves feeling heard and understood. They had no qualms about going for an appointment as they expected to be treated seriously, at least on account of their weight. It's a different prospect altogether for the fat person. And sure enough, they leave feeling ignored and disrespected. They are worried about their knee pain. They feel angry and/or hopeless; being disrespected and feeling anxious add to their pain.

    The production of knowledge on weight overlooks the tacit knowledge of the fat body.

17. How might size discrimination impact healthcare and health-seeking behaviours? There are examples given at the end of this Think Paper©. Also explain that, in addition to the direct hazards of poor treatment, experiencing size discrimination involves living with stigma, which as we have seen, is a health hazard.

18. Given that fat people do get knee problems and it can be harder for them to use public exercise facilities or get relevant advice, what would a useful healthcare response be? How about access to leaflets on suitable exercises for prevention/management of knee pain?

19. POINT TWO: The Well Now way is relational (and takes note of our embodied responses in relationships). Of course we want to ensure that any condition is taken seriously. But there is more to it than that. To ensure equity we need to take into account any and all specific needs of fatter patients. This includes paying attention not only to treatment pathways but also to the relational dimensions of the encounter. Seeing knee pain as the only problem emerges within the 'body as

machine' metaphor and misses the significant therapeutic value of 'being with' people in ways that validate their experiences and affirm their dignity.

20. POINT THREE: The Well Now way is intentionally political. It pays attention to how language structures our ideology and informs our actions. It highlights body knowledge, privilege and bias in its theoretical framework and in the way it is practised. Seeking weight equity, rather than weight neutrality, supports this project.

21. This relational, embodied, political awareness embracing meaning and context, alert to power, privilege and dignity, is at the heart of Well Now. Weight-equity means we need to acknowledge that living with fat shame is a personal and collective trauma. (People of any size can experience shame because of their weight; fat people additionally experience social oppression). Fat folk who have not engaged with politicised communities (fat activist, HAES, size acceptance, body positive) are likely living with internalised oppression and shame. In which case, it becomes imperative that we explicitly state that their body - anyone's body - is not a problem. Make clear that in medical and moral terms pain always warrants acknowledgement and alleviation, never judgment. This means there is no basis for anyone to judge themselves or feel guilty or ashamed for being in pain (or guilty or ashamed for feeling guilty or ashamed). Medical and social attitudes that view bodies and weight as morally laden are plain wrong: 'and I am sorry you have been made to feel this way about your body. I am sorry for what you've experienced because of fat bias and bad science. That shouldn't have happened.' It may help to remind someone that thin people get knee pain; to spell out that often non-weight bearing joints are painful too - showing that pain occurs where weight is not a factor. Reiterate that no-one should be made to feel guilty for being in pain. Not those of us who are fat, not those of us who are thin: everyone deserves respect and good treatment full stop.

22. Perhaps your client is considering trying to lose weight as a way of reducing their pain. Return to the table to explore what's at stake in making, or not making, the shift from weight-loss to health-gain and body respect. Remember not to offer advice but to support someone's process and be a curious questioner. If you notice incorrect assumptions, do they want the science explained? Is there any ambivalence around someone wanting to be thinner while also realizing dieting isn't effective? What does acceptance mean to them? Acceptance can be a stumbling block where it is translated as being 100% happy with your body. Accepting our body doesn't have to mean we like it and want to stay just as we are. It means acknowledging the reality of the body we have, and not judging it as good or bad: it just is. This enables us to work with our body and view ourselves kindly. Self-care and acceptance is a viable option - even if someone also wishes they were thinner, and pain-free, and more self-accepting.

23. The alternative, non-acceptance, emerges from a harsh place of not-okness. It results in us fighting the current reality of our body which will lead to more pain and feelings of failure and frustration, fuelling a cycle of yet more shame and self-blame. Make links between (1) current struggles with body shame and self-blame, (2) what they have previously been told about dieting, and (3) how they have been treated because of their weight. It is not ok they have been treated badly. It is wrong that they were encouraged to diet. What they have endured is an outrage and should never have happened. Help someone locate any harassment and

disrespect as wrong, as real issues that they are not responsible for. Remind them that they are, and have always been, doing the best they can to take care of themselves. And that they are, and always were, worthy of respect. Be clear that respect means everybody – not just healthy or pain free people. Not just people who agree with you. Not just fat people who keep active and eat vegetables or love themselves 24/7 or are trying to stop dieting

24. Depression: Changes in self-care, grounded in kindfulness, can support self-management of, and recovery from, depression in people of any weight. Remember, self-esteem is not measured on the scales or by a tape measure. It is not 'improved' by weight loss. Self-esteem is influenced by self-worth and acceptance, in turn influenced by respect. Discrimination and oppression on all counts is wrong. Suggesting people lose weight to improve feelings of self-worth adds to the problem of size stigma and stereotyped thinking more generally. It is an example of assimilation. Assimilation suggests that the way to tackle racism is to paint people white. It involves attributing the problem of stigma to the stigmatized and putting the onus on them to fit in. So it shores up the status quo and creates a blamed and powerless underclass of marginalised persons required to hide their identity in some way. This means they live lives inconsistent with their sense of self in order to stay safe or merit opportunity. You can see the human rights implications immediately. Health-wise it also ties in with lack of coherence and lack of sense of agency, not to mention the health risks from increased risk of violence and aggression in divisive communities built on judgment. Another relevant concept is that of dramaturgical stress.
This refers to the stress that arises when we try to conceal our identities, keeping up appearances that don't match our feelings and self-concept (Freund, 2002).

Exploration Questions

- Psychologist and activist Deb Burgard enjoins us to ask: Do thin people get this condition? (If yes, it shows that weight is not causal ie. not 'to blame'). If so, what is the medical pathway? How are they treated by the practitioner?

- If someone is being treated unfairly does responsibility for the cause of the problem lie with the victim or the perpetrator?

- What does the table tell us about the belief you need to lose weight if you have high blood pressure, or diabetes, for example?
(Blood pressure and diabetes can improve with behaviour change ie. without weight change; focusing on weight can be harmful; focusing on health-gain, and on body respect is not harmful and supports sustained change. Note that any reference to 'health behaviour change' in this context implies change in behaviours arising from compassionate self-care).

- Reflect back if your client already knew some of this – where you just helping them sort through the maze of myth and fact.

Background: Beyond Non-Diet or Lifestyle Change

Alongside self-care behaviours, the table lists respect as a social determinant of health and recognises that other social factors impact health outcomes. To recap, there is a social gradient in most health conditions that remains even when weight and health behaviours are controlled for. It cannot be wholly explained when material deprivation is also taken into account either. It occurs because living with stigma has a metabolic impact through pathways mediated by cortisol. This happens regardless of health behaviours. It is important that this information informs our work.

The convention of ignoring the impact of social factors ('the body politic') when discussing lifestyle-related conditions has meant that disadvantaged groups are seen as culpable for poor health outcomes and stereotyped as having 'bad habits'. It has meant that health promotion efforts continue to target 'fixing behaviours' when what is really needed is fairer societies. This approach is especially harmful as it does nothing to change the view of life as a level playing field where privileged groups have earned their better health (and life opportunities) and where marginalised groups just need to work harder and take more personal responsibility. By putting social determinants on the map whenever the conversation turns to lifestyle or weight we can help seed the change wherein critical appraisal skills can no longer masquerade as critical thinking. Every time we tell a story about health that ignores the body politic we reinforce the status quo.

In a pirate copy of the Well Now 'Untangling' table, the column on SDH and Respect is presented as 'stress management'. This choice reflects a paradigmatic misunderstanding. It misses an opportunity to bring in the body politic and its language streamlines with a 'personal responsibility' narrative. In this way, it reinscribes the politics of status quo wherein health arises from individual behaviours. In contrast, Well Now views health as emerging in relationships predicated by compassion, criticality and connection.

Background: Integrating Critical Thinking and Compassion

Working through the chart it becomes apparent that it is unethical to recommend weight loss to manage xyz (eg. diabetes/heart disease/knee pain) as dieting is not an effective, necessary, or a safe option for individuals. It is also unethical because it perpetuates messages and practices that increase stigma and health inequalities. It would be more accurate (and ethical and effective) to say:

> *"it might be that thinking differently about how you take care of yourself could help improve xyz. Is this something you'd like to know more about?*
>
> *Switching to focus on health-gain, and body respect, can help people stick with changes in eating and activity that they have found difficult to maintain when dieting.*
>
> *And have you heard of relaxation (mindfulness)? Surprisingly perhaps, taking a short time to 'tune in' like this can help manage (diabetes/heart disease/knee pain) as well. Finding out what works for you in terms of eating, activity and tuning in, means you're likely to feel better in yourself on a day-today basis. I*

don't know if your weight will change or not but we know xyz can improve even if your weight stays the same.

It sounds like you've learned to be down on yourself because of your weight. Believe it or not, this can change too. I mentioned that people's circumstances impact their health: that there's more to health than lifestyle or weight. So often people are given the wrong impression and led to believe that health is all down to lifestyle and weight which means they feel guilty, or have been blamed, for being ill.

Whatever contributes to your condition, the best way I can support you is around looking after yourself. What does this sound like to you? Would you like to know more about what support might look like?"

In summary, weight, health and health behaviours are often conflated in a way that is misleading and unhelpful and that misses the body politic.

This activity untangles the different variables and any links between them. This helps people understand the information so they are better placed to make informed decisions about how to take care of themselves and to act with a sense of agency. It also draws attention to the fact that talking about weight and health without talking about social determinants is misleading, does not amount to evidence based practice, reinforces oppression and privilege and is disempowering. It points to the role of language in eclipsing or emphasising 'the body politic'. It lets people know 'our stories matter' and 'respect impacts wellbeing'. In health-speak, how we are treated by others has embodied consequences, as does how we feel about ourselves, and these are linked. Social change takes time, which us why now is such a good time to start.

How Fatness Gets Linked to Poorer Health

There is a lot of important critique in HAES research and fat activism on this topic. Some of the ways that fatness can be associated with poorer health are through sub-standard healthcare such as under-prescribing of antibiotics and chemotherapy drugs, missed diagnosis, poor treatment, denial of surgery on non-medically justifiable grounds, prescription of diet drugs and lack of research attention to any specific health needs of fat people as a group. The relational aspects of healthcare were covered earlier. Poorer health can arise due to size bias leading to poorer opportunities in work, education and so on, as an adverse effect of dieting, and of course through the embodied consequences of living with stigma and shame. Stigma and shame can also impact people's self-care including health-seeking behaviours, the latter seen, for example, in delayed screening. Be sure to practice explaining the difference between fatness being associated with poorer health and fatness itself causing poorer health – how association and causation are not the same thing.

HAES® stands for health at every size and both are trademark terms of the Association for Size Diversity and Health.

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