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## REFERENCES

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# CREATING KNOWLEDGE FOR TRANSFORMATION: UNDERSTANDING HEALTHISM IN NUTRITION DISCOURSE

**In this article, I begin to explore the question: what's at stake in how we talk about health? Our answers will differ depending on our personal views and values, shaped in turn by our life experience, including our professional education.**

In particular, in this article, I want to consider the concept of healthism and how it is adopted or repudiated, intentionally or otherwise, by different groups of nutrition professionals. I will consider how health and healthism appear within mainstream dietetics, within the non-diet approach (HAES)<sup>5</sup> and in my own Well Now practice, which uses a health justice approach.

## DEFINING HEALTHISM

When I talk about healthism, I am referring, in part, to a belief system that sees the pursuit of personal wellbeing as a moral obligation. In this healthist mindset, 'being healthy' becomes a civic duty, ranked above everything else, like professional accountability, world peace or being kind.<sup>1</sup>

The moral dimension of pursuing personal health is taught and transmitted in everyday food talk, from 'I've been good today' to 'I know I shouldn't'. It is strongly evident in public health campaigns that focus on weight conversion and that conflate body size, lifestyle and health. These campaigns construct thin people as healthy - and therefore (sic) morally responsible. In comparison, fat people are constructed as unhealthy, irresponsible citizens whose behaviours and attitudes are to blame for everything from climate change to spiralling healthcare costs. At its core, this healthist, neoliberal ideology conceals and ratifies a morally heinous supremacist mindset. In this case, the supremacist mindset gets enacted through fat stigma and thin supremacy.

By focusing on lifestyle as a route to health, healthism ignores the fact that early life events, how we get treated by others in our everyday lives and our current circumstances, strongly impact on health via pathways that have nothing to do with what we eat or whether we're active. For example, because healthism explains hypertension through salt intake, physical activity and weight, it overlooks data on racism and hypertension.<sup>2</sup> In this way, healthism amplifies and hides the detrimental metabolic impact of living with racism, and other oppression and involves status syndrome denialism.<sup>1</sup>

Of course, wellbeing and privilege can also overlap with 'lifestyle'. Daily yoga practice, being free of addiction and relying on meals made from an organic vegetable box delivery can materially affect our health whatever our social class or life circumstances. But if you've got PTSD, live in a polluted neighbourhood, subsist on a zero hours contract, are daily shamed and marginalised, these factors detract from wellbeing even if you can find the time for yoga and have the money, time, impulse, storage capacity, prep and cooking space, equipment, mental bandwidth, physical dexterity and pain-freeness to enjoy home-cooked organic meals. As well as ignoring the corporal experience of power, healthism overlooks how structural injustice impacts health through exposure to traffic, industrial pollution, access to

clean water, nuclear contamination, plastics in the food chain and other environmental factors. In short, healthist practice and discourse denies the direct and indirect roles of power in determining health. We have an epidemic of PRDs (power-related diseases) and healthism secures privilege by calling them NCDs (non-communicable diseases).

Using a healthist ideology means we cause harm. This happens directly as we influence clients within the therapeutic relationship. It happens as the attitudes and perspectives we perpetuate cement the status quo and it happens via the missed opportunity to offer a more caring, socially-aware response to disease.

### MAINSTREAM DIETETICS AND HEALTHISM

Mainstream dietetic texts do not name healthism and authors reveal uncritical adherence to a healthist ideology throughout their work. It is easy to see that dietetic discourse is premised on the healthist belief that health is primarily derived from correct body/mind management practices, concerning diet, exercise, sleep, mindfulness, smoking, resilience, alcohol, and so on. This view authorises healthisms' moral judgement as the notion of wilful culpability sanctions blame and shame. After all, it would be nonsensical to blame someone for poor health outcomes if this was outside their personal control. Mainstream dietetics is strongly committed to the idea of personal responsibility for health and perpetuates healthist beliefs that embed moral judgement and superiority.

Within a healthist ideology it is taken for granted that (1) everyone has the cognitive and financial capacity needed for self-care, and (2) making 'good' lifestyle choices secures health. This 'make simple changes' stance is embraced by Public Health England and British and international dietetic organisations. Here, the message is simply eat well and be active to enjoy thinness (sic) and health.

Editors of *The Manual of Dietetic Practice*,<sup>3</sup> a core undergraduate text in the UK, reflect an explicitly healthist stance in statements such as: 'Much of the world's disease burden results from a few largely preventable risk factors, most of which are related to diet and lifestyle.' (p 2) 'Mortality and morbidity from chronic diseases

are greatest in those who are least advantaged, much of it attributable to adverse diet and lifestyle influences.' (p 4)

These statements are not grounded in any conventional scientific reality and exemplify status syndrome denialism. We need only read an introductory book in critical public health<sup>4</sup> to see the claims as post-truth disinformation. Instead, we can more accurately state that much of the world's preventable disease burden results from patriarchy, colonialism and capitalism. Related pathways to ill-health are growing up in a war zone, experiencing racism, sexism and poverty. Yes, clean water and the ability to feed our family and ourselves with dignity matter, but these cannot be described as diet and lifestyle factors. Yes, health inequity is largely preventable: remedy requires a thoughtfully theorised decolonised, trauma-informed approach.

In a fantasy world where everyone's lifestyle meets recommended guidelines, we will remain a weight diverse population and health inequalities will persist as long as there is environmental degradation, racism, abuse, fat stigma, thin supremacy, professional unaccountability, and so on.

### TACKLING HEALTHISM

Advocates of the non-diet approach HAES<sup>5</sup> recognise healthism as a social problem that they are committed to addressing by interrogating their own and other's practice. The phrase 'health is not a moral obligation' is a truism used within the HAES community to challenge the core assumptions of healthism that link human worth and health status. I previously situated my work within HAES and have doubtless said it myself. Today I theorise my work as a health-justice approach, which is distinct from a non-diet approach, and this discussion usefully highlights some differences between the two ideologies.

I argue that, instead of dismantling healthism, repeating 'health is not a moral obligation' in fact inadvertently secures its hold. This is because the phrase embeds health within a reductionist framework, in other words, it locates health in individuals and lifestyle, and it ignores the role of power relations on health.

A number of expanded versions of the phrase are discussed. Experts in the official HAES organisation, ASDAH,<sup>5</sup> note that, 'Pursuing health is neither a moral imperative nor an individual obligation,' and continue, 'Health status should never be used to judge, oppress, or determine the value of an individual.'<sup>5</sup> I am in wholehearted agreement with the second part of the phrase. Tying human worth to health status supports supremacist views, stigma and shame. Enacted in individual lives, it can be (simultaneously) a source of profound personal distress and a means of managing our distress. Connected to this, I also believe that no one is morally obligated to pursue 'health behaviour change'.

However, the assertion that 'pursuing health is neither a moral imperative nor an individual obligation' mistakenly embeds neoliberalism. It does this by framing health, not as socially determined, but as a personal property, and as a function of individual decision-making around eating and body management. Theorising health like this unwittingly closes the door on talking about how power, or rape, or shame, or immigration policy, impact health. Lifestyle is ensconced centre-stage and so seamlessly streamlined with the dominant discourse that there is not the mildest shadow of a question mark to foothold critique.

By erasing eco-social determinants of health, it also ignores the way that our individual behaviours impact on others' health. We are back in a scenario where the role of privilege in assuring health for the privileged and damaging the health of the oppressed is overlooked. 'Health is not a moral obligation' paints a world where the decisions we make in our personal and professional lives, in how we build knowledge and talk about health, are free of wider consequence. It functions to reinforce a system of thought that denies the corporal reality of our inter-relationality. Its deep structures are reductionist and body-unaware, they hide trauma. In overlooking the body politic, it denies the role of power relations in shaping our sense of self, our life opportunities and our health outcomes. The fact that we may not intend our actions to have the outcomes

they do, does not alter the reality of the actual outcomes.

Outside of healthism, health is understood as a function of our circumstances and histories: the dynamic sum of oppression, privilege, trauma, luck, access to clean water, green spaces, community and so on. Well Now is theorised to be body-aware, relational and intentionally political, through which lens 'health' is reappropriated to account for these connections. Now health is not conceptually reducible to self-care, and it is also anything we do that creates a fairer world, such as paying taxes and speaking up against bigotry and misogyny. In this relational mindset, 'pursuing health' then involves tackling racism and building a safe and sustainable world. If this isn't a moral obligation, I'm wondering what is.

We need to tackle healthism and the thinking that sustains it in order to work together towards health-justice. At the same time, hearing the idea that our human worth is not decided by our health status can be hugely liberating. Paying attention to praxis and community knowledge-creation<sup>6,7</sup> can help us communicate both these truths, ensuring congruence between intent and outcome.

## CONCLUSION

Many of us, myself included, entered the health professions legally qualified but lacking the skills, training, knowledge and vision that we need to be safe and competent practitioners. I was taught to use a reductionist ideology, one that did not recognise the person-society-planet complex in theorising health. I was trained to be healthist. Just as we can be sexist, racist, sizist, whether or not we intend to be, whether or not we know what the terms mean, or have any interest in understanding what's at stake, we will be pro-healthist, or anti-healthist even if we've never heard the words before. This can be a startling, unwelcome realisation. And also a liberating one. Because every new awareness makes transformation a more meaningful concept. We get to choose. Some of the options we have are to repress the knowledge and opt for oppression as usual, to hand-wringing, or wait to be sent on a course; or to reject complacency, educate ourselves, strategise for justice and speak up.<sup>8,9</sup>