EFFECTING CHANGE IN PUBLIC HEALTH

Lucy Aphramor
PhD RD
Dietitian,
Self-employed

Lucy Aphramor developed 'Well Now', an approach to nutrition that teaches compassion, fosters self-care and advances social justice. They are an award-winning dietitian and a spoken word poet.

Is the role of dietetics […] to "find the behavioural equivalents of protease inhibitors"?[1]

Dietetics places lifestyle at the centre of improved public health. This focus has aimed a spotlight on individual health behaviour change, while casting a shadow over other vitally important and more complex factors that shape public health outcomes. In broad strokes, this article asks: "Is the focus on individual health behaviour change creating a streetlight effect?"

The streetlight effect is a type of observational bias that occurs when we look for something only where it is easiest to do so.

For many people working in public health, it seems self-evident that behaviour change techniques are pivotal to the success of our work. After all, how else are we to effect health improvement? In primary care, we consider a client's readiness for change and then support the client to set realistic SMART goals. A patient-centred approach is deemed to ensure that this goal setting is shaped by broader material factors, such as a client's financial resources and food availability, which impact a person's ability to make any 'choice' a meaningful reality.

In this article, I take a critical look at the streetlight effect which the focus on individual behaviour change is creating. I also highlight some key features that underlie two different models in public health: reductionist, which currently shapes public health practice, and relational, which offers a more socially just and evidence-based approach to shaping public health practice.

By 'taking a critical look', I mean applying critical thinking. This is related to and expands skills learned in critical appraisal, where critical appraisal is a systematic process used to identify the strengths and weaknesses of a research article to determine the value of findings within the perimeters of reductionist science. Critical thinking also identifies the strengths and weaknesses of research articles. However, it goes beyond the scope of reductionist science, seeking to further understand the truths of things in service of fairness (Figure 1). While this has obvious links with the impetus for evidence-based medicine (EBM), a key difference emerges. This is that critical thinking assesses the assumptions of the frameworks used for critical appraisal and EBM. This helps us to avoid mere superficial tweaking of less-than-useful frameworks or approaches and encourages transformational change. It's not the same as criticising, which may stop at finding fault when something doesn't support our view of things, or harsh judgement for the sake of it.

Critical thinking involves engaging with ideas from a range of perspectives so we include many ways of knowing and embrace views that go beyond accepted, albeit sometimes problematic, norms. It helps us identify assumptions, omissions, flaws and contradictions in practises and beliefs that might be commonly accepted as factually correct. This means that it is integral to the moral and ethical landscapes of our work. Developing critical thinking skills helps us to be clear about our biases and values. It is a step in figuring out any mismatch between theory and practise. This helps to ensure that the work we do really does enhance people's welfare and advance the common good.

Figure 1

Criticality: this involves us holding our truths up to the light of others' understandings. It helps us find our blind spots. Critical thinking skills can be taught. They move us away from stereotype, hierarchy and judgement. They move us towards an open-minded discernment that values difference. This enables us to claim our many identities and be cool with others claiming theirs. Criticality advances social justice.

Critical appraisal: involves assessing research to see whether researchers have stuck to the rules of their discipline. It determines trustworthiness and usefulness within the accepted norms of a group. It discourages investigation of group rules, norms and values. As such, it inadvertently entrenches biases and so mitigates against social justice and robust science.

CRITICAL APPRAISAL AND HEALTH BEHAVIOUR CHANGE

Behaviour change is often situated within psychology with a plethora of health behaviour change models and theories to draw on, including the stages of change (transtheoretical) model, health beliefs model, theory of reasoned action, theory of planned behaviour and the health-action process approach, to name a few. Self-efficacy is an important aspect of many theories. These theories describe factors that influence someone's motivation and opportunity for changing health behaviours, for example, risk perception, outcome-expectation, intention, and triggers. Models place a different emphasis on the relative importance of variables that lead someone to kick-start, and then follow through on, an eventual pathway of sustained behaviour change.

There are plenty of critiques of behaviour change models in the literature. Some critiques point to scant evidence of successful real-life application of a particular model. Others question whether the discrete stages proposed by a model can actually be validated in practise.[2]

We can add that these models rely on a cognitive model for decision-making. This adopts a mechanistic mind-set and assumes rational volition. In other words, actions are deemed to follow step-wise from thought processes that largely exclude non-rational input. This scenario assumes that we end up with a balance sheet of pros and cons and when the pros outweigh the cons, we are tipped over into taking action. In fact, non-rational knowing informs all human behaviour: it is unhelpfully simplistic to construct them as distinct for the separation exists in theory only, not reality.

Moreover, critiques of behaviour change models often occur within pre-determined perimeters. They are an example of where critical appraisal encourages us to improve on what is offered, but not attend to or question core beliefs or values. This type of critique fits within the reductionist paradigm through which health behaviour and health outcomes are often understood. The issue with this type of critique, and critical appraisal more generally, is that it doesn't prompt us to seriously question any underlying assumptions of reductionism. In fact, the somewhat formulaic approach used may embed our blind-spots, and with robust interrogation thus stymied, move us away from the robust science we seek.

CRITICAL THINKING AND HEALTH BEHAVIOUR CHANGE

Several unarticulated assumptions underlie reductionism and the behaviour change models it spawns. We can identify these assumptions through thinking critically about scientific quality, ethics, and social justice. For example:

Assumption 1: *Health behaviour change models are derived from a reductionist paradigm. Hence, they present embodiment and reason as separate domains, and they do not routinely integrate psycho-social variables. Is this good science?*

Short answer: No, scientifically speaking it is nonsense to use cognitive models that assume a body-mind split. To do so requires us to write off the whole of quantum science and neurobiology, thereby undermining professional credibility.

It can be easy to get caught up in debating the finer details of the various behaviour change models to try and improve shortcomings (i.e.

critical appraisal). But if we take a step back and look through a critical thinking lens, a different picture emerges. While critical appraisal looks to improve current models, critical thinking recognises that an inherent limitation of these models is that they apply a mechanistic mind-set to human behaviour and health. It becomes apparent that a different paradigm approach that theorises the body-mind as inextricably linked and can incorporate the 'social body', is needed. Such an approach would make use of trauma physiology and integrate data that links racism and hypertension, for example:[5,11]

Assumption 2: *If we succeeded in perfecting health behaviour change models, the extrapolated lifestyle change would make a significant difference to public health outcomes and reduce health inequity.*

Short answer: Seventy years of research has shown that lifestyle factors (health behaviours) account for as little as 5-25% of social differences in health outcomes.[3,4]

We need to reconsider the behavioural approach to public health when up to 95%[4] of inequalities in 'lifestyle diseases' can be explained by people's experiences of oppression and trauma.

Health promotion based on behaviour change has greatest benefit in groups for whom structural, socio-political factors are already very much in their favour.[5]

By disproportionately benefiting people in higher social classes, it increases health inequalities. It also obscures injustice and stigma as health hazards. This contravenes the goal of health promotion as enhancing health equity.

A reductionist approach is not ethical.

Research into effective behaviour change in public health is underpinned by the notion that helping people to alter diet, activity, alcohol intake and smoking, will be effective in improving nutrition-related conditions like diabetes, hypertension and heart disease.

While health behaviours can have an immediate impact on our sense of wellbeing, they explain only a small percentage of population health outcomes. In other words, even if everyone in a population followed recommended guidelines for health behaviours, differences in health outcomes would persist among and between groups. Group differences would still be seen along the lines of poverty, which links to status and power. People with more power would still be statistically healthier than people with less power - even if we matched up on health habits. Focusing on behaviour change habituates an observational bias (of reductionism, or materialism) that obscures the pertinent fact that those of us who live with material disadvantage and/or oppression will experience poorer health than those of us who don't and these differences cannot be remedied through lifestyle change. Of course, there are pathways that inter-connect behaviour, oppression and trauma. However, living with oppression and trauma also impacts wellbeing through disease pathways that are not primarily mediated by food intake and activity levels. Here, toxic stress leads to long-term metabolic change through the effect of chronic cortisol release on regulatory processes.[4,7]

When we shine a spotlight on individual health behaviour change and lifestyle choices, the social determinants of health, like access to power and respect, are often elided and get misunderstood as meaning 'the socially distributed ability to eat well and be active'.

The current focus on lifestyle change as a route to improved public health ignores the influence of toxic stress on metabolism and does not address the social determinants of health.

***Assumption* 3.** *Helping people alter their lifestyle is empowering.*

Short answer: For whom? And what do you mean by empowerment in this context?

For sure, it is vital we consider the role of power, including an individuals' sense of their power or ability to influence their own lives (sense of agency), in determining health and illness and in shaping healthcare delivery.

However, real empowerment is a process that involves systemic social change, with action preceded by collective consciousness

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raising. It does not stop at self-esteem. It is not about compliance or coercion. Lifestyle change falls under the rubric of 'impowerment', which relates to self-care. Impowerment was initially used to refer to the process of conferring power on a patient by someone in authority.[8] I think this fails to understand different types of power. I use impowerment to refer to a meaningful sense of one's power-from-within. Impowerment fosters empowerment through links with a critical awareness of power-over and increased capacity to engage in and influence power-with relationships.

Teaching lifestyle change as the route to improved health can lead to shame and victim blaming. The current narrative occludes the social embeddedness of health and illness and as such is disempowering.

This is not the same as saying that food and activity are irrelevant to wellbeing, or that the role of the public health dietitian should be scrapped. What it does illustrate is the urgent need to move away from reductionism and approach public health nutrition in a radically new and truly empowering way.

ETHICAL DECISION MAKING: WHAT'S A PUBLIC HEALTH FOOD WORKER TO DO?

If not behaviour change, then what? Vast amounts of research in health and community development show the real-life benefits of a more holistic, socio-politically aware, or relational approach to health and equity. This suggests that health behaviours must be newly defined as 'behaviours that build a fairer world'. The onus is on those of us who have privilege to work for systemic social change. Within this, it behoves health practitioners to challenge and rewrite dietetic narratives that shine the streetlight on lifestyle and hide the bigger picture.

For this shift to happen, it is imperative that we reset our nutrition work compass towards health-gain in its widest sense. Health-gain embraces self-care *and* social justice. We need to untangle confusions around health, weight, social determinants and behaviour change. And in the current morally laden and anti-fat climate of health, it remains imperative that we speak up for respect for people of all shapes, health status, earning capacity, fitness levels and so on. More than ever, public health needs us to clearly communicate our belief in self-worth and dignity as a birth right, not things earned by our actions or bestowed on us by others. In teaching self-care we need to adopt a relational approach, not a reductionist approach. A relational approach works to strengthen body-mind-(and -spirit-planet) integration, not dismiss it. It integrates data on the embodied (physiological, psychological, epigenetic) consequences of power operating via the socio-political realities of people's lives (e.g. stigma, poverty), rather than disregarding this knowledge as an inconvenient complication. In short, whether it takes place in individual consultations or groups, ethical public health nutrition work must be compassion-centred, trauma-informed and justice-enhancing. These are hallmarks of Well Now, an approach promoting body respect and health-gain that I developed to help build a fairer world through nutrition work.

In the short term, a new focus on body respect and health-gain in its widest sense will beneficially influence people's relationships with food and their bodies, expand understandings of health, foster compassion, and address size bias. In time, it would be expected to change funding and research agendas and be reflected in dietetic education. The good news is that this vision is being made reality by a growing number of UK dietitians and allies, working within[9] and outside the NHS[10,11] and overseas.[12] My hope is that reading this article inspires you to explore our work, and read more on the topics introduced.

CPD Questions
(The article provides a brief overview of many related issues. Further reading and reflection, is recommended before answering CPD questions.)
1. Were there any surprises?
2. Describe key characteristics of two conceptual approaches to public health nutrition.
3. What are the differences and similarities between critical appraisal and critical thinking?
4. Outline some of the scientific weaknesses of cognitive behaviour change models. Can these models be salvaged, or is a new paradigm approach required? Explain your rationale.
5. There is a social gradient in health. How much of this is explained by health behaviours?
6. Define social determinants of health.
7. What are the distinctions between impowerment and empowerment?
8. What is the role of the food worker (dietitian, nutritionist, community development worker) in public health?
9. How does what you have learnt by reading the article affirm or challenge your existing knowledge?
10. Is there anything you read that evokes confusion or another emotional response? If so, what can you learn from this?
11. What is the ethical response to reading this article? What will support this? What impedes this?
12. Can you suggest behaviours that will help dietitians build a fairer world (a) as individual practitioners and educators (b) as a profession?

References

1 Buchanan D (2000). An ethic for health promotion: Rethinking the sources of human well-being. Oxford: Oxford University Press, p 46

2 Stages of change. A critique. Available from: www.researchgate.net/publication/11405552_Stages_of_change_A_critique [accessed May 26, 2017]

3 Work Stress and Health: the Whitehall II study. Published by Public and Commercial Services Union on behalf of Council of Civil Service Unions/ Cabinet Office. Copyright © 2004 CCSU/Cabinet Office. Ed: Jane E Ferrie. www.ucl.ac.uk/whitehallII/pdf/wii-booklet. Authors state that there is a social gradient in smoking and physical activity and that 'these aspects of lifestyle and associated measurements, such as plasma cholesterol and blood pressure, are responsible for about a quarter of the social gradient'. They list weight status too, which I omit here, as weight is not a behaviour, p 16

4 EJ Brunner et al (2002). Adrenocortical, Autonomic, and Inflammatory Causes of the Metabolic Syndrome: Nested Case-Control Study. Circulation 106 (21): 2659-65; Richard Wilkinson and Kate Pickett (2010). The Spirit Level: Why Equality is Better for Everyone. Penguin, UK

5 Baumann (1989) in Ministry of Education, New Zealand (2003), in Aphramor L and Gingras J (2009). That Remains to Be Said: Disappeared Feminist Discourses on Fat in Dietetic Theory and Practice. In The Fat Studies Reader. Eds: E Rothblum and S Solvay. New York University Press, New York, p 97-105

6 Shannon Sullivan (2005). The Physiology of Sexist and Racist Oppression. OUP, USA

7 Björntorp P, Holm G, Rosmond R (1999). Hypothalamic arousal, insulin resistance and Type 2 diabetes mellitus. Diabet Med. 16(5): 373-83; Rosmond R, Björntorp P. (2000). The hypothalamic-pituitary-adrenal axis activity as a predictor of cardiovascular disease, Type 2 diabetes and stroke. J Intern Med. 247(2): 188-97

8 Macdonald TH (1998). Rethinking Health Promotion: A global approach. Routledge, London

9 Clarke F, MacDonald V and Huc S (2015). What next for Well Now? A group based weight management intervention which prioritises health gain over weight loss. Presented at NHS Highland: Research, Development and Innovation Annual Conference, 13 November 2015, University of the Highlands and Islands, Inverness. http://lucyaphramor.com/dietitian/wp-content/uploads/2016/12/nhs_highland_evaluation_2015_poster.pdf

10 Aphramor L0 (2017). Welcome to Well Now. http://lucyaphramor.com/dietitian/wp-content/uploads/2016/11/welcome_to_the_well_now_way.pdf Aphramor L and Khasteganan N (2016). Re-orientating Dietetic Interventions for Adults with Eating and Weight Concerns: A Qualitative Study of the Well Now course - Part 1. Journal of Critical Dietetics, 3 (2), 56-66; Aphramor L and Khasteganan N (2016). Re-orientating Dietetic Interventions for Adults with Eating and Weight Concerns: A Qualitative Study of the Well Now course - Part 2. Journal of Critical Dietetics, 3 (2), 67-76; Aphramor L. Mindfulness in healthy weight and diabetes. Journal of Diabetes Nursing, 19: 401-7

11 Dietitians for Social Justice. http://lucyaphramor.com/dietitian/dietitians-for-social-justice/

12 Gingras J, Asada Y, Brady J and Aphramor L (2017). Critical Dietetics. Challenging the Profession from Within. In Critical Perspectives in Food Studies 2nd edition. Eds: M Koç, J Sumner and A Winson, pp 95-107