Listen… and Speak: A Discussion of Weight Bias, its Intersections with Homophobia, Racism, and Misogyny, and Their Impacts on Health

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ABSTRACT

This article is a version of the Ryley–Jeffs Memorial Lecture, delivered on 8 June 2018. It discusses weight bias and the intersections with homophobia, racism, and misogyny, and how these impact health. While the dominant discourse attests that people can lose weight and keep it off, evidence informs us that maintenance of weight loss is unlikely. Using a flawed epistemological framework, obesity has been declared a disease, and weight bias been perpetuated. Weight bias is pervasive, both in the general public and amongst health professionals, often using inappropriate tools to assess the impact of weight on health. This contributes to overlooking the life circumstances that truly cause morbidity: social determinants of health such as income, social connectedness and isolation, adverse childhood experiences, and cultural erasure. A variety of tools dietitians can use to appropriately assess health risk are provided, along with examples of actions that can be taken to reduce weight bias. Dietitians who are leading the profession in taking action against weight bias and stigma are profiled.

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RÉSUMÉ

Cet article est une adaptation de la conférence commémorative Ryley–Jeffs prononcée le 8 juin 2018. Il porte sur les préjugés par rapport au poids et les recoupements qui peuvent être faits avec l'homophobie, le racisme et la misogynie, et l'incidence que ceux-ci peuvent avoir sur la santé. Alors que le discours dominant laisse entendre qu'il est possible de perdre du poids et de ne pas le reprendre, les données probantes démontrent que le maintien de la perte pondérale est peu probable. Nous appuyant sur un cadre épistémologique déficient, nous avons déclaré que l'obésité était une maladie, perpétuant ainsi les préjugés liés au poids. Les préjugés par rapport au poids sont omniprésents, tant chez les membres du public que chez les professionnels de la santé, qui se tournent souvent vers des outils inappropriés pour évaluer l'impact du poids sur la santé. Ce faisant, ils contribuent à la mise de côté des véritables causes de la morbidité : les déterminants sociaux de la santé comme le revenu, les liens sociaux et l'isolement, les expériences négatives au cours de l'enfance et l'effacement culturel. Une variété d'outils auxquels les diététistes peuvent avoir recours pour évaluer de façon adéquate le risque pour la santé est proposée. Des exemples de mesures pouvant être prises pour combattre les préjugés par rapport au poids sont aussi offerts. Enfin, des diététistes qui agissent à titre de leaders au sein de la profession pour contrer les préjugés et la stigmatisation entourant le poids sont présentés.

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INTRODUCTION

I want to talk to you about listening and speaking about weight bias and the intersections with homophobia, racism and misogyny, and how these impact health.[1] For those who have not met me, I am gay. I tell you this because gay men of my generation learned early to be critical. We were told by everyone—by our parents, our families, our teachers, our priests, our friends—that we would grow up, fall in love with a lovely young lady, get married, and live happily ever after. And we knew inside that that wasn't true. And so we learned to be critical; sometimes, even with the best of intentions, people tell us lies.

Weight loss and the associated discourse

Let's talk about weight loss. In 1995, the great Kim Raine wrote in *Eating Agendas: Food and Nutrition as Social Problems* [1] an outstanding discussion of discourse. Simply put, discourse is the dominant way that people talk about things. Our dominant weight discourse tells us that people can lose weight and keep it off. Yet, the evidence tells us that this is not true.

One hundred, seventy-six thousand records reviewed from the United Kingdom Clinical Practice Research Data Link from 2004 to 2014 [2] found that people with a body mass index (BMI) of 30–39 have an annual probability of attaining

[1]In this paper, I will be using the word "fat." I do this based on the recommendations of the National Association to Advance Fat Acceptance (NAAFA), who want us to reclaim the pejorative nature of this word. NAAFA."Fat" is not a Four Letter Word; 2015 [cited 2018 June 22]. Available from: https://www.naafaonline.com/newsletterstuff/oldnewsletterstuff/July%202015%20NAAFA%20Newsletter.html#LETTER.BLOCK9

normal weight of 1 in 210 for men and 1 in 124 for women. This increased for folks with a BMI of 40–49, to 1 in 1,290 for men and 1 in 677 for women. The annual probability of achieving a 5% weight reduction was 1 in 8 for men and 1 in 7 for women. However, amongst the participants who lost that 5%, 53% at 2 years and 78% at 5 years, had BMI records indicating they had regained weight to more than their original loss.

Many will query, "What about the U.S. Weight Control Registry?" The Weight Control Registry is not randomly selected; it's a skewed sample. Rena Wing and James Hills' definition of successful weight loss maintenance is that you lose weight and keep it off for 1 year [3]. Registrants must meet these criteria, before they can register. Wing and Hill have noted in published articles that their data are not generalizable to the public [4]. The thing is, even if 1% of people maintain their weight loss, we still get some pretty big numbers when we talk at a population level. And yet, we don't actually talk about the percentages and the statistics behind population data.

It is very challenging for people to maintain weight loss. In 2007, Mann et al.'s [5] systematic review of dieting studies showed that although people lost weight in the first 9–12 months, they regained all but an average of 2.1 pounds over the next 2–5 years. It appears that weight regain is the typical long-term response to dieting, rather than the exception. Garner and Wolley's [6] 1991 article iterates the failure of weight loss interventions.

To review, there is no effective intervention for long-term weight loss. Further, weight does not change our intervention as dietitians. We urge people to choose healthy foods, to be active, to feel good about themselves, and to do spiritual development, because these things make us healthy. Let's discard weight as an evaluator of health and counsel about behaviours—something that makes a difference.

Ontology and epistemology of obesity

Ontology is that which is known. Epistemology is how it came to be known. So when talking about epistemology, consider this: until I was 14 years old, I was considered mentally ill. In 1973 the American Psychiatric Association hosted a symposium, which recommended that homosexuality be declassified as a mental illness [7], and it was removed from the Diagnostics and Statistical Manual on 23 December 1973 [8]. So we need to remember that any research about homosexuality prior to about 1975 is flawed by its epistemological framework: the premise that homosexuality was an illness.

Where does this leave us in our studies of weight? In 2013 the American Medical Association recognized obesity as a disease [9]. In making the decision, the Association went against the recommendation of the committee that they had struck to study this issue [10]. In 2015 the Canadian Medical Association (CMA) followed suit and stated, "*This move by the CMA speaks to the importance of addressing obesity and dealing with the stigma that is often associated with the condition*" [11]. I can tell you personally that declaring HIV a disease did not reduce its stigma. When I was in my 20s, all of my friends died. I had to watch them literally waste away to nothing, while governments and senior health officials dilly-dallied and preached about abstinence and shame. That was a load of bad cess. Surely, we can learn from our mistakes. Research shows us that the solutions to HIV transmission are pride [12] and safe sex [13]. So let's grab a new epistemology, one that embraces body positivity and healthy behaviours, and let the weight discourse fade into the oblivion it deserves.

Weight bias

We need to recognize that weight bias hurts. The words we use to label fat people cause emotional pain [14]. Weight bias makes us lie. It makes us lie about our weight. It makes us lie about things that "help" people lose weight. It makes us lie about the things that we eat, and it makes us tell stupid stories about weight.

Weight bias makes us judge. My friend, dietitian Cristel Moubarak, is a successful businessperson and the founder of NutraFoodie, which runs nutrition education and cooking summer camps for children aged 8–13 years. She's shared with me some of the feedback she's gotten when presenting proposals to companies about working with their staff to improve nutrition and health: *"Here we also walk the talk, not just talk the talk." "I wouldn't trust a fat dietitian because I can't look up to them." "I can see all your food photos online; starting to show on you, too."* These comments sidestep the point that Cristel is, statistically, the size of an average woman in Canada, and could provide an empathetic approach and collaborative engagement for their staff, not to mention the fun time that she provides when she's cooking and teaching with people.

Weight bias makes us deny care. Transmen here in British Columbia (BC) are often refused top surgery because of their weight, despite the fact that many of them purposefully gain weight to protect themselves from the violence that they deal with, and the denial of surgery actually puts them at risk for suicide [15]. Martina Dockers wrote of receiving a variety of diagnoses for her knee pain, with the sole intervention being told to lose weight [16]. Finally, she met a physiotherapist who prescribed her exercises that resolved the pain after 6 months of therapy.

Weight bias contributes to a lack of critical analysis. We're told time and again that the loss of 5% of our body weight will result in phenomenal health changes. Why is this attributed to weight and not to improvements in healthy eating, physical activity, and self-worth? In 2013 Mann and colleagues revised their systematic review [17] concluding that increased exercise, healthier eating, and engagement with the healthcare system could confound the relationship between weight loss and health. Again, weight bias makes us lie. It makes us steal people's dignity. And it makes us cheat ourselves out of the truth. Weight loss is not related to health.

BMI as a predictor of risk for chronic disease

BMI is a poor assessor of health [18, 19]. In Practice-based Evidence in Nutrition (PEN) [20], we see that key practice point #1 summarizes the evidence that BMI can be used with other indicators like waist circumference as a screening tool. Okay… key practice point #2 tells us that BMI is "*a highly reliable and convenient measure used to screen for obesity*", but it does have some limitations: the data are not really appropriate for muscular athletes; it's not appropriate for anyone under 19, because they're in growth; it's not appropriate for anyone over 65; it's not appropriate for any person of colour because it's based on Caucasian populations. Not Chinese, South Asian, not for the Indigenous population. So why doesn't key practice point #2 say this: "*BMI is a convenient measure used to screen for obesity. Its usefulness is limited to white guys between 20 and 60 who really aren't very muscular*"? The reason is because we love the status quo, and that's perpetuated by weight bias amongst health professionals.

Weight bias amongst health professionals

There are a variety of public health campaigns that perpetuate weight bias [21]: 2 examples are from Minnesota Blue Cross [22] and the state of Georgia [23]. The good news is that there is pushback to these campaigns and protests against shaming people for their body weights [24].

There is a discourse of an "epidemic" of type 2 diabetes in youth. The 2018 Diabetes Canada Clinical Practice Guidelines (CPG) states that the incidence of type 2 diabetes in youth less than 18 years of age was 1.54 per 100 000 people, with some regional variation [25]. Yet eating disorders affect 1500 per 100 000 people, aged 15–24 years [26]. Hence, the incidence of eating disorders is 975 times more than type 2 diabetes. Where are the discourses about eating disorders in youth? Why are we campaigning about obesity when those very campaigns contribute to people adopting maladaptive eating?

Weight bias is pervasive; it's comprehensive across all health professions, including dietetics [27, 28]. Even something as simple as telling people to lose weight has associated harms [29]. To start, we have recommended an intervention that is ineffective. People told to lose weight are less likely to utilize health services and may delay or forego preventive care like pap smears or mammograms. They are less likely to engage with the healthcare system. Patients are more likely to begin maladaptive eating behaviours. And they are less likely to participate in and may even avoid physical activity. When we tell people to lose weight, the outcomes we achieve are the exact opposite of behavioural outcomes we want.

Further to this, the harms that we associate with obesity may, in fact, be caused by weight stigma. It might be even stronger than other types of discrimination in its associations with disease [30, 31]. We know there are associations between stigma and health: from racism, from our treatment of Aboriginal peoples. What is really making people sick?

What is really making people sick?

When it comes to things that make people healthy, number 7 on the list is personal health practices and coping behaviours [32]. Numbers 1 and 2 are income/social status and social support networks. Diabetes incidence amongst the lowest income quintile is almost twice as much as in the highest quintile [33]. Some of you might have seen the 10 alternative tips for staying healthy [34]. Let's look at number 1: "*Don't be poor. If you are poor, try not to be poor for too long*" [34]. Income has an enormous impact on health. So do race, socioeconomic class, ethnicity, social interactions, sexual orientation, and even ability and education. We need to address and acknowledge the structural causes of ill health through approaches rooted in social justice and advocacy. This is recommendation number 18 from the Truth and Reconciliation Commission [35], which pertains not only to Indigenous people but to all people across Canada.

It was the nutrition experiments in residential schools that shaped the diabetes incidence in Aboriginal populations [36]. Diabetes Canada's 2018 CPGs state we need to recognize that colonialism is the origin of much of the incidence of diabetes in Canada's Aboriginal population [37].

Adverse childhood experiences and a toxic stress response can greatly impact the risk for disease [38]. Toxic stress response occurs when a child experiences strong, frequent, and prolonged adversity. This could simply be the accumulated burdens of family economic hardship, or it could be things like physical or emotional abuse, chronic neglect, or substance abuse. This kind of prolonged activation of the stress response disrupts the development of brain architecture and can increase risk for stress-related disease well into our adult years [39].

Social isolation has an enormous impact on health. The impact of loneliness and isolation is comparable to risk factors like cigarette smoking [40–42]. It also increases risk for cognitive impairment and dementia. Vancouver Coastal Health reports that people with a very strong sense of community belonging were 2.6 times more likely to report good/excellent general health when compared to those with very weak sense of belonging [43]. When people are isolated, it makes them ill.

I'd like to share the First Nations' Perspective on Health and Wellness [44]. I love this model of health, because it centres on the human being and the physical, mental, spiritual, and emotional health. It sets health in a milieu of responsibility and respect, of wisdom and relationships, and looks at the influence of land and community. And it examines everything in the context of the environmental, economic, social, and cultural setting in which wellness occurs. This, the First Nations people tell us, is the way it has always been passed down from our elders and traditional healers. Wellness belongs to every human being, and their reflection of this perspective will be unique to them.

Listen… actions dietitians can take

The diet history is a foundational tool for dietitians to assess people's health, but we also need to assess for poverty, for a history of poverty, for experiences of stigma, and a history of weight cycling. We need to acknowledge the connections between adverse life experiences and a capacity for management of that adversity. And we need to explore people's perspectives on their adverse experiences in the context of health, in order to help them address what they identify as their priorities for health.

So next time you're doing a Framingham or a CANRISK, how about using the *Poverty Intervention Tool* [45] from Doctors of BC? It asks 1 simple question, a sensitive tool for identifying poverty: "*Do you ever have trouble making ends meet at the end of the month?*" There's also the United Kingdom's Campaign to End Loneliness, which has a number of assessors for social isolation [46]. Dietitians can talk about community gardens [47] and community kitchens [48–50], common interventions with real benefits for social isolation and social connectedness.

We also need to think about internalized weight stigma [51, 52]. How do people feel about their bodies? How do they feel about their trans bodies? [53–55] How do they feel about the utility of their bodies? What do they feel they are able to do? A real foundational question is to ask people what will be different in that future, idealized body that you have? Will it get love? Will it fit in a size 2? Why?—These questions quickly help us to understand the changes clients want in their lives, rather than changing their weight.

…And speak: actions dietitians can take

And of course, I urge you to speak. First, chart what you do. I've had hundreds of clients referred to me by physicians for weight loss, and I've charted exactly what I did: I talked to them about healthy eating, about physical activity, about mental health, about spiritual development. I gave them the statistics and information about the likelihood of weight loss maintenance over the long term, and I charted exactly that. And no physician has ever asked me about my intervention. Does this mean that (*i*) they don't read my charting or (*ii*) that they support my intervention?

We also need to speak up when we see BMI used as an assessor for health. Write to organizations that promote the use of BMI as a health assessor, and urge them to use more accurate assessors. We need to write to people and organizations and tell them when they are perpetuating weight bias.

We need to ensure that we include fat people when we are making decisions and developing programs. These are the people who have been denied a place at the table [56]. "Let's have a childhood obesity program" you say. Well, let's ask some fat kids to tell us what they think of the program.

We also need to support cultural reclamation projects. The strongest association with the reduction of diabetes risk is cultural identity [57]. Using language knowledge as a proxy indicator for cultural identity amongst Alberta's Aboriginal populations demonstrated a decline in the risk for diabetes when people knew their own language. We need to work towards the recommendations of the Truth and Reconciliation Commission in order to reduce diabetes in the Aboriginal population [35].

Dietitians are Leaders

The good news is that dietitians are leaders. The following are some I'd like to highlight: **Lucy Aphramor**, PhD and Dietitian, and **Dr. Linda Bacon** who wrote *Body Respect* [58]; **Dr. Jacqui Gingras**, one of the founders and the steward of the criticaldietetics.org [59]; **Maria Ricupero**, the secretary of the Association for Size Diversity and Health [60]; **Flo Sheppard**, who collaborated to develop a position to move away from weight as a predictor of health [61]; **Helen Yeung** was on the committee that developed the paper *"The Focus is on Health, not Weight"* an internal Vancouver Coastal Health policy that encourages people to focus on health rather than weight [62] (Please contact Gerry Kasten (gerryk@telus.net) for a copy of this paper.); **Lindsey Mazur**, who lobbied the provincial government to include weight discrimination in the Human Rights Code [63]; **Dana Sturtevant** and **Hilary Kinavey**, who started benourished.org [64], offering courses to health professionals to identify internalized weight bias, and to practice stigma-free; **Kori Kostka** [65] launched a project to educate people about how to attract clients while discarding a weight-centred approach [66]. And last but not least, we have Balanced View, an online learning resource [67]. The evaluation showed that it reduces weight bias for the period of 6 months [68].

CONCLUSION

And so to review: knowledge of weight does not change our intervention with that person. We live in a toxic pool of weight bias, and we must be vigilant to avoid it. And that the social aspects of one's life, such as income, social isolation and adverse childhood experiences, are the key determinants of health and they must be addressed in step with our nutrition interventions. Lastly, dietitians are leaders in action against weight stigma and will continue to lead.

Kathleen Jeffs wrote in 1947 that "*… the future of our profession is what you and I make it. At present, opportunities for members in every field seem boundless. Our present membership falls short of meeting the demand for dietitians, and it is the duty of every dietitian to create a good understanding of the important role our profession plays in serving the community*" [69].

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