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Breaking WEIGHT BIAS

Promoting Health without harming through digital training tools

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Module 6: Tools for a healthier relationship with food and body

6.1. Weight-inclusive approach

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TRAINING CONTENT

Learning objectives:

- become aware of the weight-inclusive approach and its principles,
- learn the principles of the Health at Every Size® (HAES®) model and how it can be applied to policy, within healthcare, and in personal life,
- gain awareness of weight-inclusive strategies to reduce weight stigma in healthcare settings,
- become familiar with mindful & intuitive eating, as two different non-diet approaches that can improve individuals' relationship with food and help them reconnect with their internal cues,
- recognise what trauma is and its impact on people's health, how it can be related to diet culture, and why trauma-informed care is every healthcare professional's business,
- understand how the weight-inclusive approach can be implemented in public health.

6.1. Weight-inclusive approach

Weight-normative vs weight-inclusive approach

Imagine a person that has been facing different forms of weight bias and discrimination in many aspects of their personal and professional life and how all those stigmatising experiences have affected their physical and psychological health, as described in module 1. A person who keeps turning to health professionals to ask for help and support, and instead, faces weight bias again and again, including receiving unsolicited advice for weight loss, not really being listened to, and receiving poor treatment or even misdiagnosis for serious health problems, as it has already been mentioned in module 2. All those repeated stigmatising events have already led to internalisation of weight bias by the individual, which makes it even harder for them to take good care of their health, as we discussed in module 3. The individual also feels pressure from the societal stereotypes of diet culture that equate having a thin body with beauty and health, as described in module 4, and thus, keeps trying the one "new promising diet" after another since childhood, which only triggers weight-cycling and its harmful impact on their health, as it has already been analysed in module 5.

The above, imaginary scenario represents a typical example of a weight-normative approach, which focuses almost exclusively on weight and seems to consider weight-loss as the main indicator of health (Dada, 2020). Such perceptions are widely spread among our society and can act as a serious barrier to proper diagnosis and treatment of individuals. In fact, the harmful effects of weight-normative approaches are represented thoroughly in all the previous modules of the training, and this is exactly the reason why in this last module we chose to introduce the **weight-inclusive approach** in the place of weight-normative approach in health.

The weight-normative approach can create a very serious dilemma for healthcare professionals, as they feel like they "have to" urge people to lose weight (since according

to this approach, weight-loss is considered to be the most important contributor to health), whereas it is well-documented that weight loss is not sustainable long-term for most people, and weight loss efforts can induce weight cycling, which is associated with many undesirable health outcomes. This pressure can very easily lead health professionals to move away from the basic ethical principles in the care of their patients by perpetuating harm instead of promoting benefit (Tylka et al., 2014).

6.1.1. Description and principles

The weight-inclusive approach recognises and supports that individuals have little impact on their weight due to the complex interplay between genetics and many other different factors, including the social determinants of health (Silventoinen et al., 2010; MacLean et al., 2011; Sumithran & Proietto, 2013), as we already discussed in module 5. This approach aims to make health care accessible for all shapes and sizes by inviting healthcare professionals to recognise weight-normative biases and practices in health care settings and challenge them (Bacon, 2006;2010; Burgard, 2009; Tribole & Resch, 2012; Watkins, 2013; Bacon & Aphramor, 2011; Mansfield & Rich, 2013; Cohen et al., 2015). The weight-inclusive approach does not take into consideration BMI ranges as a health indicator as well as it supports that BMI doesn't show if individuals take care of themselves, and that neither their health condition nor their BMI is a moral issue. As body weight is not a behaviour, weight-inclusive care promotes healthy behaviours, including being attuned to and honouring their internal body cues like hunger and satiety, and promoting engagement in pleasurable and mindful body movement. The adoption of those behaviours can be sustainable and improve health, independently of body weight. Weight-inclusive care is an approach that helps individuals improve their health and well being, while eradicating weight stigma.

The first ethical aim of weight-inclusive care is "**above all, do no harm**" (Bacon, 2006;2010; Burgard, 2009; Tribole & Resch, 2012; Watkins, 2013; Bacon & Aphramor, 2011; Mansfield & Rich, 2013; Cohen et al., 2015) and that is why this approach does not focus on the BMI reduction as the core goal in the health care settings. In this framework of weight-inclusive care, stigmatisation is getting limited in healthcare settings and thus creates spaces where people who live in large bodies can discuss their concerns about their health (National Association to Advance Fat Acceptance, 2012). In alignment with the basic intention to eliminate iatrogenic weight-based practices within health care and to end the stigmatisation of health problems, Tylka et al. (2014) suggests the following principles of weight-inclusive care:

1. Do no harm.

2. Appreciate that bodies naturally come in a variety of shapes and sizes, and ensure optimal health and well being is provided to everyone, regardless of their weight.

3. Given that health is multidimensional, maintain a holistic focus (i.e., examine a number of behavioural and modifiable health indices rather than a predominant focus on weight/weight loss).

4. Encourage a process-focus (rather than end-goals) for day-to-day quality of life. For example, people can notice what makes their bodies rested and energetic today and incorporate that into future behaviour, but also notice if it changes; they realise that well being is dynamic rather than fixed. They keep adjusting what they know about their changing bodies.

5. Critically evaluate the empirical evidence for weight loss treatments and incorporate sustainable, empirically supported practices into prevention and treatment efforts, calling for more research where the evidence is weak or absent.

6. Create healthful, individualised practices and environments that are sustainable (e.g., regular pleasurable exercise, regular intake of foods high in nutrients, adequate sleep and rest, adequate hydration). Where possible, work with families, schools, and communities to provide safe physical activity resources and ways to improve access to nutrient-dense foods.

7. Where possible, work to increase health access, autonomy, and social justice for all individuals along the entire weight spectrum. Trust that people move toward greater health when given access to stigma-free health care and opportunities (e.g., gyms with equipment for people of all sizes; trainers who focus on increments in strength, flexibility, V02 Max, and pleasure rather than weight and weight loss).

6.1.2. Health at Every Size Model

The Health At Every Size® (HAES®) model is a **social justice movement** that is aligned with the **weight-inclusive approach** and is supported by the Association for Size Diversity and Health (ASDAH), an international non-profit organisation with a mission to promote size acceptance. As a justice movement, HAES® aims to end weight discrimination and decrease the thin idealis ation in modern culture that opress people in different body shapes and sizes. HAES® promotes balanced eating, life-enhancing physical activity, and respect for the diversity of body shapes and sizes.

The Health At Every Size Principles according to The Association for Size Diversity and Health (ASDAH) are:

*"1. **Weight Inclusivity**: Accept and respect the inherent diversity of body shapes and sizes and reject the idealising or pathologizing of specific weights.*

*2. **Health Enhancement**: Support health policies that improve and equalise access to information and services, and personal practices that improve human well being, including attention to individual physical, economic, social, spiritual, emotional, and other needs.*

*3. **Respectful Care**: Acknowledge biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socio-economic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.*

*4. **Eating for Well being**: Promote flexible, individualised eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.*

*5. **Life-Enhancing Movement**: Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose."*

The figure 6.1.2(a) describes the HAES® model using the weight-inclusive approach in policy applications, within health care and in personal life, helping individuals and communities to find long-term sustainable practices.

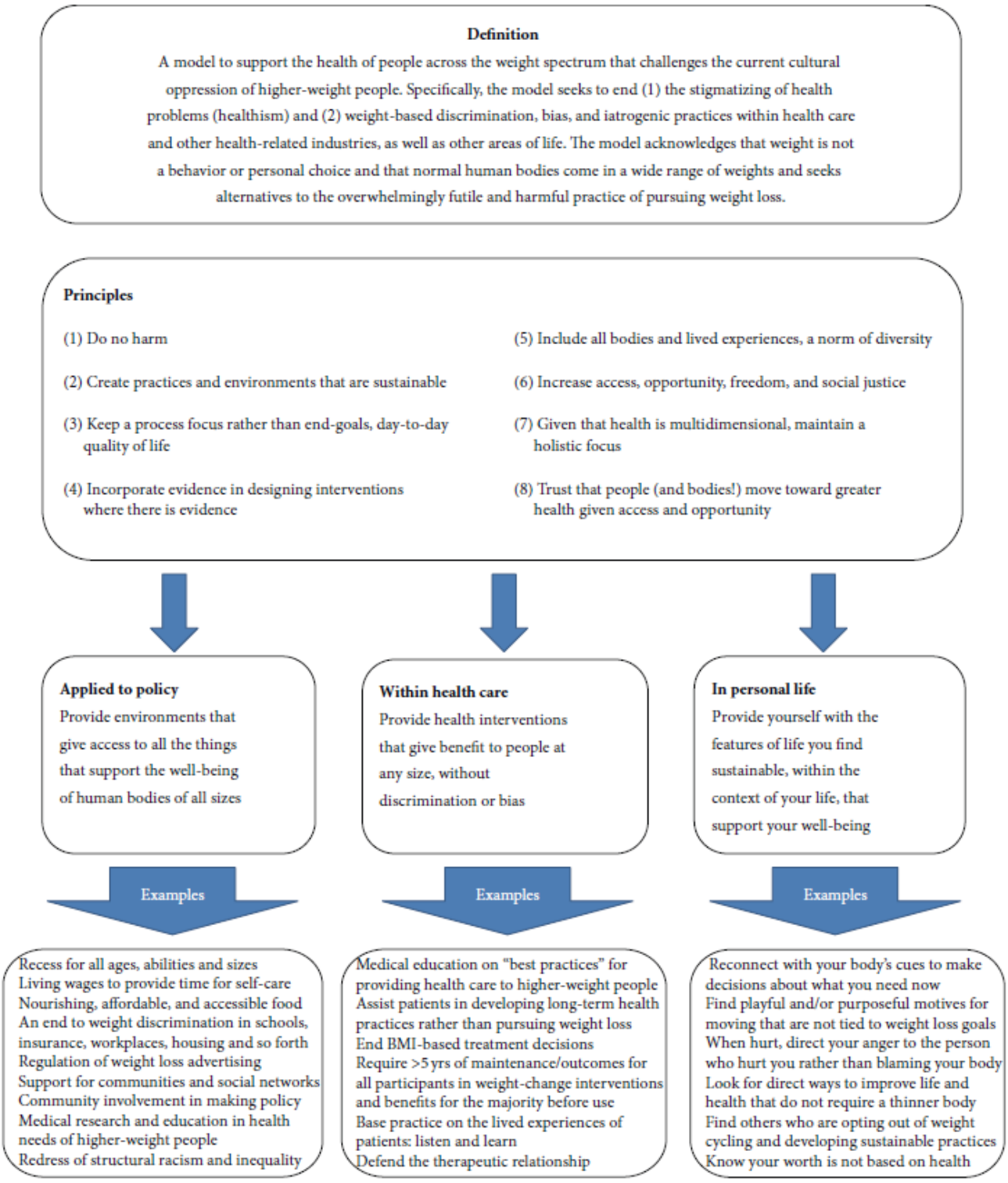

Figure 6.1. (a) Health at Every Size (HAES): a model using a weight-inclusive approach (Tylka et al., 2014).

Health care should be conceived as a service available to every individual, regardless of health condition, social class, or body size. Health status should not be an aspect of judgement, oppression or a determinant of an individual's worth. Thereby HAES® upholds

the principles of beneficence and nonmaleficence by putting an end to the weight stigma, respecting individual's body diversity and pursuing empirically supported interventions that promote physical and mental health (Tylka et al., 2014).

6.1.3. Weight-inclusive strategies to reduce weight stigma in healthcare settings

In weight-inclusive care, there are strategies that can help healthcare professionals to reduce stigma in the health system and facilitate processes that support and improve patients' physical and mental health.

The weight-inclusive approach challenges healthcare professionals to examine their own biases around weight and invite them to be a source of support for their patients in combating stigma, and reinforcing the healing power that can be induced by the quality of the connection between healthcare providers and their patients and their mutual trust and regard (Fischer et al., 1998).

The following table 6.1.3. (b) provides a list of weight-inclusive practices and examples of how healthcare professionals can implement them in their practice, as cited by Tylka et al. (2014).

Weight-inclusive principle	Weight-inclusive practice
(1) Eradicate weight stigma	Conduct training to inform other health care professionals about the weight-inclusive approach. Ensure medical offices have medical supplies and accommodations for all patients across the weight spectrum. Talk with patients' families, friends, and partners about the types of comments that are stigmatising and negatively impacting the health of their loved ones. Promote the weight-inclusive approach and strategies for following it. All health care professionals.
(2) Target internalised weight stigma	Help patients reduce placing blame on their bodies (and others' bodies). Challenge adoption of societal appearance ideals. Consider conducting cognitive dissonance interventions (e.g., [134]) to lessen adherence to unrealistic appearance ideals. Mental health professionals
(3) Target body shame	Help lessen patients' embarrassment, hatred, and dissatisfaction toward their bodies by helping them define "beauty" more broadly and to appreciate their bodies. Cognitive dissonance interventions may help increase body appreciation. Mental health professionals
(4) Redirect focus from external critique of weight and size to a "partnership" with the body	Direct attention to what is happening within their bodies rather than "picking apart" their appearance (e.g., lumps, appearance of moles, lack of energy, shortness of breath, etc.). This partnership with their bodies may help detect and prevent the progression of disease. Physicians

(5) Look for signs of diminished well being	Present options to alleviate distress and heighten life satisfaction; options should not be limited to medication. Know mental health professionals who follow a weight-inclusive approach in the community and refer patients as needed. Physicians
(6) Look for signs of disordered, emotional, and/or binge eating	Rather than BMI, explore each patient's weight trajectory across time to detect unusual gains and losses that could be reflective of disordered eating. Do not praise weight loss. Do not immediately address weight gain with weight loss recommendations. Physicians Explore with patients whether there is a connection between disordered eating patterns and emotional regulation. For instance, if they report bingeing behaviours , ask about how they felt at the time and contextual factors. If there is a connection, distress tolerance and mindfulness interventions (e.g., Acceptance and Commitment Therapy) may be helpful. Mental health professionals
(7) Respond to requests for weight loss advice with a holistic approach	Respond (when asked by patients for advice or help with weight loss) with a holistic approach to health via encompassing and encouraging emotional, physical, nutritional, social, and spiritual health, rather than a weight-focus. Physicians, nutritionists
8) Sustain health promoting practices	Identify and facilitate access to healthy, sustainable behaviours for patients. All health care professionals
(9) Reconnect with food and internal cues	Help patients (a) abandon dichotomous thinking about foods as "good" and "bad" and the morality surrounding food restriction, (b) relearn how to recognis e and respond to their hunger and satiety cues, and (c) determine how certain foods affect their bodies. Nutritionists

Table 6.1. (b) Translating weight-inclusive principles into weight-inclusive practice (Tylka et al., 2014).

These practices can be better implemented when various healthcare professionals cooperate and work as a team under the lens of weight-inclusive care. A multidisciplinary team of health professionals that encourage their patients to develop positive feelings and appreciation for their bodies, reconnect with their bodies' needs, and focus on internal body awareness, could be an important source of support against the weight-stigmatising experiences that people living in large bodies face in their everyday life.

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