From Theory to Policy: Reducing Harms Associated with the Weight-Centered Health Paradigm

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From Theory to Policy: Reducing Harms Associated with the Weight-Centered Health Paradigm

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This article provides an overview of harms associated with public policy promotion of the weight-centered health paradigm and suggests that a shift away from weight-centered health policies is required. Given the evidence about the negative health implications of weight-centric health policies, the objectives are to explore why public policy officials uncritically rely on and promote the weight-centered health paradigm and to propose policy alternatives. Based on findings from discourse analysis of “obesity”-related policy documents, public health policy solutions to the weight-centered health paradigm are proposed and analyzed, drawing from ten key informant interviews with stakeholders working within the policy, academic, and medical contexts.

KEYWORDS public policy, public health, weight-centered health paradigm, health at every size

BACKGROUND: DANGERS OF THE WEIGHT-CENTERED HEALTH PARADIGM

Following the 2003 declaration by the World Health Organization (WHO) that almost all countries were experiencing an “obesity epidemic” (Campos et al., 2005), public health officials internationally have devoted increasing attention to “obesity reduction” (O’Hara and Gregg, 2010). The presumption underlying such weight-centered public health efforts is that “overweight”
and “obesity” cause disease and early death and that weight loss will therefore improve health and extend life.

Such beliefs are readily apparent in what O’Hara and Gregg (2010) have termed the “weight-centered health paradigm.” As adapted from the six tenets proposed by O’Hara and Gregg (2010), the weight-centered health paradigm can be distilled into three main beliefs, outlined subsequently, along with a discussion of how such approaches to health may not only be ineffective, but also cause significant harm.\(^2\)

The first belief underpinning the weight-centered health paradigm is that weight is associated with energy intake or energy expenditure. Put simply, it is commonly believed that people who are fat eat too much and do not exercise enough. However, substantial evidence suggests this is untrue. The energy balance hypothesis fails to account for homeostatic evolutionary mechanisms whereby, when presented with energy deficits and the perception of famine, the human body will eventually slow its metabolic rate to maintain or gain weight and may also send hunger signals to increase energy intake (Bacon, 2010). Additionally, the notion that individuals should be able to (or should want to) control their weight and manipulate the energy balance equation promotes prejudice and stigma (Aphramor and Gingras, 2008). People who are unable to maintain (or choose not to strive for) lower weights are labeled with negative moral values such as laziness, poor self-control and gluttony (Evans, 2006). Stigma in turn is associated with a host of health problems, such as poor mental health (Eisenberg, Neumark-Sztainer, and Story, 2003), as well as physiological consequences, including increased risk of chronic disease resulting from stress (e.g., coronary health disease, hypertension, diabetes) (O’Reilly, 2011).

The second belief inherent to weight-centered approaches to health is that fatness is associated with excess disease and early death. Despite widespread adherence to this belief in mainstream discourse, the evidence supporting this assertion is questionable at best. In fact, research examining the relationship between weight and health outcomes actually suggests people in the “overweight” category live longer than those in the “normal weight” category and that health outcomes do not change until statistical extremes (Durazo-Arvizu et al., 1998; Flegal et al., 2005). Additionally, the majority of studies outlining causal relationships between weight and health fail to control for diet, fitness, socioeconomic status (SES), or weight cycling; when these variables are controlled for the correlations between weight and health disappear (Campos et al., 2005). This suggests that weight may actually be a proxy for other variables and that the more appropriate public health response would be to promote healthy eating and movement for all people regardless of size. This is an especially important point given the difficulty in sustaining long-term weight loss (Mann et al., 2007) and the harm that may result from the pursuit of weight loss at the individual level (e.g., eating disorders and weight cycling; Bacon and Aphramor, 2011).
The third fundamental belief associated with weight-centered approaches to health is that weight loss will invariably improve health. Substantial evidence suggests that this is not only untrue, but also a possibly harmful message for public health officials to promote (Bacon and Aphramor, 2011), particularly given the high failure rate of diets. A literature review of diet studies with a four-year or longer follow-up period found that within all the studies that reported rates of weight regain or made it possible to compute such statistics, a substantial percentage of participants actually weighed more at follow-up (Mann et al., 2007). Moreover, evidence has suggested that weight cycling is more harmful to health than maintaining a high but stable weight (Ernsberger and Koletsky, 1999). Attempts at weight loss are also associated with increased rates of eating disorders (Patton et al., 1999). This suggests that public health promotion of the weight-centered health paradigm may in fact increase negative health outcomes such as eating disorders, mental health issues, and health consequences from weight cycling and social stigmatization.

Consider, for instance, that when public health messages posit weight loss as necessary to improve health, the correlation between dieting and eating disorders is often entirely ignored. This is despite research that suggests dieting and attempts at weight loss increase the likelihood of clinical or sub-clinical eating disorders by up to 18% (Patton et al., 1999). Furthermore, disordered eating is an increasingly serious health concern, with an estimated one in four teenage girls afflicted with disordered attitudes or behaviors (Jones et al., 2001). It is important to note that while some believe that “obesity” is an eating disorder, this neglects the evidence that estimates one third to half of all “obese” people are metabolically healthy (Shea, Randell, and Sun, 2010) and that weight is largely influenced by genetics (Bacon, 2010).

Yet another concern of weight-centered approaches is that such messages fail to acknowledge that attempts at weight loss are associated with weight cycling. Weight cycling, which refers to the repeated loss and regain of weight, often through dieting (WHO, 2000), is particularly harmful to health. Weight cycling is correlated with increased risk of death from cardiovascular disease (Hamm, Shekelle, and Stamler, 1989), diabetes, stroke, and myocardial infarction (French et al., 1997), elevated high-density lipoprotein cholesterol (Olson et al., 2000), and increased all-cause mortality (Blair et al., 1993). In the Framingham Heart Study, a longitudinal study initiated in 1948 (Lissner et al., 1991), and the National Health and Nutrition Examination Survey (Diaz, Mainous, and Everett, 2005) excess mortality was attributable to weight cycling, not weight. In fact, as mentioned previously, research suggests that that weight cycling is associated with higher rates of mortality than high but stable weights (Ernsberger and Koletsky, 1999).

Further, the presumption that weight is within individual control contributes to a value-laden discourse, promoting negative stereotypes and associating fatness with laziness and unrestrained eating (Evans, 2006),
which contributes to weight stigma (O’Reilly, 2011). This is problematic given the associations between stigma, lack of well-being, psychological disturbances (Eisenberg et al., 2003; Friedman et al., 2005), and physiological responses such as high blood pressure and diabetes (O’Reilly, 2011; Puhl and Brownell, 2006).

In the field of fat studies, the correlations between weight-centered approaches to health and subsequent harms discussed previously are widely understood. Additionally, Health at Every Size (HAES), and the values and benefits associated with it, is widely espoused by the fat studies community as an alternative to the weight-centered health paradigm. For example, a number of research trials have been completed on HAES. The results suggest that, unlike diet-focused programs, HAES results in sustainable health improvements, independent of whether weight is lost (Bacon et al., 2002; Bacon et al., 2005; Ciliska, 1998; Provencher et al., 2007; Provencher et al., 2009; Tanco, Linden, and Earl, 1998).

However, while the benefits of HAES are clear, what is yet to be well explored is how to best influence public health officials so as to achieve a policy or paradigm shift at a population level, away from weight-centered approaches to health and towards a weight-neutral, HAES-informed approach. As such, the purpose of the current research was twofold: (1) to understand why the weight-centered health paradigm continues to dominate public policy in the face of contradictory evidence, and (2) to develop policy alternatives to weight-centered approaches to health.

METHODOLOGY: DISCOURSE ANALYSIS AND POLICY ANALYSIS

The research question guiding this study was to explore why policy makers uncritically rely on the weight-centered health paradigm. This research question was focused specifically on public policy in British Columbia (BC), Canada, and was part of a larger research project completed by the authors (see O’Reilly, 2011). To examine this research question, discourse analysis was conducted on five BC-specific “obesity”-related policy documents (BC Healthy Living Alliance [BCHLA], 2010; Heart and Stroke Foundation of BC and Yukon, 2009; Jayatilaka, 2009; Legislative Assembly of BC Select Standing Committee on Health, 2006; Provincial Health Services Authority [PHSA], 2010), which were examined for their discursive and textual practices (Jacobs, 2006; O’Reilly, 2011). Discursive practices, a term common to discourse analysis (Parker, 2002), were defined as the way in which a text warrants or justifies its claims (Jacobs, 2006). Within this we specifically assessed whether claims about “obesity” were justified by methodologically reliable references and, when this was the case, we tracked the original study about which each citation was premised to see if it controlled for diet, fitness, or SES. Additionally, we explored textual practices, or how grammar,
Reducing Harms Associated with the Weight-Centered Health Paradigm

metaphors, and language are used to talk about a subject (Jacobs, 2006), to shed light on why policy makers uncritically rely on and promote the weight-centered health paradigm.

Following discourse analysis, we conducted “policy analysis,” whereby policy options or alternatives are considered, designed to reduce harms associated with the weight-centered health paradigm, and focused on reducing public health reliance on the beliefs underpinning weight-centered approaches. To assess the portfolio of options and understand respective strengths and drawbacks of each option, key stakeholder interviews were undertaken with a range of informants. Ten people participated in semistructured interviews, including four professionals working in eating disorders prevention in BC, three people involved in developing “obesity” reduction strategies in BC, one medical professional with experience with clients with disordered eating, and two proponents of fat studies, consisting of a psychologist specializing in eating disorders and a fat acceptance activist. Interviewees were selected on the basis of their knowledge about weight, eating disorders, “obesity” policies, and weight stigma and gave their informed consent to participate. Following interviews, thematic analysis was employed (Braun and Clarke, 2006), enabling themes to be developed from the recorded and transcribed interviews and interview notes. Themes identified were used to inform the policy analysis and design policy recommendations.

RESULTS

The discourse analysis identified two primary reasons explaining why policy makers and public health officials believe negative health claims about fatness and subsequently adhere to and promote the weight-centered health paradigm.

Discursive Practices: Reliance on Expertise

Rather than drawing validity from research regarded by mainstream academia as evidence-based, the source of claims about weight are often premised on claims made by health “experts” or on scientific studies with methodological flaws. For instance, in the texts examined, claims about the deleterious health impact of “obesity” on individuals and populations can often be linked back to sources such as the WHO, whose findings are uncritically accepted as fact because of their status as health experts, even when the claims are not based on strong scientific evidence. For example, the BC Healthy Living Alliance (2010) text referenced WHO (2010) when justifying the need to take action on weight loss to improve health. When we checked this citation on the
WHO website, the perceived consequences of “obesity” were discussed at length without substantiating this with evidence.

At other times, policy makers uncritically accept assertions about weight because these claims are based on findings from published scientific studies in peer-reviewed journals that are seen to be valid and reliable. An interesting point revealed through the analysis was that, in such instances where scientific studies were cited, tracing the original source of the assertion revealed that nine out of ten times claims about the consequences of fatness originated from quantitative studies in which one or more variables of diet, fitness, or SES was not controlled for (O’Reilly, 2011). The lack of rigor in the measurement and evaluation of such confounding variables, which are known to affect the relationship between weight and health, raises concern about personal and professional accountability and ethical research standards. This suggests that to reduce policy promotion of and reliance on the weight-centered health paradigm, evidence-based standards are required and, in accordance with research ethics, should be lobbied and advocated for by researchers.

**Textual Practices: Language Use in Texts Creates and Sustains a Moral Panic about Fatness**

Analysis of textual practices illustrated that language used to discuss “obesity” in policy texts is unnecessarily inflammatory, evoking an emotional response that fuels a moral panic. Specifically, many metaphors were used within the texts to construct the feelings and associations we have about weight and fatness (O’Halloran, 2006). Consider, for instance, the use of metaphors with military connotations present within the texts, such as use of the term “combat” (Heart and Stroke Foundation of British Columbia and Yukon, 2009; Legislative Assembly of BC Select Standing Committee on Health, 2006). Additionally, fear-mongering words such as “epidemic” (BCHLA, 2010; Jaytilaka, 2009; Legislative Assembly of BC, 2006; PHSA, 2010), “alarming” (BCHLA, 2010) and “crisis” (Legislative Assembly of BC, 2006), or phrases like “[r]ates of overweight and obesity have exploded” (BCHLA, 2010, p 1), were often employed. The use of such terms is not innocuous, especially when considering the high level of preexisting weight bias among health care professionals (Schwartz et al., 2003; Teachman and Brownell, 2001).

**POLICY OPTIONS TO SHIFT AWAY FROM WEIGHT-CENTERED APPROACHES TO HEALTH**

Recently, fat studies scholars such as Bacon and Aphramor (2011) have suggested that a paradigm shift is required from weight-centered approaches to
Reducing Harms Associated with the Weight-Centered Health Paradigm

However, ways to achieve this paradigm shift given the current deeply entrenched, and arguably increasing, emphasis on the importance of weight reduction are not yet clear. The policy options presented subsequently are a preliminary attempt to leverage government to change to a more HAES-friendly approach. The four policies suggested are designed to be integrated into existing global public health interventions aimed at improving healthy eating and activity. Although they were calibrated specifically for the BC context, they can likely be integrated into extant and emerging public health initiatives internationally without substantial alterations.

Given the deeply entrenched reliance on weight-centered approaches to health, the goal of the policy options is to mitigate harm and also to reduce government promotion of and reliance on weight-centric health policies. A further goal is to build an evidence base for a more substantial future shift toward a weight-neutral paradigm. The four policy options proposed, which emerged from discourse analysis and background research, are the following: (1) guidelines mandating health surveillance not be limited to measuring weight alone and account for unintended outcomes (e.g., eating disorders); (2) replacement of weight-centric, dieting language with weight-neutral, HAES language; (3) government-led studies of HAES in clinical and educational settings; and (4) weight bias training for health care professionals with a HAES educational component.

Policy Option One: Data Collection, Analysis, and Evaluation Guidelines

This policy option suggests that public health officials involved in health promotion develop comprehensive guidelines so that all health measurement accounts for a range of variables that may influence health and not be limited to measuring weight as a variable in isolation. This would imply that all population-level data collection activities and analysis also account for variables such as health behaviors, fitness levels, SES, and weight cycling, so as to enhance current understandings about the correlations between weight and health. Second, such guidelines would imply that all evaluation related to weight, eating, or exercise interventions also track for unintended negative outcome variables such as body image dissatisfaction or eating disorder indices. Such evaluation is an important part of ethical practice and research and is reflected within HAES studies (Bacon and Aphramor, 2011).

Policy Option Two: Framing Messages in Weight-Neutral, HAES Language

A second policy option consists of replacing weight-centric terms—illustrated through discourse analysis as sustaining a moral panic discourse about
fatness—with weight-neutral ones. This would imply that governments avoid using terms such as “epidemic.” This option also suggests that rather than prioritizing and using “obesity” reduction language, HAES language instead be used. Within this, public health platforms would promote health for all people, regardless of weight, and would recognize the natural diversity in body weights.

Policy Option Three: Anti-Weight Bias Training with a HAES Component

Given the harms that are associated with weight stigma, this option suggests that government-sponsored anti-weight bias training—inclusive of a HAES awareness component—be provided to health care professionals. This is considered as anti-weight bias training has been proven to reduce internalized weight bias among health care and educational professionals (McVey et al., 2009). Although not explored in detail in this article, HAES has been evidenced as effective at improving psychological and physiological health and health behaviors (Bacon and Aphramor, 2011) and as such would likely be beneficial when paired with anti-weight bias training.

Policy Option Four: HAES Studies in Clinical and Educational Settings

Considering the evidenced efficacy of HAES, this policy option proposes that a limited number of government-sponsored HAES trials be initiated in clinical and educational settings to further test and establish their efficacy as a health promotion tool. This would shift the focus from weight to health for all participants, regardless of weight. The goal would be to improve health and reduce harms associated with weight-centered approaches and build evidence in support of HAES.

ANALYSIS OF POLICY OPTIONS

In policy analysis, once options are formulated, it is common practice to develop a set of criteria with which to assess the relative strengths and weaknesses of each option. In determining which of the previous options are appropriate for government pursuit we considered the following criteria: efficacy, equity, cost, political and public acceptability, and implementation complexity. For the effectiveness criterion, we considered the extent to which each option would reduce reliance on, and promotion of, the weight-centered health paradigm and its consequences. Equity of the options was assessed by whether the option would be fair, treating fat people without prejudice and reducing stigma. Regarding cost, the economic costs to
implement and sustain the option were examined. The political and public acceptability criterion assessed whether the government would endorse the option at this time and whether stakeholders would support or oppose the option, thus making it likely to become more or less acceptable over time. Finally, the complexity of implementing each option was examined—referring to the level of difficulty associated with implementing the option based on facilitators and barriers to implementation. The scoring of each policy option against each of these criteria was determined through a literature review and ten key stakeholder interviews as described in the methodology section.

The political acceptability, cost, and implementation complexity criteria were chosen for their relevance to policy decision-making. For example, political acceptability is often an important precursor to government action. Similarly, governments are more likely to pursue a policy option if it is seen as cost effective and simple to implement. Conversely, effectiveness and equity were considered given the serious concerns raised in recent years not only about the possible health consequences but also the social prejudice that may result from weight-centered health policies.

Based on the five criteria discussed previously, the options were ranked as follows: (1) framing public health messages and interventions in health at every size, weight-neutral language; (2) anti-weight bias training; (3) data collection, analysis and evaluation guidelines; and (4) government-initiated and -sponsored HAES studies. The results are presented in Table 1.10

As is evident from the table on the following page, framing health promotion initiatives and campaigns in HAES, weight-neutral language emerged as the strongest of the four options. This option is likely to be easy to implement and politically feasible. All government interviewees agreed that they would prefer not to market health promotion activities in “obesity” reduction language – that harms may come from this—and that they would rather utilize weight-neutral terminology. Additionally, this option is low to no cost and is also expected to be highly effective and reduce prejudice and stigma across the population. As stated by one interviewee, a medical professional: “the war on ‘overweight’ and ‘obesity’ becomes a war on ‘overweight’ and ‘obese’ people,” and it is imperative that the language used to promote health be reframed to be kinder, more compassionate and to reflect the natural diversity in body weights.

Additionally, anti-weight bias training with a HAES component was also assessed favorably, as it has been shown through research trials to be effective at reducing internalized weight bias and prejudice among professionals (McVey et al., 2009). This option would help health care professionals learn about the benefits of HAES and some of the detriments associated with promoting weight loss (e.g., weight cycling). Further, because such training could feasibly be implemented through an online medium, it is assessed as low cost. Such an approach is also simple to implement, insofar as there are
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Measures</th>
<th>Option: Data and evaluation guidelines</th>
<th>Option: Weight-neutral, HAES language</th>
<th>Option: Weight bias training</th>
<th>Option: HAES studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacy</td>
<td>Will it reduce public health promotion of, policy reliance on and harms associated with the weight-centered health paradigm? (Score 0 [not effective] to 4 [very effective])</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Equity</td>
<td>Measure 1 (M1): Is it likely to reduce prejudice associated with ‘overweight’ and ‘obesity’? (“yes” coded as 2, “somewhat” coded as 1, and “no” coded as 0) Measure 2 (M2): Population-wide impacts coded as 2, select individual impacts coded as 1; Aggregate measure = M1 × M2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Cost</td>
<td>Cost to implement (high, medium, low) and qualitative analysis of other costs</td>
<td>High cost if fully implemented; low cost if partially implemented</td>
<td>Low cost</td>
<td>Medium-high cost</td>
<td>Medium cost</td>
</tr>
<tr>
<td>Political and public acceptability</td>
<td>Primary measure: level of government acceptability using Overton window (Mackinac Centre for Public Policy, 2010) ranging from unthinkable (1), radical (2), acceptable (3), sensible (4), popular (5), to policy (6) Secondary measure: Based on stakeholder acceptability is it likely to become more acceptable over time? (Yes, unknown, or no)</td>
<td>Sensible (4/6)</td>
<td>Sensible (4/6)</td>
<td>Acceptable (3/6)</td>
<td>Radical (2/6)</td>
</tr>
<tr>
<td>Implementation logistics</td>
<td>How difficult is it to implement based on barriers and facilitators to implementation? (Easy, medium, hard)</td>
<td>Medium</td>
<td>Easy</td>
<td>Medium</td>
<td>Hard</td>
</tr>
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</table>
already existing curricula (e.g., McVey et al., 2009). This option is also relatively politically feasible. As one interviewee pointed out, given the growing awareness of the importance of avoiding harm and preventing eating disorders, governments and medical professionals alike may be receptive to anti-weight bias training, especially if framed as eating disorder prevention.

Data collection, analysis, and evaluation guidelines, while possibly expensive, also scored relatively well in the analysis. Such guidelines would help build an evidence base that may reduce reliance on and promotion of the weight-centered health paradigm as they would likely illustrate harm from weight-focused approaches by providing data which would shed light on the correlations between health and variables suggested to be proxies for weight (e.g., diet, fitness, SES, and weight cycling). This option also may reduce prejudice and stigma over time, as by collecting evidence on other variables that influence health beyond weight, a gradual shift away from stigmatizing weight-centered approaches to health may occur in the long-term.

Unfortunately, government-sponsored HAES studies did not fare as well in the analysis. Although effective and equitable at the individual level, HAES studies were not assessed as having population wide benefits, at least not in the short term. Additionally, despite the overwhelming evidence pointing to the benefits of HAES studies at the individual level (Bacon, 2010), the primary barrier to government endorsement of HAES studies is the lack of political feasibility and government unwillingness to dedicate dollars towards an intervention-type of study that is not likely to reduce weight. As one interviewee involved with weight reduction at the government level shared when asked whether the government would financially support a HAES study: “. . . in order for us to adopt and . . . stand behind . . . and . . . financially support a model we need to be able to recognize it and promote it as a way to decrease the medical costs associated with ‘obesity’.”

**POLICY RECOMMENDATIONS**

From the policy analysis, three of four options emerged as suitable for governments to pursue: (1) framing interventions in weight-neutral, Health at Every Size language, (2) implementing anti-weight bias training, and (3) developing research guidelines that mandate variables beyond merely weight are included in research and that evaluation account for possible harm.

Using weight-neutral, HAES language in particular is highlighted as desirable. Given the ease with which interventions and programs could be framed in HAES-friendly language and the ease with which governments could cease to use stigmatizing terms such as “epidemic,” coupled with the possible effectiveness and equity gains from this option, this strategy is recommended. Indeed, from an ethical perspective, given the stigma
associated with weight reduction, such reframing can be seen as morally imperative. However, as one interviewee, a fat studies scholar, pointed out: “While a name/goal change might reduce stigma, if implementation still focuses on weight-loss goals and ‘obesity’-blaming, then it would rebound badly.” This quote suggests that, given the deeply entrenched cultural beliefs that only someone within the “normal” body mass index (BMI) weight range can be healthy, it is likely possible that government use of weight-neutral, HAES-friendly language may exclude those at statistical extremes and as such fail to address the harms of weight-centered approaches to health. To avoid these harms anti-weight bias training may be useful to implement in conjunction with this option, as this would help health care professionals understand the natural diversity in body weights and the consequences of weight-centered approaches to health.

Unfortunately, HAES studies, although assessed as effective, are politically unfeasible for governments to sponsor. However, given the necessity to have a further evidence base for the benefits of HAES and the already demonstrated advantages of a HAES approach, this study recommends that stakeholders interested in advancing a weight-neutral agenda independently prioritize HAES studies, possibly through seeking research grants.

Additionally, given the crucial role of stakeholders in influencing what is politically acceptable (Mackinac Centre for Public Policy, 2010), we recommend that stakeholders interested in advancing a weight-neutral agenda—such as those in the disordered eating prevention community or involved with fat acceptance—form committees and come up with action plans to influence policy makers in their region. In British Columbia, such a committee has been formed, comprised of stakeholders interested in preventing weight bias and reducing structural determinants of eating disorders. To date there has already been one successful meeting between members of this committee and the Ministry of Health in British Columbia, discussing the need for collaborative approaches to reduce weight bias and avoid inadvertent harm that may result from the weight-centered health paradigm.

CONCLUSION

Current approaches to health promotion internationally are largely weight-centered, creating a healthist and moralizing dominant “obesity” discourse likely to cause harm (i.e., weight cycling, eating disorders, mental health issues, and social stigmatization). Fortunately, increasing evidence is being generated from within fat studies about the harms of such approaches and the benefits of HAES. This article summarizes some of the arguments in favor of a paradigm shift and provides concrete action items for government and other interested stakeholders to begin to shift away from weight-centered policies.
Reducing Harms Associated with the Weight-Centered Health Paradigm

Such a shift is medically necessary and morally imperative. Recent evidence has shown that weight-based discrimination is now on par with race- or gender-based discrimination (Puhl, Andreyeva, and Brownell, 2008). Unfortunately, via public health weight reduction efforts, systemic discrimination may be inadvertently promoted (O’Reilly, 2011). Consider, for example, that policies advocating the benefits of weight loss rarely acknowledge the evidence suggesting that the pursuit of dieting may be harmful, resulting in eating disorders or weight cycling (Bacon and Aphramor, 2011). Further, proponents of weight-centered approaches to health continue to promote weight loss as a realistic goal, despite much research in dispute of this.

Given the harm from weight-centered approaches to health, paired with the evidenced benefits of HAES, a paradigm shift is necessary. Following policy analysis, considering criteria including effectiveness, equity, cost, political, and public acceptability and implementation complexity, we recommend that governments internationally reframe public health messages in weight-neutral, HAES language. Governments should also implement anti-weight bias training for health care professionals with a HAES educational component and consider more comprehensive research and evaluation that accounts for harm from weight- or nutrition-related programs and measures and analyzes the range of variables influencing health. All three of these options are likely to reduce the harms associated with, and reliance and promotion of, the weight-centered health paradigm. These options also fared well when considering their aggregate assessments across criteria such as political feasibility, implementation logistics, and cost, and should be realistic and simple for governments to pursue.

Given the all-pervasive nature of weight bias in today’s society and the harms associated with it, a two-pronged approach—involving government action and stakeholder lobbying—is recommended. Such an approach, involving interest groups in addition to government action would maximize the likelihood of policy change.

NOTES

1. In this paper “overweight” and “obesity” are put in quotes in recognition of the stigmatizing and medicalized nature of these terms and the preference expressed by many in the fat studies community to instead use the word “fat” (Wann, 2009).

2. The six tenets proposed by O’Hara and Gregg (2010) are the following: (1) that fatness is a result of energy in exceeding energy out, (2) that weight is reflective of current health and can predict future health, (3) that fatness causes morbidity and early mortality, (4) that weight loss is possible and methods to achieve this are well known to science, (5) that losing weight will invariably improve health, and (6) that weight is within an individual’s control.

3. HAES is a registered trademark of the Association for Size Diversity and Health and used with permission.

4. The documents listed were chosen as the only policy-related “obesity” documents published that were aimed at the general public in the last five years in BC, as located through a literature review. See O’Reilly (2011) for more information.
5. Additionally, social practices (Jacobs, 2006)—the ways in which a given discourse is used to reinforce wider power structures and ideologies—were also explored. However, the findings of this are beyond the scope of this article. For more information see O'Reilly (2011).

6. Four people were interviewed in person, two by e-mail and the rest by telephone. Interviews were approximately an hour and a half each.

7. The definition of evidence-based research is derived from the overwhelming importance in mainstream scientific research placed on quantitative studies that favor random sampling and longitudinal duration. It is important to note that this definition is constrained by the traditions of postpositivism and prohibits research favoring the lived experiences of fat people from being heard or seen as “evidence-based” research.

8. Policy options can be defined as the actions taken by government to achieve a desired policy outcome.

9. Additional information about the benefits of HAES—as well as variables explaining the success of HAES—is provided through case studies in O'Reilly (2011).

10. A high score is used to denote a favorable rating, whereas a low score represents an unfavorable rating. For more information see O'Reilly (2011).

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Reducing Harms Associated with the Weight-Centered Health Paradigm


**CONTRIBUTORS**

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