Dietary Approaches to Weight-Loss, Health-At-Every-Size® and Beyond: Rethinking the War on Obesity

Abstract

Despite considerable contestation, 'excess' weight/fatness is commonly framed as fatal and in need of behavioural interventions. This article reviews literature which places a question mark over or challenges dietary approaches to weight-loss before critically discussing an alternative weight-inclusive intervention, Health-At-Every-Size®, which is filtering into mainstream discourse while also becoming increasingly fractious. After discussing principles, tensions, resonance and controversies, we reflect on the politics of health and the need to reject the all-too-common definition of weight/fatness as a proxy for individuals' unhealthy lifestyles and personal irresponsibility. In conclusion, we tease out some of the implications of our discussion for social theorizing of health and efforts to rethink the war on obesity.

Keywords: obesity; fatness; dieting; Health-At-Every-Size®; critique.

Introduction

The definition of obesity as a massive problem is taken-for-granted within public health. The 'fat as fatal frame' (Kwan and Graves, 2013) is hegemonic in nations such as the USA and much of the economically developed world wherein war has been declared on obesity. Nonetheless, there are different frames, with *Social Theory & Health* (STH) providing a lively arena for ongoing debate. In 2014, STH dedicated its inaugural special virtual issue to obesity, showcasing some of the journal's most highly cited articles that had been published over the previous decade on the topic. Whilst the freely accessible virtual special issue was presented as a vital critical resource for theorists, researchers, clinicians and practitioners in public health, the 'fat as fatal' frame persists and has been given further gravitas by authoritative agencies. For example, the World Health Organization's (WHO, 2016) report on ending childhood obesity is a relatively recent manifestation of their long expressed concern to eradicate the 'global epidemic' (WHO, 1998). The war on obesity may have failed, but it apparently must continue despite its inconsistency with a human rights approach to public health (O'Hara and Gregg, 2012).

The 'fat as fatal' frame is also reproduced in social science texts that lament the consequences of a toxic mode of globalized political economic organization, with obesity described by Schrecker and Bambra (2015) as a 'neoliberal epidemic' (for a critique, see Authors, 2017). Proposed solutions are manifold, though, in line with the energy model of bodyweight - and what Keith et al. (2006) term 'the Big Two' (diet and physical activity) - populations are routinely extolled by health authorities to ingest fewer calories relative to those expended by eating less and exercising more. If the public are loath to consciously act in their own long term interests, then, according to

policymakers' reasoning, the social milieu might be modified in order to render 'healthier choices the easier choices'. Indeed, a notable attempt to address 'the social determinants of obesity' has been through an ecological model (Foresight, 2007), leading to efforts to change the 'obesity environment', defined by Swinburn et al. (1999: 564) as 'the sum of influences that the surroundings, opportunities or conditions of life have on promoting obesity in individuals or populations'. Associated interventions involve rational persuasion techniques (Peeters and Schuilenburg, 2016) via the modification of the 'choice architecture', defined as '(the physical, socio-cultural, and administrative environment) in which people live out their lives and make decisions'. Traffic light schemes for food, placing healthy snack options in fastfood stores, 'walking' school buses, taxing various foods and beverages, and restricting food advertisements to children (Gortmaker et al., 2011) are examples of attempts to 'nudge' people towards making the 'right choices' and influence behaviour change (Jones et al., 2011, 2013). So-called 'nudging' within a context of liberal paternalism is promoted with the aim of making risky, or at risk, populations less likely to (keep) fall(ing) victim to the 'obesogenic environment'.

We anticipate readers of STH will be interested in keeping abreast with critical weight scholars' efforts to 'rethink obesity' under current social conditions, drawing from accumulating evidence that places a question mark over the hegemonic narrative and the persistence of ultimately behavioural responses. The present article draws from relevant literature within and beyond the social sciences, focusing in particular on dietary approaches to weight-loss (herafter dieting), alternative interventions and some limitations with a commonly proposed 'size acceptance' paradigm. Substantively, we will focus on and critique dieting, a long-standing concern in STH (Aphramor, 2005; Broom and Dixon, 2008). We will also discuss the current issues with which Health at Every Size (HAES®) approaches (Bacon, 2010; Bacon et al., 2005, Burgard, 2009;

Author A, 2014; Mensinger et al., 2016) are grappling in a predominantly healthist and neoliberal society. Formally, our approach is aligned with critiques of 'lifestyle drift' (Popay et al., 2010) and 'liberal paternalism', or efforts typically favoured by 'fiscally responsible' (cost-cutting) governments to encourage or 'support' the population to 'choose' to behave in a manner deemed most felicitous to health. As we will elaborate, we have difficulties with typically neoliberal (self-responsiblizing, individualizing and increasingly marketized) responses to a so-called 'neoliberal epidemic' (Schrecker and Bambra, 2015), and the recurrence of behavioural prescriptions within alternative 'non-diet' approaches, notably HAES®. This does not mean that we are 'against' this intervention. Despite limitations and sometimes vociferous opposition (e.g. Sainsbury and Hay, 2014), weight-neutral approaches such as HAES® arguably offer a useful *starting point* not only for individuals affected by weight stigma but also clinicians and educators by questioning the 'scientific truths' that underlay fat fighting.

Our article is structured into three main sections. First, we introduce literature which questions or challenges the soundness of dieting. Second, we critically explicate HAES® in social context, exploring inter alia: its lifestyle focus, efficacy, ambivalences, the moderating effects of stigma, broader societal resonance and controversies. In conclusion, we reflect on some of the implications of our discussion for the obesity debate and social theories of health.

Questioning Dieting: From Inappropriateness to Possible Dangers

Is it always the case that levels of body mass labelled overweight or obese by medicine are dangerous and in need of correction? Findings that contradict the 'obesity canon' (Moss and Petherick, 2016) are termed obesity paradoxes (McAuley and Blair, 2011). Such contradictions

include individuals deemed obese and with particular health conditions surviving longer than their normal weight counterparts, overweight status being protective of mortality risk compared to normal weight, cardio-respiratory fitness eliminating the heightened mortality risk associated with obesity, and the large component of 'overweight' and 'obese' populations who are metabolically healthy (Bacon and Aphramor, 2011; Barry et al., 2014; Flegal et al., 2013; Lavie et al., 2016; McAuley and Blair, 2011; Tomiyama et al., 2016; Wildman et al., 2008). Such paradoxes are not exclusively present in studies using the BMI, and they therefore cannot be dismissed as an artefact of this flawed measure (Hebert et al., 2013).

Even so, weight-loss, on an individual or societal level, is invariably presented as the 'solution' to the presumed health risks of 'excess' weight (typically defined as a BMI of 25 and above, itself a crude proxy for fatness and behaviours prejudicially assumed to be obesogenic and unhealthy). Indeed, even literature that points to myriad possible contributors to secular trends in obesity (e.g. sleep debt, side effects from medicines, smoking cessation, endocrine disruptors in the environment), return to what are presented as personally modifiable, individual-level, behaviours, i.e. diet and physical activity (Keith et al., 2006). This is reflective of, inter alia, the culture of healthism that emphasizes personal responsibility (Crawford, 1980) and the degree to which the physical body is itself an index of moral worth in consumer culture (Featherstone, 1991). However, the feasibility and biomedical benefits of weight-loss are not conclusively supported by the same positivist forms of knowledge used to assign health risks to obesity, and other positivist research suggests the presumed health benefits of weight-loss are minimal (Mann et al., 2007; Tomiyama et al., 2013). These benefits are also nearly impossible to determine at a population level given the state of epidemiological knowledge (Campos, 2011), and the small sample of individuals who have sustained weight-loss given homeostatic pressures to regain weight (Mann et al., 2007;Maclean et

al., 2011; Schwartz et al., 2017). Moreover, benefits such as lower medication use and reductions in diabetes and hypertension incidence, are difficult to disentangle from the physical activity and dietary changes that might help produce (some) weight-loss (Mann et al., 2007; Tomiyama et al., 2013).

The Diabetes Prevention Program is long touted as the study indicating that moderate weight-loss (5-10%) can prevent diabetes and reduce cardiovascular disease risk (DPP Research Group, 2002, 2009; Hamman et al., 2006; Orchard et al., 2013). However, important nuances of the study's results are often missing in blanket statements about the trial's effectiveness. All participants were already considered pre-diabetic (i.e. defined as at high risk of developing type 2 diabetes), apart from American Indian participants who were deemed 'high risk' due to heritage. Again, these inclusion criteria mean that results may not be generalizable to the general population. Certainly, those participants who lost weight were the least likely to develop diabetes; however, increased physical activity in the absence of weight-loss also led to reductions in diabetes incidence. Critically, on average participants regained most of their lost weight and increased weight-loss during the program was associated with diabetes incidence over time, which may have been a result of weight regain (DPP Research Group, 2009; Hamman et al., 2006). Ultimately, these findings indicate that the most beneficial and risk-free approach to diabetes prevention may be through physical activity while maintaining a stable weight (including a stable higher weight that medicine might label 'excessive').

Epidemiological studies often rely on surrogate endpoint measures, not health-relevant endpoints. Altering these far more critical endpoints through weight-loss remains elusive. The problematic reliance on the use of surrogate measures was illustrated in the Action for HEAlth in Diabetes

(Look AHEAD) Study (Gregg et al., 2012). This very large and long-running trial was funded by the National Institute of Health to ascertain whether intentional weight-loss in persons with diabetes would produce a decrease in cardiovascular events, actual endpoints that matter for people's health, such as stroke, myocardial infarction and mortality. Despite reductions in risk factors for cardiovascular disease, cardiovascular events were not reduced and few individuals experienced sustained diabetes remission (Gregg et al., 2012). That is, weight-loss did not save lives nor spare individuals from heart attacks and strokes. Ultimately, these disappointing results led to the trial being halted early and debate among researchers over whether the trial constituted a success or failure (self-reference, 2014).

The findings from Look AHEAD align well with other studies on mortality and weight-loss. For healthy persons classified as obese, it would seem that the most beneficial course of action is to maintain a stable weight, not to lose weight, which might increase mortality risk (Bosomworth, 2012). This has important implications for the health of larger persons given the pervasiveness of dieting and the high likelihood of weight-cycling, which might have independent and significant adverse effects on health (Aphramor, 2005). In the United States, over 50% of 'obese' respondents in the nationally representative 2005-2012 National Health and Nutrition Examination Survey were found to be metabolically healthy, and 30% of 'normal' weight adults did not meet these criteria (Tomiyama et al., 2016). Therefore, advocating weight-loss for all persons labelled obese may not lead to health gains and may be harmful in some instances. Note, for instance, that dieting is associated with a long list of documented problems, including: weight and fat gain, low mood, loss of bone and lean mass, compromised immunity and skeletal integrity, poor body image, weight-cycling (itself associated with inflammation, hypertension, diabetes, and cardio-metabolic risk), and the release of persistent organic pollutants into the body (Aphramor, 2005; Bacon and

Aphramor, 2011; Beavers et al., 2011; Delahanty et al., 2014; Schulz et al., 2005; Strohacker and McFarlin, 2010; Villalon et al., 2011). Green and Buckroyd (2008) and Burns and Gavey (2004) recount the congruence between weight-loss groups' and health promotion strategies and disordered eating, and evidence suggests school obesity prevention policies, programmes and pedagogies may be associated with disordered eating in students (Beausoleil, 2009; C.S. Mott Children's Hospital, 2012; Evans et al., 2004; 2008; Isono et al., 2009; Rich et al., 2004; Rich and Evans, 2009). Furthermore, the effectiveness of these childhood campaigns in achieving their stated aims is questionable (Gard and Vander Schee, 2011). For example, well-publicized 'BMI report cards', a school-based strategy to 'combat obesity', have not produced thinner children (Almond et al., 2016). Ethnographic research also indicates that anti-obesity interventions may unwittingly perpetuate bullying among youths labelled overweight or fat (self-reference, 2014).

While advocates of public health sometimes cite the problem of bullying and associated poor self-esteem as a rationale for tackling obesity, it is worth noting that the purported benefits of weight-loss do not necessarily extend to wellbeing (Warkentin et al., 2014). Indeed, high levels of depression and stress characterize some clusters of even sustained weight losers (Ogden et al., 2012). Individuals who do lose weight for a sustained period of time and are members of the National Weight Control Registry report major lifestyle alterations including: regular exercise, the consumption of low fat diets with an average caloric consumption of 1381 kcal/day and hyper-vigilance regarding food and weight (Wing and Hill, 2001). Importantly, some reported strategies to fight fat are decidedly less 'healthy', such as skipping meals (Ogden et al., 2012). Such tactics are nonetheless evidenced among people whose identities are colonized by the mantra of 'eat less' and 'exercise more' in a not always successful attempt to become a virtuous weight-loss champion (Author, 2015a). Notably, many individuals from studies of the National Weight Control Registry

have not necessarily ‘cracked’ the coveted ‘normal’ BMI category but remain categorized as ‘overweight’ or ‘obese’ (Ogden et al., 2012; Wing and Hill, 2001).

Alarmingly, and in reflecting tendencies towards ‘health and body fascism’ (Edgley and Brissett, 1990), a shift may be occurring in which dieting is simply encouraged for all individuals. This is a potent example of society’s ‘anorexic ideation’ as described by Campos (2004: 147-149). Anorexic ideation valorizes behaviours that would otherwise be deemed pathological. In the ‘war on obesity’, methods that might be considered counterproductive, unhealthy or dangerous have become commonplace or normalized, such as: fasting, skipping meals (O’Connor, 2016) and daily weighing (Wing et al., In press) even for people in ‘normal weight’ categories. Here, disturbing connections, contradictions and paradoxes emerge vis-a-vis reported medical ‘conditions’ such as *orthorexia* (obsession with eating healthy foods), *anorexia athletica* (compulsive over-exercising) and other restrictions on food intake. Indeed, some researchers have analyzed the discrepancy between behaviours labelled as ‘eating disorder pathology’ among the thin but as ‘health behaviour’ among the fat (Gotovac and Lafreniere, 2016).

Critically Explicating HAES in Social Context

This section, in offering a critical appreciation of the features and limitations associated with an alternative ‘size acceptance’ paradigm, is structured into four parts: (i) HAES® as a healthy lifestyle intervention, (ii) studies of HAES® interventions and reported (moderated) efficacy, (iii) the resonance and challenges of societal fat acceptance, and (iv) controversies, fractures and inconsistencies within and beyond HAES®. This discussion, in addition to presenting readers with

a map of HAES and a means of critically orienting to the paradigm, serves as a basis for our final section when reflecting on possible ways forward in theory, policy and practice.

(i) HAES® as a Healthy Lifestyle Intervention

The HAES® movement argues for a weight-inclusive, self-care-centric model of health promotion that focuses on intuitive and healthy eating, size acceptance and enjoyable physical activity (Bacon and Aphramor, 2011; Burgard, 2009). When reviewing HAES®, Aphramor (2016: 2, our emphasis) states that it is 'primarily concerned with a (1) critical appraisal of weight science within the parameters of its usefulness *as a lifestyle change model*, (2) offering a non-diet alternative, and (3) challenging fat stigma'. Gingras and Cooper (2013) maintain that what is or is not HAES® is subject to debate, and there is disagreement and contestation over who has the authority to define the movement and the attendant positioning of insiders versus outsiders. However, according to the Association of Size Diversity and Health (ASDAH), which presents itself as 'a leading voice in the international HAES community' (ASDAH, n.d.) and which holds the trademark to HAES®, there are five main principles (see Figure 1).

[INSERT FIGURE 1]

In short, this model promotes size acceptance over dieting as a route to health and wellbeing. When advocating HAES®, practitioners utilize the concept of 'intuitive eating' (Bacon et al., 2005), with individuals urged to follow *internal* cues of hunger and satiety, rather than relying on *external* cues to either restrict caloric consumption or eat to excess. To support their recommendation, advocates cite, inter alia, research conducted on toddlers which found that, when allowed to eat from an

assortment of nutritious foods, children would self-compensate and eat roughly the same amount of calories and macronutrients over a 24 hour period over 6 days, despite exhibiting considerable variation in consumption over the short term (Birch et al., 1991; Scheindlin, 2005). HAES® practitioners also invoke 'set-point theory' which posits that individuals will return to within a particular weight range, regardless of attempts to modify size (Bacon, 2010; though, for a critique, see Gard, 2011; Lupton, 2012, 2013).

Taken together, the above indicates that HAES® proponents are arguing for a lifestyle model of health that is more holistic than the reductionist focus on numbers on a weighing scale, tape measure or BMI chart and which is respectful of 'natural' bodily diversity, needs and pleasures. Whilst the division between nature and culture and other dichotomies is justifiably challenged by body theorists (Williams and Bendelow, 1998), it is worth noting that the emphasis in HAES® on health and the role of personal behaviours in health has also been critiqued. One crucial concern raised is that HAES® arguably continues to support the adoption of individualist behaviour change to the relative neglect of broader social factors; or, at least, it fosters tendencies that reproduce health as a super-value and index of moral worth, as part of an ultimately politically conservative project (Aphramor, 2016). We will return to this after outlining HAES® interventions and reported efficacy as moderated by stigma.

(ii) HAES® Interventions and Reported (Moderated) Efficacy

The original randomized control trial (RCT) of HAES® by Bacon et al. (2005) produced better psychological, cardiometabolic and behavioural outcomes in the HAES® group compared to a dieting control group. These beneficial outcomes outlasted the control group participants' often

transient weight-loss and the HAES® intervention did not generate negative outcomes. Furthermore, while weight-gain is often a feared consequence of HAES® among its detractors, HAES® interventions have not resulted in weight-gain (see also Bacon and Aphramor, 2011). Accordingly, Bacon (2006) has urged the medical and public health community to end the war on obesity and make peace with their patients.

More recent interventions have also been conducted and assessed. A HAES® general education course conducted with college students found that, compared to standard dieting control and comparison groups, the HAES® intervention produced greater body esteem and intuitive eating, less dieting behaviours and reduced anti-fat bias (Humphrey et al., 2015). Another non-dieting intervention was conducted with mostly Caucasian women categorized as 'morbidly obese' (Borkoles et al., 2016). The intervention produced increased physical activity and better psychological function for at least 12 months. Emphasizing the sometimes ambivalent positioning of HAES®, the authors reference the potential of this ostensibly non-dieting intervention to produce weight outcomes (although these outcomes were ultimately not produced) (Borkoles et al., 2016).

Mensinger et al. (2016) usefully identify literature on the effectiveness of weight-neutral approaches that explicitly draw from or are aligned with HAES®. For reviews, they point readers to Cadena-Schlam and Lopez-Guimera (2014), Clifford et al. (2015) and Schaefer and Magnuson (2014). In summarizing main observations, Mensinger et al. (2016: 33) write:

> studies that have tested weight-neutral programs demonstrated improvements (compared to baseline values) in many physical health, eating, and well-being indices such as: lower total

cholesterol, lowdensity lipoprotein cholesterol, triglycerides, systolic blood pressure, disinhibited eating, bulimic symptomatology, drive for thinness, body dissatisfaction, poor interoceptive awareness, and depression.

However, what is unclear from these studies is 'whether there are moderators that strengthen or weaken their effectiveness. Moderators answer the question of *when* or *for whom* a given relationship exists or an effect occurs' (p. 33, emphasis in original). Critically, as part of their own randomized control trial with 80 'community women' with a BMI>30, Mensinger et al. (2016) found that the beneficial effects on eating behaviours produced in a non-dieting healthy living program were mediated by internalized weight stigma (IWS), defined as 'the adoption and personal endorsement of negative weight-based societal stereotypes' (p. 33). The sustained benefits produced by the intervention, as compared to a conventional dieting program, were only evident in those with low IWS. Comparable results were found for physical activity (Mensinger and Meadows, 2017). Similarly, among women labelled obese and living with depression who participated in a healthy living intervention incorporating HAES® principles and Acceptance and Commitment Therapy (ACT), participants emphasized the value of incorporating self-acceptance and learning methods of coping with psychosocial issues (Berman et al., 2015). Therefore, even when HAES® programs are conceptualized primarily as individual lifestyle interventions, it is the size acceptance component that may be the most critical aspect or moderator of their effectiveness. This remains challenging. As discussed by Author B (2017), underlying social structures (such as those pertaining to class and gender) are generative of stigmatizing body norms that amplify the degradations of 'living big' in neoliberal nations.

(iii) Societal Fat Acceptance: Resonance and Challenges

Size or fat acceptance may be challenging, but in recent years HAES® and its underlying principles have received broader recognition. For instance, articles on body image cite HAES when discussing larger women's ability to relate to health promotion images (Lawson and Wardle, 2013). Temporal shifts in ideal sizes and the possible influence of HAES® are also referenced (Roberts and Muta, 2017; Webb et al., 2013, 2017), and the growing areas of weight stigma interventions and positive body image are emerging areas of exploration (Gumble and Carels, 2012; Lee et al., 2014). HAES® is also being discussed at large mainstream health and obesity conferences (Bacon, 2014a, 2014b). The lead author has spoken on HAES®-relevant content at standard public health or obesity conferences such as the American Public Health Association Annual Meetings and the Canadian Obesity Network Congress. And, there are numerous examples of HAES® being used in teaching practices to challenge weight centred approaches in health pedagogy and health professions (Ward et al, 2016). Further exploration of various approaches utilized to disrupt dominant obesity discourse can be found in the *Fat Pedagogy Reader* by Cameron and Russell (2016: 3) which 'explor[es] various ways in which educators are politically positioning critical perspectives of "obesity" and fatness in formal and informal educational settings and thereby helping develop this emerging field of fat pedagogy'.

Within contexts of everyday life, among women of a larger, or previously larger, size in Canada, the HAES® movement was referenced by name (see Authors, 2017), suggesting the public are increasingly aware of health-based alternative approaches to dieting. Some of these participants, however, even when invoking HAES®, continually referenced an ongoing impetus to engage in particular health behaviours as part of their ambivalent relationship with weight (loss), patriarchal

norms of feminine beauty (the aesthetics of slenderness) (Kwan and Graves, 2013), and their wish to avoid anticipated health problems in older age (Author 2015a, b; Authors, 2017). This internalization of health moralism (which is evidently entangled with sizism, ageism, sexism, stigma and medicalization) suggests HAES® may be taken up as a less radical and more assimilative approach to size acceptance in everyday life (LeBesco, 2004; Authors, 2017).

The ambivalence hinted at in the above study is indicative of the degree to which 'thin' may be 'in' with regards to 'conventionally' defined images of feminine beauty in Western culture (Kwan and Graves, 2013). However, we remain cognizant of possible resistances by laity. Preliminary findings from Australia suggest that criticism around 'fat shaming' is growing in online commentary (Cain et al., 2017). Even the popular site Buzzfeed featured an article on community members' reasoning behind quitting dieting and adopting self-acceptance (Tamarkin, 2016). Despite this seeming growth in size acceptance, advocating for the widespread adoption of HAES® within the current public health environment may be difficult for a whole raft of social cultural, political and economic reasons (Author, 2008, 2017). Within academia and policy-making contexts, support is higher for adopting weight-neutral language and guidelines that ensure potential confounders and side effects be incorporated in research reports than for funding HAES® research. Yet, the latter would more profoundly influence policy that is presumably based on scientific evidence (O'Reilly and Sixsmith, 2012).

Well-evaluated HAES® teacher-resources, which encourage healthy behaviours without triggering body-image issues or eating disorders, have been produced and may be used instead of more weight-centric school health programs (McVey et al., 2009). However, challenges persist in broadly disseminating size acceptance. Some teachers have expressed resistance to teaching body

acceptance, so as not to 'excuse' fatness, especially in classes with larger students (Robertson and Thomson, 2014). Similar scepticism is seen in fitness contexts. Australian fitness trainers viewed HAES® as only acceptable as a last resort for their clients when all attempts to lose weight through behaviours have failed (Donaghue and Allen, 2015). Among the general public, recent Latino immigrants viewed HAES® as an intriguing concept but one that did not align with cultural norms of 'cleaning one's plate' or of women's familial roles (Greaney et al., 2012). Therefore, while HAES® is making inroads within public discourse around health and size, it continues to grapple with, inter alia, entrenched notions of the mutability of the body, gendered body aesthetics, cultural constraints (shaped, in part, by a history of poverty and economic marginalization), and the ideology of personal responsibility for health.

(iv) Controversies, Fractures and Inconsistencies within and beyond HAES®

In recent years, lively debate, tensions and disruptions have appeared among the various camps supportive of fat acceptance. For example, recently after ASDAH trademarked HAES® (avowedly to protect it from 'misappropriation' by the dieting industry), Gingras and Cooper (2013) offered a critique. In particular, they raised concerns about the negative effects of trademarking in a (corporatized) field that lacks transparency. Gingras and Cooper argued that moves to trademark HAES® may lead to exclusionary, protectionist and commodifying practices. They contended that it may collapse and foreclose complexities that have long shaped body acceptance work, or even erase the rich history of fat activism(s) as lived by participants with diverse biographies and priorities. There are additional elements in this critique, especially from the viewpoint of those immersed in radical fat activism and queer theory who are concerned about the relationship between professionalized organizations and grassroots activism. Cooper expressed her

ambivalence about HAES® more generally given, for instance, its concern for academic respectability and producing a sanitized account that reduces 'fat identity and fat culture ... to a question of health' (Gingras and Cooper, 2013: 2-3).

The processual nature of HAES® and ASDAH's move to trademark the name mean that it will likely continue to witness internal strains and dissent. However, certain core principles of HAES® appear to have filtered into the broader healthcare and research community albeit in a not always consistent manner. For instance, a cursory review of articles identified by the search term 'Health-at-Every-Size' reveals numerous articles that ostensibly state their focus to be on HAES®, but that continue to frame HAES® interventions as potentially beneficial in terms of weight-loss or preventing weight-gain (e.g. Borkoles et al., 2016; Greaney et al., 2012). This framing is inconsistent with a legitimately 'weight neutral' approach to health, and it may suggest the strategic positioning required to receive funding and get published in the health field or find acceptance within neoliberal social and political contexts.

Mainstream biomedical stakeholders, such as those at the University of Connecticut's Rudd Center for Food Policy & Obesity, have positioned themselves as opponents to obesity stigma and have made considerable strides in advancing this agenda. This work tends to focus on ensuring treatment in clinical contexts is respectful (Author et al., 2016), which is important given anti-fat bias in the health professions influences health outcomes and patients' uptake of care (Mensinger et al. 2016; Phelan et al. 2015; Schwartz et al. 2003). However, authors such as those at the Rudd Center rarely critically situate their work within existing social theory. Nor are they interested in interrogating the problematization of body size *per se* (Author et al., 2016; Author, In press). Hence, their

approach retrenches existing disparities in clinical practice, for instance the offensiveness of labelling somebody 'obese' (Aphramor, 2009), despite an apparently well-intended concern to improve the health of people defined (pathologized) as such.

Conceptual models have also been developed that explore the multiple pathways through which weight stigma may affect health (Brewis, 2014; Hunger et al., 2015). These models are intended to explicate some of the associations found between weight stigma and cardiovascular reactivity, activation of the 'fight or flight' responses, lower self-acceptance, mood and anxiety disorders, and attempts to avoid and escape stigma. At the same time, the inclusion of over-eating, refusal to diet, self-control, and decreased physical activity in their models, and the persistence of weight-gain as an adverse consequence of weight stigma, illustrate the uncertainty and tensions in adopting a size acceptance approach (Brewis, 2014; Hunger et al., 2015; Tomiyama, 2014).

There is a surprising paucity in the literature on attempting to accept life in a larger size and adopt a size/fat acceptance or a HAES® perspective. Most of the literature in the area explores individuals' induction into the Fatoshpere (the online size acceptance community) (e.g. Donaghue and Clemitshaw, 2012), or is the auto-ethnographic discussions of scholars who encounter ambivalence in personally desiring altered bodies while critiquing weight-centrism (Heyes, 2006, 2007; Longhurst, 2012; Murray, 2008; Throsby and Gimlin, 2010). Murray (2008: 109, emphasis in original), for instance, critiqued what she sees as fat activism's proposal that 'fat persons' can 'simply *chang[e] [their] mind[s] about [their] bod[ies]*'. This critique was taken up by Lupton who argued that the focus of HAES® on natural set-points and internal cues ignores the cultural and discursive context in which individuals live. This context, she explains, shapes both eating behaviours and individuals' capacity for self-acceptance (Lupton, 2012). Current literature would

suggest the focus of HAES® on individualistic behaviour change and self-acceptance does little to alter societal attitudes, and without such shifts, advising individuals to be more size accepting may be futile. Lupton's posting on her blog motivated a response from then-prominent HAES® proponents Bacon and Aphramor. Their response focused on the value, including the political value, of individual size acceptance and re-iterated the HAES® movement's commitment to encouraging societal size acceptance.

The HAES® movement's perceived uncritical neoliberal concentration on individual behaviour or 'healthy lifestyles' has also been recently challenged from within. Aphramor (2016) argues for the necessity of a greater focus on inequity and the social determinants of health, including social status and its significance in explaining social gradients in mortality and morbidity (Marmot, 2004). Aphramor, along with several colleagues, have continually sought to reframe the tenets of the HAES® movement in a more political, equity-centric direction (Aphramor and Gingras, 2011; Brady et al., 2013). Over time, for Aphramor, HAES® gave way to Health-in-Every-Respect (HIER), in an attempt to further politicize HAES® and extend its impact beyond individual non-dieting approaches to focus on social justice and challenge healthism. Eventually, however, Aphramor left the movement to develop a more revolutionary approach, which she terms Well Now and which she teaches to other health professionals (Aphramor, 2016).

ASDAH appears to have recognized this critique of HAES® (notably, the charge that it reproduces healthism and individual responsibilization for health), and has responded by adding the following statement to its website:

> ASDAH's HAES Principles reject judgments about health and any discourse of individual *responsibility* around health, in favor of a discourse of individualized health *needs*…ASDAH also recognizes that many of the factors that determine our health are not individual in nature. Social, political, and cultural factors … may have an even greater impact on health outcomes than individual choices. On a collective level, we support creating health-promoting environments and removing barriers to access. On an individual level, we seek to empower people to engage in those personal practices that best support health and wellbeing for the individual. There should be no judgment about what people choose to do (or not do) to enhance their well-being. (ASDAH, n.d.)

These distinctions do not appear to resonate with critics of the HAES® movement within the size acceptance realm. Critics remain dissatisfied with efforts to modify the architecture of HAES® ultimately as a *lifestyle intervention* rather than radically redraw its plans by *integrating* concepts such as 'allostasis, metabolic inheritance, somatophobia, power, silences, gender and nutrition justice, critical pedagogy, trauma and shame alongside critical appraisal of weight science and the need to challenge fat stigma' (Aphramor, 2016: 1). Arguably, what these divisions reflect is the promising, growing, critical mass of the size acceptance movement, resulting in different emphases, epistemic assumptions and (more or less ambitious) politicized concerns. Size acceptance and its various camps generate sufficient self-reflexivity to now host, albeit sometimes uneasily, multiple divergent viewpoints. Yet, the degree to which more radical arguments are

digested or rejected by size acceptance leaders remains inseparable from the broader neoliberal context in which health policies are debated and funded.

Conclusion: Going Beyond Bodily and Behavioural Change

Health research and policy in the anti-obesity terrain typically focus on exhorting or 'nudging' individuals to fix their purportedly unhealthy, and thereby burdensome, bodies through personal behaviours such as eating less and exercising more. Yet, ongoing research on the extent to which structural inequalities perpetuate 'health gaps' (Marmot, 2015) and stigma challenges the reliance on behavioural explanations of health differences. In redressing the over-reliant focus on the individual, explanations of the influence of wider social determinants and social context have provided important evidence of inequalities, particularly those associated with social class (for a useful review within the sociology of health and illness, see Scambler, 2012). Nonetheless, a 'lifestyle drift' persists within public health, or 'the tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors' (Popay et al. 2010: 148). More disturbingly, the focus is on presumed or prejudicially inferred lifestyles with reference to body mass which can never be anything more than a crude proxy for behaviours and health (risk).

By failing to challenge this tendency to foreground lifestyles, body mass and implied notions of personal culpability, public health approaches could themselves be regarded as stigmatizing and largely remain unable to capture the complex relationalities within which embodied health practices and knowledge about these take place (see Rock et al., 2014). Critical policy theorists

provide some insight as to why more complex and critical perspectives have yet to find their way into a policy terrain; their work makes clear how policy is shaped by and interacts with philosophy, theory and methodology (Taylor, 1997, cited in Ulmer, 2016). In other words, policies are shaped by the orientations within the existing knowledge of obesity, which informs the 'evidence base' from which policies are developed or analyzed. Policies tend to be dominated by neoliberal approaches to improving public health which rely on either individualized morally accented lifestyle change or environmental interventions. These knowledge traditions shape government policy, social groups, health organizations and individuals in considering both the causes and effects of obesity. Seldom are more complex theorizations of systems and power relations that shape (conceptions of) health recognised.

The poor outcomes in reversing what public health policymakers perceive to be catastrophic rates of obesity have led to both mainstream criticism (e.g. Hebert et al., 2013) and the development of critical counter-movements in the form of fat studies scholarship, HAES® (Cooper, 2010), 'critical weight studies' (Authors, 2011; Lupton, 2013) and highly cited articles in STH on this topic. As outlined in our article, whilst not without critique, the inroads made by HAES® also deserve broader recognition in social scientific and policy debates. They have at least helped to open this counter-discourse to expansion, diversification, internal fractures and the potential to imagine strategies for advancing body equity in multiple domains. In that respect, it could be argued that despite various limitations, HAES® remains an invaluable launching-point to challenge individuals, educators, practitioners, and trainees embedded in health disciplines in which striving to be responsible, healthier citizens is an entrenched goal. As Gard (2016: 244, emphasis in original) states, HAES literature provides these groups the opportunity 'to work through the *very discursive substance* of the "obesity epidemic" itself' through its deployment of positivist science

and clinical, measurable outcomes. By relying upon, but challenging, what is familiar territory for many audiences, HAES® allows us to take the requisite time necessary to answer the question, 'what does this mean for me as a practitioner, researcher or educator?' before aiming for more critical, and indeed, more crucial, stakes.

In order to advance an equitable and inclusive policy environment for all people, an explicit social justice argument must be made for the elimination of discrimination and prejudice based on size, rather than immingling these goals with health behaviour change. By unequivocally placing health equity at the forefront of policy discussions, and not prevaricating over individuals' 'healthy' or 'unhealthy' behaviours, endlessly reformulating the energy imbalance model, or assigning worth or access based on 'lifestyle choices', we would align ourselves against the structural inequalities that impact a populations' health and wellbeing (Marmot, 2004; Popay et al., 2010). Within a context of stretched public resources, these inequalities are pressing health concerns and as such it is necessary to draw upon a more diverse range of social theories of health. In part, we see this as a necessary endeavour to challenge the linearity of obesity policy production, largely dominated by individualist models of behaviour change that are hardly concealed by appeals to paternalistic nudging and obesogenic environments. The work above suggests that far from being the result of an individual's behaviour, what medicine labels 'overweight' and 'obese' need to be better understood in relation with other bodies, discourses, affect economies and material contexts and the interweaving of these factors. There has not been space to fully explore the contributions of other research in this regard, but future work might begin to explore the potential contributions of recent theories which bring relationality and materiality into these conceptualizations of embodied inequality. This might open up the debate and consider not only what such readings might offer,

but what these might mean for the existing knowledge 'traditions' within public health, policy and the social sciences.

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Figure 1: HAES® Principles, as defined by the ASDAH

1. **Weight Inclusivity:** Accept and respect the inherent diversity of body shapes and sizes and reject the idealizing or pathologizing of specific weights.
2. **Health Enhancement:** Support health policies that improve and equalize 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 our 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, individualized 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.

Source: ASDAH (n.d.).