

*“Body Respect is a ground-breaking, dogma-busting book that will change how you think about health forever.”*

—Christopher Kennedy Lawford, *New York Times* bestselling author  
and former UN Goodwill Ambassador for Drug Treatment and Care

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# BODY RESPECT



What Conventional Health  
Books Get Wrong, Leave Out, and  
Just Plain Fail to Understand about Weight

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For everyone looking to incorporate the principles of this book and *Health at Every Size* into clinical or social care, let's return to where we started—contrasting the health impact of personal behaviors like nutrition and lifestyle habits—through the old and new paradigms of weight focus and HAES.

## **How Health Providers Advise Patients**

### **A Conventional Model**

Consider a hypothetical patient, Janet, newly diagnosed with diabetes. Janet feels the stress of balancing full-time work with caring for her two children and disabled father. She has advocated for improved safety conditions at her worksite and worries that her outspokenness threatens her job. Even with overtime, her wages are low. She yearns to take a moment just to sit in the park or treat her children to something special, but lacks the time or money.

Billie, a nurse at her health provider's office, is empathic and experienced, and strives to be patient-centered. She advises Janet to lose weight, eat a more nutritious diet, and engage in more physical activity to manage her diabetes. As if Janet hasn't tried all this! While periodic diets have brought her short-term "success," Janet's always ended up heavier in the long run than before, feeling demoralized and ashamed to boot.

Still, it's not as if Janet doesn't *want* to improve her diet, by adding vegetables, beans, and whole grains, for instance. She does try to "eat right" and is actually meeting many diabetes care recommendations by the time she next meets with Billie. Janet feels less bloated, she notices, and has more energy in the mornings now that she eats breakfast. Her weight is down slightly.

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Still, Billie is less than satisfied—for Janet’s sake. She points out to Janet that her blood sugar and pressure haven’t budged, and she’s concerned about the salt content of Janet’s diet. When Janet says she’s made every change they discussed, Billie seems incredulous. If this were true, she insists, Janet would have dropped more weight and reduced her blood pressure.

Janet is disheartened, and Billie is discouraged. Her years of health care study just aren’t worth it, Billie thinks, if even with skilled support and a listening ear, patients like Janet just can’t seem to take personal responsibility and follow her recommendations.

Here is why the conventional model is broken. We can look at the supposed facts of the story, but they don’t tell the full story. What’s really going on in this scenario with Janet and Billie? The conventional model explains weight, blood sugar, and blood pressure as products of diet and exercise. Beholden to this model, Billie believes that Janet’s physiological measures would reach the healthy range and she would lose weight predictably, if only she followed medical advice. True, Janet’s energy levels, mood, and gut health have improved, but in the conventional model, that counts for little. The traditional paradigm also ignores a significant hidden threat to Janet’s goals: her experience of chronic stress.

No matter how she changes her diet or physical habits, the factors that make up Janet’s lifeworld—stigma, insecure work, poverty, caring responsibilities—remain unchanged. Healthier eating can improve her sense of well-being and strengthen her against adversity, but it can’t remove the stressors she faces. Billie’s disappointment and skepticism, in fact, add a new stressor: They give Janet a way to blame herself for not doing better, for

failing at weight loss, and even for bringing her diabetes on herself in the first place.

### **The HAES Model**

Now imagine this scenario featuring a Billie who has adopted a Health at Every Size perspective. When Janet makes that first appointment, Billie's sympathetic ear frees Janet to bring up the shame and guilt that surround her dieting history and weight and to share anxieties about embarking on a new round of lifestyle changes. What Janet really wants, she tells Billie, is a diet plan she can *stick to* this time. Billie listens to the challenges Janet faces in altering her lifestyle, so Janet feels heard and respected. *I take your body dissatisfaction and weight concerns seriously*, she assures Janet, before sensitively introducing the idea of a HAES approach.

Together, they make a list of practical suggestions to support Janet in taking care of herself. Eating more regularly is one of them. Another is exploring how her food choices influence her mood and energy levels and how her mood governs what she eats.

This HAES perspective sounds a bit unlikely to Janet—it goes against everything anyone in health care has ever said to her, and now that she has diabetes, which is nothing to toy with, she is even more reluctant to deviate from the conventions she's always known. On the other hand, she knows from experience that the traditional route hasn't been working out very well for her. In fact, she acknowledges, after some discussion, her personal experiences do look astonishingly like the statistical outcomes Billie describes: yo-yoing weight, low mood, and food preoccupation.

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By the end of the conversation, Janet may not be a HAES convert, but she feels they have come up with practical steps that can help her, like adding beans and seasonal veggies to meals. And she is intrigued by the HAES imperative of compassionate self-care, even if she's not completely sold on it yet. When Billie explains the links between our histories, life circumstances, and diabetes, it makes sense to Janet. She begins to feel angry at having been hoodwinked into believing her own illness and the high rates of it she sees among her friends and neighbors were all their own fault. She wonders if she's been let down by people she trusted. All this comes with no small measure of relief, as the guilt she's associated with her diagnosis starts to lift.

By her second appointment, Janet's energy levels, mood, and gut health are improved. She is sleeping better and less irritable. More than that, her customary feelings of pre-appointment dread have been replaced by the expectation that she will find herself supported and valued. Members of Janet's church group have noticed her changes and enthusiasm and have invited Billie to give a talk.

In the clinic, when Janet learns her blood pressure has gone up, she suggests it may relate to her struggles at work. She is glad to have the chance to talk about those with Billie. They discuss the pros and cons of blood pressure medication, given that lifestyle changes aren't lowering Janet's blood pressure. But Janet decides to hold off on that in order to give the changes more time.

When she works with patients like Janet (who, unlike some of her patients, at least has a job), Billie can feel overwhelmed at times. She fears that so many social changes are needed for true health improvement in her patient population, and she sometimes feels that she is only a bit player with no impact. Still, she

does see a difference already in Janet's emotional resilience, and relishes the chance to speak to the church group. She resolves to check in later with colleagues for support, which may boil down to the useful reminder to keep both the bigger picture and the individual in mind and merely do what we can, when we can. She reminds herself she can't shoulder the burden of the world alone, but that she remains part of a larger social movement that is having an impact.

Thanks for checking out

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