



Rainbow Health Ontario

Fact Sheet

Because LGBT health **matters**

A CRITICAL UNDERSTANDING OF WEIGHT IN LGBT COMMUNITIES

Body weight is monitored in healthcare settings as a key indicator of health risk. This fact sheet considers evidence about the high prevalence of raised body weight in LGBT communities, examines the critiques about using body weight as an indicator of health, and finally explores some alternative approaches to understanding raised body weight and supporting people to be healthy at every size. The fact sheet focuses on overweight and obesity, since being underweight, although it carries health risks, is generally regarded as less of a health concern in the culture at large (1,2).

A CRITICAL APPROACH TO BODY MASS INDEX (BMI)

BMI, a mathematical formula for calculating a measure of height and weight, is the standard form of measuring body weight in clinical settings. Several studies have found that LGBT people report higher BMI than their straight peers. However, few studies take a critical approach to BMI as a measure of health, so we urge practitioners to be cautious when using BMI in their practice.

- BMI is used not only as a measure of healthy weight, but often as a measure of health itself. Few health care providers, or members of the public, have a critical understanding of the problems with using BMI as a short hand for health.
- BMI measures the amount of space a body takes up in the world. It is not a measure of behaviour, habit, social context, genetic inheritance, history of weight loss attempts/weight cycling, or other essential health impact factors. As a measure of 'healthy' weight, BMI fails to account for muscle density, the variety of human embodiment, or the cultural context in which fatness is constructed (3).
- BMI has come to stand in as an indicator of health and wellness. Many studies have found that poor health outcomes are correlated with higher BMIs. Many assume that this correlation indicates that higher BMIs (30 and over) *cause* poor health outcomes. However this is not necessarily the case.
- Little research has distinguished between the association of higher weight with poor health outcomes and higher weight as the demonstrated cause of poor health. Some recent studies have started to demonstrate the importance of this distinction, although this critical work is in its early stages (4,5). It is important to remember that correlation does not indicate cause.
- For example, women with high BMI are reported to be at higher risk for gynaecological cancers. A unique US study of 498 women, that included 60 obese women, and 129 health care providers found that this differential rate was more likely to be caused by barriers to screening, including disrespectful



treatment in the clinic, inappropriate medical equipment and negative attitudes of health professionals rather than as a result of body mass itself (6).

- An analysis of OHIP (Ontario Health Insurance Plan) data found that although some diseases led to a modest increase in healthcare costs when combined with obesity, obesity itself was not associated with higher healthcare costs. This analysis highlights the importance of focusing on attending to disease processes themselves in people who are overweight (7).
- Many studies have suggested that lesbians tend to have a higher BMI than straight women (8-13). This is often regarded as problematic because high BMI is assumed to correlate with increased risk for breast cancer, cardiovascular disease and Type II Diabetes. Because of the problems associated with BMI as a measure for health, these correlations cannot be simply assumed.

OBESITY AND STIGMA

- A World Health Organization report, published in 2000, classified obesity as an epidemic (14). The WHO report was criticized on the basis of methodology and for the influence of commercial weight loss interests on the data (15). Nevertheless, the report influenced global obesity policy at a high level. Critics of the report note that it ignored contradictory evidence about the health implications of being overweight, created a moral panic, and framed obesity as a crisis, contributing to the acceleration of stigma and discrimination, particularly against young people (16-19).
- Obesity epidemic rhetoric maintains stereotypes associated with body fat, food consumption and physical activity. Stereotyping based on body size contributes to social stigma, and internalized body shame. US studies have found that anti-fat bias has a significant effect on an individual's ability to get work, affecting their mental health, economic status, and access to health care (20-24). Weight stigma can create social marginalisation and may combine with other forms of prejudice such as ableism, racism, classism, trans-, bi- and homophobia.
- A document recently released by the Provincial Health Services Authority in British Columbia suggests that anti-fat bias, stigma and discrimination also have significant impacts on the health of fat people (25). This has been confirmed elsewhere in other studies (19,26).
- The belief that higher body weight confers ill health, or should be stigmatised, has varied over time and place (27-29). Attributes such as gender, race and class affect how fat people are socially positioned and stigmatised in relation to body weight (30). Sometimes cultural communities value people of higher weights, for instance, qualitative studies in the UK and US have explored gay sexual identities that value fat masculinities, such as Bear communities (31,32).

WEIGHT LOSS

- Weight loss via diet modification, exercise, drug therapy and surgery is typically prescribed for people with higher body weights as a health promotion strategy



and remedy for stigma and discrimination. However, numerous first person accounts, many by lesbians and bisexual women, point to the inefficacy of weight loss in promoting well-being because of its role in weight cycling, eating problems, psychological difficulties and its impact on physical health, for example disruption of natural hunger cues, and metabolic health, which have wider physiological implications (33-36).

- It is a popular belief that lesbians are immune to the social pressure to lose weight because this activity is framed as something that pleases men. While some research indicates that lesbians display lower levels of body dissatisfaction than straight women (37-39), other studies have found that lesbians also experience anxiety around body image and weight loss (40,41). Some studies have found that lesbian participants may have a less distorted body image when it comes to their weight. A US study that included 341 lesbians found that, based on reported BMI, lesbians exhibited a more accurate sense of their body weight than straight women (12).
- Among lesbians, high levels of body shame and body surveillance (hyper-awareness of one's body, and other's bodies) have been found, particularly among those who have experienced unwanted sexual attention. Shame and body surveillance have been found to predict disordered eating scores (40,41).
- Trans women are at risk from the same kinds of social messages about body size and appearance that affect all women. Hormone therapy may exacerbate these problems because it may predispose trans women to gain unwanted weight (42). A German study of 88 trans women and 43 trans men found that both trans men and women scored more highly for restrained eating, weight concerns, shape concerns, body dissatisfaction and body checking than the cis gender (i.e., non trans) control groups. This suggests that trans people need particular support in developing positive body image and that this includes issues to do with eating and gendered body ideals as well as weight (42).
- Iatrogenic refers to harm and illness caused by medical interventions. Health practitioners worried by the iatrogenic properties of weight loss are developing new approaches to working with body weight in healthcare. These authors claim that weight loss contributes to poor health outcomes in the long term and is creating a population of sick fat people (4,43-46) .

ALTERNATIVE MODELS PIONEERED BY LESBIAN AND BISEXUAL COMMUNITIES

- For many lesbian and bisexual women, size oppression and sexuality are linked. Since the 1970s, lesbian, bisexual, trans and queer feminist activists have been reclaiming the concept 'fat' as a marker of identity, community, and politics, and challenging fatphobia, the fear and hatred of fat (47-50) . This is often called fat activism, fat acceptance, or size acceptance and has been adopted by people of all sexualities and backgrounds to become a global social movement that has spawned organisations, businesses, an academic field called Fat Studies, art and more.



- Health practitioners, many of them allied to fat feminist activism, and some of them lesbians and bisexual women have developed alternative approaches to supporting and serving fat clients (5,51-55). These generally fall under the umbrella term Health At Every Size (HAES).
- The Association for Size Diversity and Health (ASDAH, www.sizediversityandhealth.org) is an organisation for health professionals, academics and activists that work with the concept of HAES. ASDAH develops the HAES model, which it describes as:
 - Accepting and respecting the diversity of body shapes and sizes.
 - Recognising that health and wellbeing are multi-dimensional and that they include physical, social, spiritual, occupational, emotional, and intellectual aspects.
 - Promoting all aspects of health and wellbeing for people of all sizes.
 - Promoting eating in a manner that balances individual nutritional needs, hunger, satiety, appetite, and pleasure.
 - Promoting individually appropriate, enjoyable, life-enhancing physical activity, rather than exercise that is focused on a goal of weight loss (7,56).

These critical ways of understanding body weight draw on a social model of health which proposes that fat-phobia, stigma and discrimination create tremendous suffering and ill-health, and furthermore that the widespread proliferation of ineffective weight loss interventions contribute to both suffering and ill-health (48,57).

- There has been some recognition of this critique amongst public health authorities in Canada. For instance, the BC Provincial Health Services Authority report upholds some of the HAES recommendations, but also articulates a commitment to lowering overall body weight in populations (25).
- A six-month, randomized clinical trial with two-year follow-up was undertaken with a US sample of 78 white, female chronic dieters aged 30-45 years, who had been classified as obese. HAES and standard weight-centered treatment models were compared. The study found that many members of the weight loss group dropped out and regained the weight they lost. The HAES group members maintained stable weights, improved their eating habits, psychological outlook, metabolic and physical fitness, and had a negligible drop-out rate (56).

GAPS IN THE RESEARCH

- Research is needed about the relationship between weight and health that is not built on the assumption that weight loss is beneficial or possible, and that is not funded by commercial weight loss interests. This would give a more balanced picture of the impact of body weight on health and could control for other



elements that influence the relationship between fat and wellbeing, including social factors and weight cycling history.

- More attention needs to be directed towards the relationship between weight and health in lesbian and bisexual populations that takes into account the limitations of BMI.
- There is a lack of obesity research that considers the interplay of body weight with stigma and discrimination, and that examines the impact of these interacting factors on health, especially in those who are already socially marginalised, including LGBT people.
- Despite the promising trial comparing weight loss regimes to HAES, there has been little clinical work building on this evidence base. More research is needed to develop an understanding of how non-weight-based interventions can enhance people's health. Including measures about the impact of different approaches on individuals' mental and emotional health should be a key element in the research.
- There is a need for Community Based Participatory Research that is designed, created and disseminated by LGBT people who identify as fat. For instance, there is considerable anecdotal evidence, and some research that suggests that lesbian and bi women's communities may have developed positive body image associations for a much broader range of bodies than are seen as acceptable in the mainstream public. There has been no research about why this is so and how this might benefit other populations. Exploring the efficacy of medical self-advocacy projects being pioneered by fat activists and size acceptance proponents would be another avenue for CBPR projects.

IMPLICATIONS FOR HEALTH CARE PROVIDERS

- Critically thinking health practitioners should consider the source and purpose of research that correlates high BMI with poor health, including whether the work is supported by organisations or individuals with financial interests in weight loss promotion (15). Many reports on obesity studies omit a methodology section altogether, which is unethical and lacks rigour (45). Critical readers should question the assumptions behind the research questions, and check that the data interpretation is consistent with the research findings (3). Practitioners are encouraged to develop working alliances with fat people themselves to add community experience to their evidence base.
- Health care providers, and other professionals, are invited to reflect on their own fat-phobia and consider its impact on their practice (58). Providers may wish to participate in fat community groups and gatherings such as NOLOSE, and should be aware of the critical literature emerging from this movement (5,47-56,59,60).
- Consider adopting alternative treatment models for overweight and obese clients, and shifting from weight-centred treatment to person-centred approaches that are more able to accommodate a matrix of factors that influence the relationship



- of weight to health, for example gender, ethnicity, socio-economic status, etc. Those practitioners who adopt such approaches should consider contributing to an evidence base built on alternative treatment models with regards to weight.
- Be aware that health issues traditionally associated with particular body sizes can occur across the spectrum of body types. This is particularly present in the field of eating disorders, where obesity is understood as evidence of binge eating, or thinness with anorexia. Misdiagnoses based on these assumptions can lead to further problems and mismanagement of client's health.
 - Health care providers need to be aware that the use of restrictive diets, for example in the management of coeliac disease, can be emotionally difficult for people who have histories of weight cycling and weight loss, or who are subjected to daily pressure to diet as a result of weight-related stigma.
 - Providers can support the Health At Any Size movement by joining the Association for Size Diversity and Health, or through Critical Dietetics, an international social justice organisation based in Ontario for dietitians and allied professionals (45,60).
 - Direct LGBT clients interested in activism to NOLOSE (<http://www.nolose.org/>), "a vibrant community of fat queers and our allies, with a shared commitment to feminist, anti-oppression ideology and action, seeking to end the oppression of fat people!" (50) .

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