Redefining Health & Wellness
#23

Featured this episode: Shohreh Davoodi & Jess Campbell

Shohreh Davoodi: It's time for episode number 23 of the Redefining Health & Wellness podcast. Today on the show I have Jess Campbell, a non-diet nutritionist and medical student. Jess and I talked about the flaws with the BMI, what the science really says about body size and weight loss, Jess's thoughts on what doctors can do to better support their patients in larger bodies, and more.

To access the show notes and a full transcript of this episode, head to shohrehdavoodi.com/23. That's shohrehdavoodi.com/23.

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Hey y'all, welcome to the Redefining Health & Wellness podcast. I'm your host, Shohreh Davoodi. I'm a certified intuitive eating counselor, and a certified personal trainer. I help people improve their relationships with exercise, food, and their bodies, so they can ditch diet culture for good, and do what feels right for them.

Through this podcast I want to give you the tools to redefine what health and wellness mean to you. By exposing myths and misconceptions, delving into all the areas of health that often get ignored, and reminding you that health and wellness are not moral obligations. Are you ready? Let's fuck some shit up.

Hey y'all, today I have Jess Campbell, all the way from New Zealand where, just to tell you guys the time difference right now, it is Thursday afternoon for me and it is Friday morning for her. And Jess is a non-diet nutritionist and medical student who is very passionate about weight inclusive healthcare practices, which we're going to be talking all about today.

Thank you so much for being here Jess.

Jess Campbell: Oh, thanks so much for having me, I'm really excited to start unpacking some of this weight-inclusive care.

Shohreh: Yeah, you're my first Kiwi guest, so I'm very excited about that [laughs]. So, let's just start by having you tell me about how you came to do the work that you're doing now, and why you decided to go to medical school?

Jess: Yeah, so, it's a bit of an interesting sort of adventure that I think I went on. I actually first enrolled in university hoping to pursue veterinary science. And that was back when I was 17, some 12 years ago. And it soon became apparent in that very competitive first semester that I was probably less academically inclined and a little bit more socially inclined at that time. [Laughter]

Shohreh: That was a very delicate way of saying that!

Jess: Discovered that I probably wasn't going to be making the grade in that semester to go through to the very competitive program. That first semester fed through to a Bachelor of Science, and I had quite a number of choices to make there about where I would go. And I sort of toyed with the idea of biotech and I kind of landed on human nutrition and physiology. So I think I'd always been very interested, very science minded in school, but wasn't entirely clear of where that was going to take me.

And so I signed up to some nutrition papers and was really happy just sort of ticking along. And then before I knew it, [laughs] I graduated with a Bachelor of Science in human nutrition and not really anywhere to go in terms of job prospects here in New Zealand because our healthcare system is more aligned to dietetic registration.

And so nutritionists here tend to work more in the private practice, or work with food industry, maybe in communication, or tend to get funneled

through into academia. None of those particularly resonated with me, and I sort of found myself reaching out to other nutritionists and dietitans. Really hopeful to find someone to sort of take me under their wing, and show me the ropes in private practice.

Because I think we operate small business models, it's particularly competitive in the weight-centric practice, and I found it really hard to find anyone who would be willing to take me on. And so I think I come from a long line of self-employed, or perhaps entrepreneurial family, and mom really encouraged me just to be bold, and take a clinic room at a local doctors office, and maybe offer private consultations once a week.

And I did that. It seems really crazy now because I had no experience, and I was really fresh, and off I went. And sort of grew from there in terms of my private practice. I also went back to university, so I've been in academic training for the last 12 years in some form or other. And I undertook my postgrad in human nutrition. Still not much of an idea where I was going.

I really enjoyed the nutrition consultation work that I was doing and I sort of segued into workplace wellness for a short time and occupational health and safety. And I found that through the work that I was doing in private practice, particularly based in a general practice with doctors, a lot of my clients were wanting to know, they were coming into the nutrition side of things, but they also wanted to better understand their own health, and their illness, and how that related to living well.

And I sort of recognized that I had quite an interest there in perhaps pursuing medicine. And I think that also came from, I took it really seriously once I sort of picked up the Health At Every Size, and the non-diet work about four or five years ago, and a passion for eating disorder recovery and prevention. So pursuing psychiatry has come to the fore for me, and that's really what drove me to apply for medical school

Shohreh: And what brought you to the Health At Every Size and non-diet movements?

Jess: [Laughs] Yeah, I love this question. So, whilst I was training in human nutrition, I had the least bit of interest in human nutrition, I think. I was much more fascinated with how we related to food, and why we ate, rather than what we were eating, and how much we were eating. And so I couldn't quite put my finger on it then as to why I felt so different to my classmates. And I felt the rigidity of nutrition science was really suffocating.

And so I stepped into private practice and working in a weight-centric paradigm for a couple of years, and really engaging in soul crushing meal plan preparation and writing. And the turning point for me was sitting in my office, noticing that one of my clients, who was due for a session in about five or ten minutes, was really upset. And she was crying whilst she was filling out her food diary.

And I just thought, I can't continue like this. I felt a lot of pressure and I felt really disconnected from the work. And I felt like I was going through the motions, but I knew that the service I was providing was deeply unsatisfying for the client as well. And so I closed my doors for a period of time. I didn't take on any new clients while I tried to figure out what it was that wasn't working.

And I'd always sort of described myself as eating intuitively and this was before I stumbled, somewhat serendipitously [laughs] across intuitive eating at that time. I'd never followed a meal plan and I couldn't understand why I needed to write meal plans for my clients. And so coming across intuitive eating in a secondhand bookstore, just jumped out from the shelf at me and I thought, wow, what's this?

And I devoured the book in a couple of hours and I thought, this is it. This is where we're going. And it took me sort of 12-18 months to really start to

wrap my head around it. And I came across a number of resources, Julie Dillon's podcast, the Love, Food podcast was one of the first that I listened to.

Savor podcast was around, probably one of the first. It's no longer available. And I listened to a lot of Christy Harrison's work. And then I stumbled across Fiona Sutherland and Fiona Willer, who have become great colleagues of mine, and the non-diet approaches. So that's really where I started.

And then very organically, over the last four or five years, and I think my observations are, anyway, that this is a really common path that we take as we find intuitive eating and we find the non-diet approaches, and then as the work develops and our learning and our process of unlearning continues, we recognize that there's social justice threads weaved throughout this work. And there's a broader conversation we have to be having about marginalization and depression and our identities, and how that influences this work.

And I think it's quite important that I probably state now that I do this work from a multi-privileged position. So, I hold a lot of privilege and I need to be aware of that whilst I'm working in this space.

Shohreh: I appreciate you saying that up front because it's so true that I don't think that we can have HAES without looking at it through a social justice lens. It loses so much of its value and its power when we don't include social justice as a part of it because we just can't separate out these identities from individuals, right? We can't have health without also looking at social determinants of health, and intersecting identities, and all those things.

Jess: Yeah, and our social location as practitioner, and again, the social location of our client, or patients, so there's two things that come into a room there. And we need to navigate that and it's very nuanced that work.

Shohreh: So you went to medical school, already kind of having this philosophy of HAES, non-diet etc. which I'm sure has been pretty interesting because I imagine your program is very weight centric, like most medical programs are. So, if there are any medical students or anybody listening who is dealing with similar programs, do you have any recommendations for maybe how they can survive, and maybe even push back against that dominant system?

Jess: Yeah, you've caught me at a really interesting time. So, I mean, at the moment I am taking a break from medical school. So just an eight month break and I'll rejoin my class in February, which will be our summer. And I've done it because I recognized that I needed to step out for a wee while, just to sort of look after my own, my mental health, but also just I recognized that I was pretty burned out.

And I needed to renegotiate boundaries with myself, personal, professional boundaries around what I had the capacity for. And I think probably one of the biggest take homes for me, over the last sort of six to eight months has been to really check in with yourself. And to make sure that you're connected to a community of like-minded practitioners, and they are out there.

And I really encourage anybody who is sort of trudging through a very Eurocentric, a very weight-centric program, whether it be medicine, whether it be a nutrition program, or whatever healthcare program, that you reach out and you make sure that you've got a good community to be connected with outside of that space.

It feels sometimes, it can feel like you're doing double work because [laughs] you're learning your professional skillset and the requirements to be a good clinician in whatever area is it. And for me, I want to be a competent doctor, but I also find I'm spending a lot of time, in the process

of learning, also unlearning a lot of cultural narratives around bodies, and particular body size.

And so you do, at times, feel like you're doing double work, learning and unlearning as you go. And so you know, that can take a toll in terms of where you spend your energy.

Shohreh: Yeah, I imagine that just adds a new level of exhaustion to an already very tiring and challenging program [laughs].

Jess: Yes. I think practically as well, some of the things that you can do as a medical student, it's a hierarchical profession, and so you're right at the bottom in terms of where you feel you can sort of express yourself, or perhaps be able to make any, or affect any change. And so work laterally, if that's what's accessible to you. Talk to your colleagues and your peers about the work that you're doing, or some of the ideas that you're currently unpacking.

And Health At Every Size, or if you don't identify as Health At Every Size, maybe weight-inclusive care, or ethical care. And have those conversations, and also be willing to have those conversations with folks when perhaps they are engaging in stigmatizing conversation around bodies or patients. Be willing to work laterally and at your level. I think that's a really good place to start.

Shohreh: Yeah, those are some great recommendations, thank you for sharing those. You have had a lot of science-based training, so I want to dive in here on many of these more 'science'y' topics. First, starting with BMI, body mass index, because I don't think we've yet had an in depth discussion about BMI on the podcast. So, maybe you could hit some of the highlights about what we know about BMI, and what it is and isn't useful for?

Jess: Yeah, so, I would highly recommend Fiona Willer's work, Unpacking Weight Science, is of interest to you, or any of your listeners. And in terms of BMI, there's a way that we categorize body size. So, for anyone who doesn't know how that's calculated, it's a relationship between your height and your weight. It's a sort of linear scale, except the issue that we've got is we've put categories in place, and there's very little difference between the upper end of one category and the lower end of another.

The only difference that really starts to show up is how we perhaps talk about bodies, or how we may modify our treatment, or how we may make assumptions about the health or the pathology that may be associated with certain bodies based on where they sit on the BMI scale. It was actually designed as a way to look at population-based measures of bodies. And so it's not a helpful tool when we're looking at individuals.

And so, if you are using BMI, and I know there'll be a lot of medical students or perhaps medical professionals who, they'll say, "We're required to use BMI." Well, that's fine, but I think record the BMI and I'd really encourage you to avoid using labels such as 'obesity' or particularly, when I'm reading medical letters [laughs], I'm seeing things like 'morbid obesity.' And that's really starting to associate a higher degree of pathology with that person's body, based on their body size. And that may not be reflective of their health status.

I think the only thing BMI and medical records tells me, really is actually how the practitioner has responded to the person in front of them. And I think BMI can also be really helpful in that we can flip it on its head and use it to inform our care in a more positive way. So, it's much like health and equity data or marginalization data. When we see differences and disparities in groups of people based on a particular identity, that can actually be used to inform us in a way in which we can provide better care, rather than pathologizing somebody based on their body size.

We can start to think, well, perhaps we maybe need to implement screening for an associated health concern sooner, or we need to recognize that this person perhaps is experiencing the healthcare system in a very different way from a patient who perhaps is coming in with a lower BMI, or a straight sized BMI.

Shohreh: I like what you suggested there about kind of flipping that on its head.

Jess: Yeah, what may this patient be missing out on because we're viewing them through a lens in which we are pathologizing them already.

Shohreh: And of course there are correlations between certain diseases, I guess I would say, and body size. I'm curious, what does the science really tell us about body size, and then perhaps more importantly, what does it tell us about the ability to change our body size?

Jess: So, I think it's really important to get clear that Health At Every Size practitioners don't deny or dismiss that BMI and body size, maybe, or adiposity, may very well be associated with some health concerns. What we are, though, is very critical of the strength of association between those health concerns and the direction of causality between those associations.

And so what that means is, a lot of the time we may be hearing health messaging that body size is causing X,Y or Z health concern, but what may very well be happening is that it's a symptom of that health concern in itself. And so we need to get really critical of the literature around the direction of causality and also the strength of the association.

And again, it may very well be an association, or a factor and a health concern, but it doesn't change the fact that for the vast majority of people it is a non-modifiable risk factor. Much like having fair skin and the risk for skin cancer, or being assigned male at birth and heart disease.

Because for the vast majority of people, intentional weight loss is unsustainable in the long term, and it is risky. It's associated with increased risk for disordered eating and eating disorders, but also weight cycling. And so what we're seeing is, in a lot of folks who are engaging in intentional weight loss patterns, where they'll lose weight in the short term, and in the long term it will be regained and then some.

So we're seeing a pattern of increased weight over time instead of a weight reduction.

Shohreh: One of my favorite things about your very awesome Instagram account that everyone should go follow if you're not already, are the graphics that you've created with how to deal with certain health issues, such as high cholesterol, high blood pressure, without dieting or putting the focus on losing weight. So, clearly you believe that there are non-diet approaches to deal with a lot of these very common health issues that are typically associated with weight and usually are recommended that you're supposed to lose weight in order to address them.

Jess: Yes, absolutely. Well, I think I want to make a couple of further points about BMI and health, and that what we see is it actually doesn't categorize metabolic health particularly well across the BMI spectrum. And so you can be categorized as low BMI, 'normal BMI,' overweight, and you can be metabolically healthy or unhealthy. It doesn't distinguish between the two. And so I think that's particularly problematic.

The other thing that we see in the science around body mass, and I want to touch on eating behaviors, because I think this is important. And again, Fiona Willer of Unpacking Weight Science and the non-diet approach training really speaks to this well. But what we see is that there is no difference in dietary composition across the BMI spectrum. And so that's looking at things like fruits and vegetable, meat intake, carbohydrates, proteins.

And what we see is very similar percentages of intake. Because what we find in conversations we're having around body size and health behaviors such as dietary intake is the assumption is made that people at larger BMI bands are not eating as well as those folks who are occupying lower BMI bands. This just simply isn't true.

And the other thing that we're seeing is that energy intake is very similar across the BMI bands as well. So, it sits around the same between normal to overweight, and again, those higher BMI categories. The only difference that there appears to be is that larger bodies are much more efficient with the fuel that they're using.

And so we need to be really mindful when we're having conversations about BMI that we're not making assumptions about dietary quality, and we're not making assumptions about the energy intake. And then the last point I really want to drive home about BMI is it's not about weight loss. It's about health-promoting behaviors. And so there's a really neat study, I'll have to get you to link it into the show notes Shohreh.

Shohreh: Yeah, I definitely will.

Jess: What it shows is that it's about healthy habits. And so this piece of research looked at four health habits, fruits and vegetable intake, I think it was exercise more than 12 times a month, alcohol intake, and whether or not someone was a non-smoker, or a smoker. And what it found was that when you added in one of these health habits, the risk reduction of dying early, when they looked at it across the BMI band, was almost at parity.

And as you added more and more of these four health-promoting behaviors, if you were engaging in all four, you had the same mortality across the BMI bands. And that shows that it's health-promoting behaviors, not weight loss that we need to be encouraging patients and clients to engage in.

Shohreh: And my understanding is that a lot of studies that show these correlations between weight and disease aren't controlling for factors like that. Because it's too difficult to control for factors like what diet they're eating and how much they're exercising, and things like that.

Jess: That's true, and I think the other thing that we see in the literature is we're really conflating lifestyle intervention with weight loss intervention. And it really drives me crazy because I think lifestyle interventions can be very helpful for some health concerns, except what we're finding is that they're constantly being sort of switched out for weight loss interventions.

And so if we could just sort of peel that back and focus the energy on actually engaging in lifestyle interventions, such as eating well, eating a wide, varied diet, or dietary pattern, should I say. Exercising and engaging in joyful movement, and looking at other health promoting activities, can we support folks in smoking cessation where possible? Alcohol intake, and social interaction and connection.

I think that's where the most gains are going to be made in helping folks to live well now, rather than sort of conflating those things [laughs] with weight loss interventions.

Shohreh: Hmm, so the issue is happening where people are taking these sort of health-promoting behaviors on, but it's in the name of weight loss. So it's not having the same effect, essentially?

Jess: Yeah, and again, in the literature we're seeing things like very low calorie diets and meal replacements and shakes, being referred to as lifestyle interventions. And that's not lifestyle to me, whatsoever. That is a weight loss, that's a restrictive, dietary restrictive intervention, and it is not sustainable in the long term. And it should never be described as a lifestyle intervention.

Shohreh: I understand, yeah, I totally agree, that's just silly [laughs]. So besides kind of de-emphasizing BMI, what do you think medical schools and doctors could be doing better to provide better care for their patients? Particularly the patients in larger bodies who we know aren't receiving great care,

Jess: Yeah, there's a lot of talk and a lot of emphasis on patient centered care, and I think some specialties perhaps do this better than others. Probably most surprisingly, or ironically, it tends to be end of life care and palliative care that do this particularly well. But I think partnering with patients and really allowing an illness narrative, or a health story to come through, and to allow yourself to learn from some of the lived experience before diving into a management plan would be particularly helpful.

And I also recognize that a lot of doctors are time pressured, but if we want to provide the best care, we really need to partner with patients to understand where they're coming from, what their priorities are, and also unpack what some of the access issues might be to engaging in their own care.

And once we understand whether or not, what a priority is, then partnering and working with that patient to support them in accessing health promoting behaviors, if that's part of the lifestyle medicine, or ensuring that they have access to things such as fulfilling a prescription. We know a lot of folks walk out of the doctor's office with a prescription, but don't have the means to pay for it or to fill it. So that would be the first port of call.

I think this comes in particularly with health inequities that are ethnically based or race based. To view inequity data as marginalization data, and to recognize that folks are experiencing differential health outcomes not because of any flaw on their own part, but because these are socially driven.

And then to use that to inform your care plans, to understand why folks from particular groups, marginalized groups, are not receiving best care. Is it because there's racism at play? Is it because there's access issues around coming into the office? Do folks feel welcome? Are folks receiving care that is appropriate, that is timely, that is acceptable to them?

So, just keeping in mind that health and equity data is actually marginalization data, and we need to be using that to inform our care plans.

Shohreh: Why do you think that HAES and weight-inclusive care, all these things, are still seen as so radical?

Jess: I think a couple of things come into play here. From a practitioner, or a professional side, it's really painful to recognize you've been complicit in harm. And I think there's a lot of resistance that comes up there. Perhaps on the initial stages of coming across this practice or this paradigm, and I think to be really mindful that it's human to want to sort of run away, and hide for a period of time [laughs].

And then just to be open and curious, and keep coming back and lifting the lid and having a look. And if for you it means just sitting quietly, observing and learning, then that's okay. But I think yeah, the first thing that I've noticed is, there's a real defensiveness. We recognize that we've been complicit, and harm when everyone who tends to come into these caring professionals, we're here to care and we're here because we want to do well by our patients, or our clients.

I think the other thing is, diet culture is just so ingrained in our psyche that it's really challenging to butt up against that cultural norm. And we've got a lot of work to do to normalize size diversity and weight inclusivity.

Shohreh: Definitely true [laughter]. Just in having done this work for the last several years, it's amazing to see how it's starting to catch on, but at the same

time, I definitely notice that it's easy to kind of create your own bubble on social media and with the practitioners that you work with so that you don't really notice that, okay, it turns out in the outside world, this is still not the norm, this is still not, people necessarily understand or respect yet.

And of course that goes the other way too. It's really easy for practitioners who aren't HAES, to create their own bubble of diet culture and weight stigma, and to stay there where it feels safe.

Jess: Absolutely, and I think probably pertinent to the conversation is we live in systems where hierarchies, cultural hierarchies, and there's inequitable distribution of power. And so that's also uncomfortable. We're asking the most privileged to relinquish some of that power in these conversations, and to allow marginalized folks to step forward. This work really is rooted in white superiority and white supremacy.

It's rooted in ableism, it's rooted in sizeism, it's rooted in classism, and elitism. I mean we see it in our professional training programs. It's no coincidence that we don't have size diversity, and there's no coincidence that we don't have indigenous folks training in these professional programs, and proper representation, or adequate representation of race.

So there's a lot of lip service, I think, from academic institutes in terms of enrollment quotas, that when folks are enrolled, and they come into these spaces, they're not safe spaces to practice. So we've got a lot of work to do in terms of strengthening our workforces across all healthcare professions. It's not just a medicine issue. We see it in dietetics, we see it in nutrition and dentistry, we see it in physiotherapy.

We really need to not only create systems which are inviting enrollment, but are also spaces that are safe to be training in. So that comes into play too.

Shohreh: That's such a good point. We need the programs themselves to be safe. So I used to be an attorney, and this is an issue that we have in the law where there will be law firms that really gun to try and get diverse hires, and they will bring them in, and they'll leave within a few years because the actual spaces aren't safe or comfortable for them to stay in.

Jess: No, and then we've got a real issue there in terms of folks aren't seeing themselves represented in the workforce. Patients want to see themselves represented. They want to see themselves in their own doctor. They want to see themselves in their own nutritionist. There's a slow shift and you can see it within the community.

And actually on this topic I'd really recommend, and I'll send this to you to link into the show notes, Shohreh, is there's a beautiful piece written by a colleague that I actually study with. She's a medical student in a large body, and she's written about her experiences as a fat medical student. And it's just a really insightful, and it's a really well written piece that I would really recommend everybody takes the time to read, and reflect on.

Shohreh: Excellent, I will definitely include that in the show notes because that sounds like an important piece.

Jess: Yeah, it's beautiful.

Shohreh: So, knowing that individual consumers may not be in the best place to get good information from their medical providers, not always the case, but sometimes it's not the best information as we've been talking about in this entire episode. Do you have any recommendations for consumers to kind of help them see beyond the headlines and the alarmist things that tend to come out in the medical field?

Jess: Yeah, so I suppose in relation to body size, I really recommend that you link in with non-diet or weight inclusive practitioners on social media. They'll run a lot of commentary around maybe what's been in the media,

what headlines are, and I do enjoy unpacking some of the headlines, and unpacking the headlines. Just watch out for alarmist titles.

So there's a lot of anti-fat rhetoric, and it tends to be quite alarmist. It talks about epidemics, it talks about burden. Those are real giveaways that it's a piece that's driving the anti-obesity narrative. And I also look for that, actually, in academic writing too. So, something that when I'm reading a piece of scientific writing, I'm always interested to see the language, or the word selection that the authors have chosen.

Scientific writing will often use a positive or a negative leader before they provide their findings. And so they may frame small amounts of weight loss as being very positive when in fact it wasn't particularly significant in the results themselves. So I find that's always interesting, just to look at what sort of language that author is using, and to always read the introduction section. You can get a good feeling from a piece of writing as to whether or not they're anti-fat from the outset, in whether they're framing body size as a pathology.

And then to really look at, when you're looking at the result section, is to just, you're looking for the significance of the findings. So, getting an understanding of confidence intervals and also p-values is really helpful. And to always look at the result section and just read through, and then compare and contrast what's presented in the conclusion.

Oftentimes we're seeing, not particularly significant results, particularly when it comes to weight loss, and yet in the findings of the paper it will always be weight loss first as a first intervention for whatever it is. And most recently I've been digging into the research around Polycystic Ovarian Syndrome and intentional weight loss hasn't been found to improve a number of reproductive outcome markers, and yet that will often be pushed as the first line.

Shohreh: Isn't it called a p-hacking, when you play with the p-values [laughs] to make them make a greater correlation that doesn't exist?

Jess: Yes, and in fact in some cases we'll see that in the results section [laughs], the results don't support the conclusion, or if there's recommendations. So, the author may make a recommendation that wasn't even explored as a primary or a secondary outcome in the piece of research, and yet we'll often see weight loss snuck into their recommendation. And again, p-hacking and statistical analysis, this is another really great topic that Fi Willer loves to dig into. So, I highly recommend the Unpacking Weight Science materials.

Shohreh: Yes, for those who don't know, Fiona sends out a weekly Unpacking Weight Science newsletter that lists a ton of different articles and studies and other materials related to HAES and non-diet, and all these things. So, I'm on it, I've been on it for a long time, it's great. I highly recommend you hop on that too. And then I'll also provide, John Oliver has an excellent video about p-hacking, and there's a great FiveThirtyEight article about it too.

I think it's really helpful for individuals just to be informed on what that is, and how it's being used because a lot of people [laughs] who aren't very science minded don't really understand that. So I'll include those too. nd something that I always tell my clients is, if you see any kind of extremist headline that makes you skeptical, ignore the article, go find the actual research study itself. And even if you're not that great at understanding it, you can learn a lot, just from like you said, looking at the introduction, going to look at the findings.

Just kind of skimming, because so often whatever the headline an article pulled out of it, sometimes that's not even what the study said at all. And then oftentimes the study itself will kind of give itself away with the biases and things that the authors have in there. They'll be like, oh, we didn't

prove this, but here's what we think is the reason for blah-blah-blah. I'm like hmm, why is that in your study [laughs] then.

Jess: Yeah, and oftentimes we're really not controlling for weight stigma. A lot of the science around weight science, so, this is something to keep in mind too. And also, social determinants and access to care, that's something we're consistently overlooking in this space, and we really need to be a lot more critical when we're reading headlines. If it's individual as cause or really pushing individual behaviors for better health, then I think we just need to slow it down a little bit, and actually go, well, what are we missing here in this conversation? And oftentimes it's the social determinants of health.

Shohreh: Yes, so true, that does not get nearly enough press, as it should.

Jess: Not at all.

Shohreh: Well, for our last question, I'd like to know how do you define health and wellness for yourself at this moment in your life?

Jess: Yeah, health and wellness for myself? I think at this point in time, really leaning into the grey, and practicing a lot of self-compassion for myself and this work that I'm doing. And giving myself permission to get things wrong, and giving myself permission to rest, and giving myself permission to relax. So I think at this point in time, for me, health and wellness is really centered around going slow. That's my focus. Slowing down, slowing down my thinking, and slowing down my pace of life.

Shohreh: I especially like how you mentioned permission to get things wrong, because I feel like especially in HAES and weight inclusive practice, we so often feel like we have to be perfect because we've got this whole movement that we care about, and the reality is, we're going to fuck it up! [Laughs] And when we do, and when we get called in or called out, then we need to assess. We need to apologize, and we just need to do better.

Jess: Yeah, absolutely, and I've come to this place, probably only in the last 12 months, this really sort of recognizing that I'd been working from a place where you were all right, or you were all wrong in this work. And I was also viewing the work of others through that lens, that it was either all right, or it was all wrong. And in the last 12 months really softened into being able to see that with the help actually of my dear colleague, Sarah, softening into that we will get things wrong.

And other people will also make mistakes along the way. We don't just land at HAES, and we're not perfect. And if you think for any one second that you are, then [laughs] you're not doing it right because it's a constant journey of development. And when you do make a mistake and you are called in, or called out, or called on, give yourself permission to feel really yuck about it in the moment.

It's important that you allow yourself to repair, but you also repair with those that perhaps you've harmed along the way.

Shohreh: Exactly, and not adding more harm on, because I think that's sometimes that automatic instinct is to defend and deflect. And I've really, that's something I've really learned in myself, is that I need to take a minute and be like, this person who is bringing this to your attention is not the enemy here.

Jess: And it's actually, they're doing a kind act, and allowing you to grow and develop. And I think the black and white thinking that we can bring into this work is a real symptom of diet culture in itself. So we hit a lot of black and white thinking around food and bodies and exercise, and I think that's something, a little bit of diet culture baggage, that we can at times bring into this practice as HAES practitioners. And so really focusing on slowing down and leaning into the grey, and allowing for this work to be complex and messy, is really important.

Shohreh: I love that. Well, thank you so much for being here Jess. If people want to find you, where can they do that?

Jess: Yeah, so the best place to find me at the moment is on Instagram, and my Instagram handle is @haes_studentdoctor. You can also find me online, so recently back up with blogging. So that would be over at our clinic website, which is bodybalancenutrition.co.nz. And you can read a variety of health related articles. At the moment we're focusing on PCOS.

Shohreh: Excellent. Thank you so much. This has been great; I can't wait to share this.

Jess: Thanks so much for having me, Shohreh.

[Music plays]

Shohreh: And that's our show for today. I appreciate you listening to and supporting the Redefining Health & Wellness podcast. If you enjoyed this episode, it would mean so much to me if you would subscribe, and leave a review with your podcast provider of choice. It will really help other people who might benefit from the podcast to find it more easily.

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