

Health at Every Size®:

Implications for dietetic practice

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SCRIPT

Tonight I'm going to firstly introduce the Health at Every Size paradigm and then explore what the adoption of the HAES ® paradigm would mean for the profession of dietetics. One of the units that I lecture into at QUT is Dietetic Business Management and so I couldn't resist the urge to explore this issue by using a SWOT analysis. That is, looking at the strengths, weaknesses, opportunities and threats of the proposal of full HAES integration into dietetics. For the purposes of drama and a persuasive narrative though, rather than as a SWOT, I'll be presenting it as a WTSO.....

So let's start with looking at Health at Every Size®. Health at Every Size is a registered Trade Mark of The Association for Size Diversity and Health (ASDAH). It has been trademarked in this way so that anyone who uses the term has a responsibility to use it in the way in which it was intended, and that is to follow these principles:

1. Accepting and respecting the diversity of body shapes and sizes.
2. Recognizing that health and well-being are multi-dimensional and that they include physical, social, spiritual, occupational, emotional, and intellectual aspects.
3. Promoting all aspects of health and well-being for people of all sizes.
4. Promoting eating in a manner which balances individual nutritional needs, hunger, satiety, appetite, and pleasure.
5. Promoting individually appropriate, enjoyable, life-enhancing physical activity, rather than exercise that is focused on a goal of weight loss.

So health at every size, for health professionals, means encouraging healthy behaviours and wellbeing REGARDLESS OF SIZE. It is a weight neutral paradigm where weight status is seen as a consequence of disease, environment, society and genetics rather than a cause of disease itself.

The HAES movement fully acknowledges research which has found an association between higher weights and poorer health but questions the causes of weight gain in those with poorer health (association ≠ cause). There is no doubt that being extremely heavy can exacerbate health problems in some people. However, by attributing illness blame solely to greater weight status and then determining that weight loss is the saviour for all is a bit like blaming the crime scene for a murder. It follows then that giving it a hose down or lick of paint will be an effective way to try to avoid it happening again. If we have no way of watching what happens in that dark alleyway, there's no way we can know for sure how, why or when it happened, how horrifying it was, or who is ultimately responsible.

Let me give you a health example. It is often accepted as fact that weight gain will result in insulin resistance, leading down the road of diabetes. However, there are many people who are insulin resistant without gaining weight, and who gain weight without becoming insulin resistant. The association between weight gain and insulin resistance is just that, an association, which as yet has not been teased out or become testable to the degree that we can use it in practice in any meaningful way – there's no way of telling for sure, yet, if this particular human in front of us has insulin resistance because of their genes, weight status, dietary history, dieting history, environment or any number of internal and external factors. In which case, a focus on weight change may make us and the patient feel like we're doing something, but in reality may make little difference physically, and contributes further to our social and medical cultures' obsession with weight watching. Certainly for people with over-concern with their body shape and weight, continued focus on weight as an outcome frequently negatively affects their psychological health.

So what do we know?

We know:

- Australians as a group are heavier than they used to be
- Some people who are overweight/obese have a greater burden of disease
- In some cases they are more expensive medically to treat
- A lot of money and effort has been spent on anti-weight research and development
- Weight loss interventions frequently succeed in the short-term but almost always fail in the long term (and frequently result in increased weight gain long-term)
- Continued weight concern costs consumers first (diet products, weight loss challenges, weight loss corporations), then the health system later (including the cost of medical 'solutions' which are almost as poor performing as the ones developed by self-styled experts)
- HAES approaches described in academic literature so far result in weight stability and improved biochemistry and psychological outcomes

Sometimes people lose weight using the non-diet approach if their intake reduces as a result of decreased overeating. Sometimes people gain some weight if their intake increases as a result of decreased restriction. Most people gain a little, lose it again and then become weight stable. I'm not telling you this because it is important, but because it is the first thing people ask. And no, once given complete freedom with food choices and the tools of mindful eating and hunger awareness, they don't tend to want junk food all day. When given the chance to really get to know the foods they've assumed are so dangerously, irresistibly delicious they conclude that they don't actually feel like eating them all the time anyway. It's a bit like the workers in the chocolate factory who can't stand the thought of eating chocolate after a few weeks on the job with unlimited access, literally, to chocolate on tap.

Long-term weight loss is not attainable for the majority of those who seek it

Even if weight loss in people who are overweight or obese did make a significant difference, we have no reliable, effective way to help them to reduce weight and stick to it for the long term. Even after huge amounts of research, expert organisations and committees agree that there is no consensus on how to achieve long-term weight loss and indeed, if this increases long term health outcomes in a meaningful way. And so if even the most well-controlled, well-designed weight loss intervention studies, conducted over long time periods and by the most well-intentioned, appropriately qualified clinicians and researchers are still finding it near on impossible to elicit lasting weight loss, we can only assume (until we have our own practice-based research culture) that we as dietitians in private practice are achieving similar, sobering outcomes.

At the moment the most 'successful' way for someone who is obese to lose weight is by having expensive and irreversible surgery, with best sustained weight loss outcomes when managed closely by a multidisciplinary health care team for the rest of their lives (also incredibly expensive). There is an alternative: look at the data with a more critical eye and choose not to see weight as the problem.

We don't know if lasting weight loss would help most people

The latest NHMRC clinical practice guidelines for the management of overweight and obesity in Australian adults concede that the vast majority of people who do intentionally lose 5% or more of their weight have regained it five years later. If we think about the tiny number of adults who do lose weight and keep it off for longer than five years (the statistical outliers), we don't even know for sure if their lives are longer or better as a result, and even if we did, that data is certainly not representative of the general population. It's a bit like looking at a subspecies of Himalayan mountain frog which can survive at 5000m above sea level and assuming that because it is a frog that *EVERY* frog should be able to do that with enough training and effort. In reality, those frogs can survive there because they are systematically DIFFERENT from other frogs. So few people are successful long-term in their weight loss efforts that we can't say for sure if they DO go on to have longer or better lives than if they were eating well and physically active at their original

weight. Unfortunately it is likely that weight loss focussed dietitians are part of the, as far as we know pointless, weight cycling cycle.

Yoyo dieters/weight cyclers/chronic dieters are such a diverse group and largely invisible in long term mortality data (despite probably being significantly prevalent in study groups) because researchers typically don't ask, record or adjust for weight loss attempts. It's an incredibly messy business to try to understand how weight status affects health status because of the huge number of variables including magnitude of weight cycling, timeframes, age, method of weight loss, nutrition status, dietary pattern, nutrient intake etc.

Wellbeing

A little trick to help you get your HAES hat on quickly is to replace the words 'weight', 'weight loss', 'overweight', 'obese' and 'obesity' with the word WELLBEING. So weight management becomes 'wellbeing management' and weight loss intervention becomes 'wellbeing intervention'.

There is a decent body of evidence which shows the negative psychological effects of continued weight loss pursuits and the damaging effects of the weight stigma which is perpetuated, in part, by health professionals' focus on weight as an outcome measure. Those who work with clients suffering from eating disorders know these effects all too well. Also, more and more studies are finding that health, longevity and weight stability are attainable at weights outside of what might traditionally considered 'healthy'.

A good starter paper in the area is 'Weight Science: Evaluating the evidence for a paradigm shift' by Lucy Aphramor and Linda Bacon. It is easily obtained online and you can follow the citation trails for more leads – it is a fast growing research field. Using wellbeing as a focus instead of weight loss (ie practising in the Health at Every Size paradigm) allows for our clients to discover the enjoyment and helpful use of a wide variety of nutritious foods in times of sickness and in health – the core values of our profession.

Q. So exactly HOW do I do this then?

A. By encouraging and providing advice about healthy food and physical activity.

Q. But that's what I do already! Isn't it?

A. The devil is in the detail: It's all about client perspective....

Providing and encouraging healthy food and physical activity choices is fine, situating those behaviours as key strategies for weight loss is not (eg control kj intake and 'burn' fat, vs enjoy foods to appetite and enjoy moving your body). Two humans may look from the outside to be doing exactly the same things, but it's their inner worlds which make all the difference.



Must...run....
until....I've....burned...
off.... that.... whole....
latte....

8 of 25 External drivers of behaviour



Goodness I feel
strong. It's such
a gorgeous day.

9 of 25 Internal drivers of behaviour



This cereal tastes like
cardboard but at least
it's high fibre and low
calorie so I am allowed
to have a fair bit of it.
I can't afford to have
milk with it too though
as that will put me
over my calorie limit.

10 of 25 External drivers of behaviour



I love the way this
cereal is really
crunchy and it tastes
really nice dry – I'll
have something else
later when I get
hungry again.

11 of 25 Internal drivers of behaviour



I am so forbidden, so
naughty, that you'll
be shoving me in to
your mouth to hide
the evidence

12 of 25

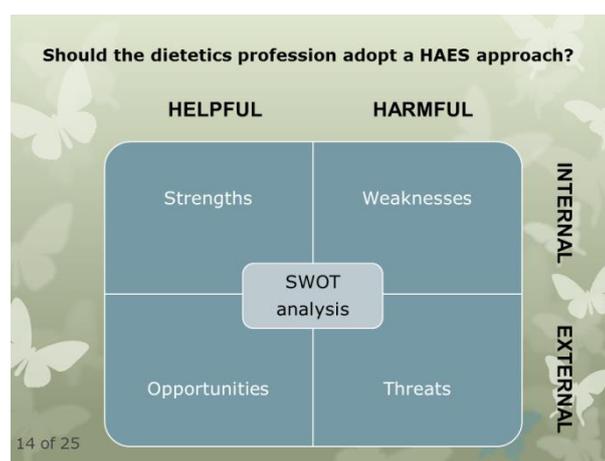


I am delicious and a
culturally appropriate
and enjoyable aspect
of your birthday
celebrations.
Enjoy every mouthful.

13 of 25

We are all in agreement about what healthy behaviours are – meet your energy needs by enjoying a wide variety of safely stored and prepared, mostly nutritious foods from the five food groups and be physically active. The non-diet approach is how dietitians can apply the HAES paradigm to attaining those healthy behaviours – in other words, it is the how by which they can be achieved.

Now on to the WTSO.....



WEAKNESSES: Internal factors which impede HAES adoption by dietitians

First, let's look at the weaknesses of the dietetic profession adopting a HAES approach. In the SWOT analysis model, weaknesses refer to internal factors (current resources and experience) which impede the adoption of this specific change.

We have clear weight bias as a profession, and have taken ownership of the obesity/overweight 'problem' with weight loss as a key area of our practice. Despite this, many dietitians admit to fearing that they are not as effective at helping people to lose weight as they think they should be. It's another layer of blame – when dieters fail, they feel it's their fault, when dietetic clients fail, both the dieter and the dietitian feel to blame – why can't more people see that it is the pursuit of weight loss itself that is the problem?

At the moment, across all clinical areas, relatively few dietitians have a good level of competence with applying the full non-diet approach, either in groups or to individuals. But those that do use a HAES approach tend to be very passionate about it! It's not part of the traditional practice of dietitians and nor is it well integrated into current dietetics courses. Dietitians need to learn new skills and a new way of thinking before they can reach competence at taking a HAES approach. In a way, their journey to the other side is similar to the client's journey from weight obsession to a wellbeing focus. This has a financial and time cost, most likely at this point to be borne by the individual dietitians themselves.

There are limited HAES resources specific to dietetic practice (although there's mine of course) because it is such a multidisciplinary field. There are many books for the public but relatively few which contextualise the HAES movement for health professionals. Up until recently it has been difficult for busy dietitians to access information about how to develop their non-diet approach skills.

Dietitians who work for businesses which currently benefit from cash flow generated as a result of weight cycling (weight loss clinics or companies, companies who make or sell 'diet' products or slimming devices, or weight loss supplements) may predictably be met with resistance from their employer when suggesting incorporating HAES – which of course means their business model is redundant.

It can be difficult for people who work in the weight management area to accept that their work encouraging continued weight loss for clients is unlikely to have the long term effect that they assume/hope (ie lasting weight loss), but is instead likely to be leading to weight regain, and probably to gaining a bit more on top of that again – ie actually adding to the perceived problem and contributing to psychological and possibly physiological harm.

In the public hospital and community health services systems dietitians are already stretched for time and funding. Weight concern is just about at the bottom of the list of public and private hospital outpatient clinic concerns.

Opposition to change is also likely to come from inside – from other dietitians who may not agree with it or who do not know about it (and assume they disagree with it). Dietitians who don't know much about the HAES paradigm tend to think that it is about encouraging people to eat junk food, that weight gain doesn't matter and that if we remove dietary restrictions from people then they will just go and eat cream cakes all day. They are typically horrified, believing the HAES movement is irresponsible because it encourages overeating and lifestyle chaos. As you are now becoming aware, it's not encouraging an endless free-for-all, it's encouraging people to eat foods that they enjoy eating to comfortable satiety. A HAES approach facilitates a way of relearning 'natural or intuitive' eating – skills which are lost when people hand their eating autonomy over to a weight reducing diet.

Lack of a DAA HAES interest group is also a weakness.

THREATS: External factors which threaten HAES adoption into dietetics

Moving on to the next section, threats. Threats are factors which threaten the adoption of HAES into dietetics which are outside of the control of individual dietitians and of the dietetics profession.

Firstly, market trends (shifts in audience needs or perceived needs). The popular belief is that because food is so familiar it isn't rocket science, they can do it themselves with Google. There are lots of diets which satisfy philosophical and moral values – paleo, vegan, no sugar etc, which are taken up by the public because they desire weight loss or 'health' (by which they may secretly mean weight loss). I think this is

because weight loss dieting is starting to feel a little uncool, and these more philosophical aims are a way of qualifying whacky and restrictive eating practices. If I were a processed food company, I'd be reinvesting in broccoli, spinach and green beans, since they're the only ones that comply with the whole spectrum of popular diets from paleo to vegan.....

Economic trends which affect dietetics as a whole – the influence of Medicare only patients in private practice as well as competition from multiple places – naturopaths, personal trainers, online weight loss programs, other dietitians (especially in metro areas, competition is fierce), weight loss companies etc.

Funding trends – there is more money available for research which helps to 'fight the war' on obesity, as well as clients increased readiness to pay for weight loss, as opposed to HAES approaches.

The obvious threat that dietitians in private practice or who work for weight loss companies always confront me with is: but if I don't offer weight loss services, I'll go out of business or lose my job!! Well to start with, our social and medical cultures have such a deep obsession with weight that people will still be presenting at dietitians for assistance to lose weight for at least the next couple of generations.

This also means that clients don't expect us to take a HAES approach because their expectation (as a result of not quite knowing exactly what we do) is that dietitians agree that weight is important, and that being overweight or obese is bad for our health. This impression has been built by dietitians both actively, through promotion, and passively, through the term 'dietitian' and 'dietetics' being all about diets, which to the lay public is all about weight (even though we also use these terms to mean therapeutic diets, dissociated from weight control concerns).

On the other hand, psychologists and other counselling professions which are not so allied with food and eating are able to introduce the concept to their clients by illuminating the unhelpful ways that weight loss pursuits have contributed to each client's poor health or unhelpful thinking, and also discuss in more detail the underlying drivers if eating or body management is being used as a coping strategy.

For clients, getting ready to take the plunge into the non-diet approach is typically a slow burn. The HAES approach is appropriate for a broad range of clients (except those with anorexia nervosa or conditions in which appetite signals are altered – eg cachexia, uraemia etc). The most ideal client is someone who has been on a weight loss diet before, regained the weight and now wants to lose it 'once and for all' (ie a fair chunk of western adult humanity).

There is pervasive weight bias and weight stigma in the community. Fat (and skinny) jokes are widely considered to be harmless fun; no one blinks an eye when a 'healthy weight' person eats a burger in a food court, yet larger people are often ridiculed for the same act. Stock footage of larger people used by the media invariably shows them from the shoulders down – the so-called 'headless fatties' – is it deemed so embarrassing to have a large body that the media try to 'save' them from being identified? Or perhaps their bodies are so culturally objectified that they do not deserve an identity? It is still legal in Australia to

discriminate against someone based on their body size. This is unacceptable. If any of you are ever in a position of influence in policy – please stand up and fight for size anti-discrimination measures. As you are aware, people who are already of a higher weight have just about as much chance of being able to permanently reduce their weight to a ‘socially acceptable’ level as they have of reducing their shoe size by half.

Opposition to change will come from other health professionals who are weight centric – medical professionals, from the clients themselves because the pervasive culture believes that being fat is bad and that weight loss dieting is the answer to this ‘problem’. In basic marketing terms, our culture (which includes loud voices from the processed food industry, weight loss industry, perpetuation of the thin ideal through media) has positioned weight status as a problem. Many profit greatly from this positioning.

The vast majority of research concerning weight is quantitative in nature. All quantitative research is at risk of missing something, because the things that are objectively measured, with validated tools, have to be justified to whoever is paying for the research – in quantitative research you will only see, or not see, the things that you thought to look for in the first place. It is in qualitative and more creative quantitative research that the weaknesses of a weight centric paradigm and the benefits of a HAES approach can be found.

STRENGTHS: Internal factors ready to support HAES adoption into dietetics

Now to get upbeat. Let’s move on to strengths, that is, the internal factors (experience and resources) which are ready to support the adoption of HAES into dietetics.

We are still the experts. We are ideally placed to be able to provide advice about healthy eating and to provide advice which increases the likelihood of adequate nutrition given various health conditions. We are trained to be able to say THIS is what foods you could eat to give your body the nutrients it needs, without having to say that weight loss in isolation will help. Often if we do say that weight loss is likely to help, what we really mean is ‘losing weight by following a diet rich in micronutrients and adequate in protein, essential fats and carbohydrates to meet your biological needs which may result in weight loss’ is likely to help. We universally agree that people should eat as widely as possible. These values are intrinsic to HAES practice too.

People present to us for weight loss because they or someone close to them has identified weight as an issue. So our patients already have weight concern and a level of motivation to change their lifestyle – they just don’t yet know that for most people, targeting the weight itself is counterproductive to achieving long term health and wellbeing.

Many dietitians are using a flavour of a HAES or non-diet approach already, in varying amounts in their practice. Many use some of the strategies, for example mindful eating and hunger-fullness awareness, whilst still encouraging the pursuit of weight loss. This is not true HAES but it is a start!

You may be surprised at how much you already know. You already practice in a weight neutral manner in some circumstances (when you have clients who fit in the healthy weight range or when clients are attending for other reasons such as IBS symptom reduction) and are deft at positive reinforcement – so there! – you do already know how to do it!

Practice settings would not need to be changed – HAES approaches can be practised in one-on-one or group settings, with no additional equipment, except an open and compassionate mind.

Using the non-diet approach can be time SAVING. Choose to stop engaging in weight centric discussions with your patients – imagine the time you'll save by not having to justify why their weight has (or hasn't) changed in the desired direction, despite their pleas of adherence. No more endless discussions about normal weight fluctuations or diet transgressions.

Funding for obesity interventions may be able to be diverted to HAES projects as the target markets can overlap.

You have the power to reinforce the healthful behaviours of your clients and offer ways to extend their confidence in looking after themselves, rather than focussing on eliminating 'bad' behaviours.

Dieting behaviours and weight concern in parents, especially mothers, is being shown time and time again to be a powerful precursor to weight concern in children, disordered eating, eating disorders and overweight and obesity in children. There are thousands of children to be saved from eating disorders by educating parents on the perils of weight concern – be part of the solution.

There's an active and supportive HAES professionals listserv, it's just off the DAA grid at the moment. Google 'HAES Professionals Google Group' - please join so you at least have a HAES ear to the ground.

OPPORTUNITIES: External factors which could help to incorporate HAES practice into dietetics

The last factor in our WTSO metric is opportunities. These are factors which are external to the profession of dietetics, outside of our control, but which stand to HELP us to incorporate HAES practice into the everyday practice of dietitians.

Market trends (shifts in audience wants and needs) – there is a cultural shift, especially in women, to push against dieting as a practice with many noting that they do not wish their children (and especially daughters) to have to worry about their weight (like they did). This trend is becoming so visible to marketers that anti-dieting ads have started to appear (Canadian advertisement for the breakfast cereal Cheerios) and Weight Watchers have for the last few years dared not to mention the word restriction in their ads – they're now about flexibility and enjoyment – have you noticed? Same intention though. You

should be on the lookout for weight loss companies appearing HAES friendly or adopting HAES terms – make no mistake, they will never be interested in discarding weight loss as a goal.

Positioning yourself as a HAES practitioner sets you out from the crowd at the moment.

Ideal clients for HAES, that is chronic dieters, are also people who self-refer to dietitians– food and body shape neuroticism tend to be a middle class malady, and dietitians tend to be (maddeningly) the last resort after many years of weight reduction efforts.

For those of you who are interested in pursuing research as your dietetics career, the HAES paradigm is a burgeoning and exciting area to investigate, there are many gaps to fill which means many opportunities to be the first to describe HAES findings in different study groups– it's a deep seam of research gold.

We have the opportunity to show strong leadership in this area, by frank interpretation of the long-term data arising from studies into the pursuit of weight loss, as well as accepting that the 'continued pursuit of weight loss' status quo is not ultimately serving the health of the population. This honesty increases our trustworthiness as health professionals.

We could position ourselves as the go-to people for a HAES approach by bringing the focus back on to food, eating and good health – regardless of weight status. WE are the ones who know about how food is assimilated and used in the body, and how different disease and nutrition status affect function, disease progression, morbidity and mortality. In hospitals we are primarily concerned with malnutrition, but step out of those hospital doors and the world is a very different place.

From a cash flow perspective, HAES approaches work well in groups and also lends itself well to one-on-one counselling. The research stats from group interventions show that, even if we take the most conservative intervention contact points, this translates into 6-12 consultations per client over at least three months, but usually closer to six months. My work has shown that there are five underlying tenants of applying a HAES approach to dietetic counselling, which translates to at least five content sessions and a consolidation session – so six points of contact at least. In a practice structure of 60 minute initial and 30 minute follow up appointments this means 3.5 hours (minimum) per client. This clearly shows that taking a HAES approach need not threaten your livelihood. It will only do so if you are unable effectively convert clients seeking weight loss into clients seeking improved wellbeing.

Having this information about likely treatment length allows this method of practice to be clearly explained to the client, so that everybody's expectations are consistent. There is no 'tricking' a client into taking a non-diet approach. Dietitians who are skilled in the non-diet approach give the clients the power to decide. They explain the likely outcomes of taking a traditional weight loss approach as well as the likely outcomes of taking a non-diet approach for reducing weight concern and improving health, and then let the client decide. This is the sort of informed consent that is sorely missing from regular practice.

Dietitians getting skilled up in HAES practice gives us a competitive advantage as the tide turns against weight loss dieting – we need to position ourselves here too so we don't miss the boat. So there are opportunities for dietitians to run HAES groups or provide HAES services as a new area of business for them. Adopting HAES practice needn't threaten your livelihood – it can improve it!

Adopting a HAES way of practice means we will not be left behind when everybody finally realises how futile and harmful the pursuit of weight loss is. Much of the data about its futility is in, it's just a matter of waiting for the data showing how harmful it can be, to reach unarguable, critical mass.

[MINDFUL EATING ACTIVITY]

Closing remarks

HAES is a burgeoning area, if we are not part of it, at the least in terms of skill acquisition, then we will be left behind. In this area, just as in most areas of dietetics, our competitors in the provision of food and lifestyle advice are vast in scope, powerful in message and great in number. Be a calm, compassionate voice of reason against the tyranny of unnecessary weight concern. Practise gratitude and compassion to yourself and others, and a HAES mindset will develop as a natural extension.

You may have considerable work to do on your own weight biases before you are able to embrace this way of practice. I encourage you to think of this shift in your focus as an opportunity to become a more helpful health professional by helping people off the diet rollercoaster and onto longer-term physical and mental wellbeing. So use your PD hours this coming year to get skilled up about HAES practice and the non-diet approach. Look for opportunities in your current and future workplaces where a HAES approach could make a positive difference. Be open to other dietitians about your embrace of the HAES paradigm and encourage open and lively discussion of it.

Dietetics, as an evidence-based profession, needs to be dynamic and able to move where the data takes us. We have survived these sorts of changes before – a case in point being the evolution from the low fat, low cholesterol dogma to where we are today. We will adapt again if we keep our focus on the story woven in the data.

So we need to keep our minds facing in the direction of truth, and our ears and hearts towards the voices and experiences of our clients, not distracted and led astray by the powerful anti-obesity movement, funded by those who offer surgical, pharmaceutical and diet product 'solutions' to the 'problem' of obesity. We are better than that and our patients deserve us to be.

Thank you!

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