Introduction to Health at Every Size®

How To Help Dietitians Create a Weight Inclusive Practice
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Your Presenter

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Introduction

From Diet Obsession to Diet Rebel, how I got here.

How I work with clients then
Objectives

● Describe why diets and weight control have a high rate of failure
● Understand the correlation between health and weight
● Describe the 5 principles of Health at Every Size®
● Understand the rationale for a weight-neutral approach to health
Diets Do Not Work...and Why
Dieting is easy.
It's like riding a bike.
Except the bike is on fire.
And the ground is on fire.
And everything is on fire because you're in hell.
What Do We Mean by “Diet”?

● Merriam-Webster:
  ○ “a regimen of eating and drinking sparingly so as to reduce one’s weight”

● Yes there are other types of “diets” that we might prescribe but for now, we are going to focus on diets whose intent is weight loss.

Why do people “diet”? Consider, what are the reasons that people decide they want to lose weight?
Dieting for Weight Loss

- BMI used as a health status indicator
- Conventional disease-prevention advice is to lose weight if BMI is in overweight or obese categories
  - 56.4% women, 41.7% of men attempted to lose weight
  - 66.7% of those classified as “obese” tried to lose weight and 49% of those classified as “overweight” tried to lose weight.
- What’s the problem with this?

Diets Don’t Work

● Doesn’t work long term – high rate (best estimate 90-95%) of regain within 3-5 years of initial weight loss
● Most people regain some, all or even more weight than they lost
● No data to suggest long-term weight loss can be sustained for all but a tiny percentage of people
● “Calories in/calories out” - great in theory, not so much in practice
● Despite the number of people attempting weight loss, the population is not getting thinner
Diet Science

- Weight loss studies:
  - Weight is lost at first
  - The longer the study, the more weight regained

*Average weight change among diet subjects in 20 studies by length of follow-up.*

Tomiyama, Ahlstrom & Mann, 2012
Why Doesn’t Weight Loss Work?

Blame

● Biology
  ○ It’s not simply a case of lack of willpower
  ○ Genes are largely responsible for an individual’s set-point range - genes account for 70% of the variation in people’s weight
  ○ Dieting vs Not Dieting result in different responses to food - dieting makes food look better!
  ○ Decrease in body fat results in hormonal changes that regulate appetite

● Metabolism
  ○ A now-smaller body will burn fewer calories than a larger body
  ○ Starvation triggers metabolism to slow down to conserve energy
  ○ Body becomes more efficient with calories - it takes fewer of them to run the body
    >>>>more can be stored as fat

Sumithran et al., “Long-Term Persistence of Hormonal Adaptations to Weight Loss.”
Why Doesn’t Weight Loss Work?

Also Blame Psychology
- Minnesota Semi-Starvation Study - Ancel Keys
- Deprivation leads to food obsession and preoccupation
- Studies show forbidden foods are the ones thought about the most
- On a diet - many foods are forbidden!

Stress
- Stress associated with weight gain
- Dieting also increases stress! (Tomiyama)
- Cortisol associated with belly fat
- Is dieting contributing to weight gain and belly fat?

Bouchard et al., “Sources of Human Psychological Differences: The Minnesota Study of Twins Reared Apart.”
Health and Weight

Health

- Studies show that fitness matters more than fatness when it comes to health
- Behaviors (eating, exercise, drinking, smoking) have more impact on health than weight
- Social determinants of health: socioeconomic status, race, education level, access to health care, stigma, social support, public safety, literacy - all impact health more than weight

Barry et al., “Fitness vs. Fatness on All-Cause Mortality: A Meta-Analysis.”
Health and Weight

● Some disease states are correlated with higher weights
● **Correlation does not equal causation**
● Many epidemiological studies that this information is based on did not control for
  ○ Fitness/activity
  ○ Nutrient intake
  ○ Socioeconomic status
  ○ Body Image
  ○ Weight cycling which is associated with
    ■ Inflammation
    ■ Hypertension
    ■ Insulin resistance
    ■ Hyperlipidemia

https://doi.org/10.1155/2014/983495.
The Bottom Line...

You might be able to fight biology for a while...

Or you might be able to overcome psychology for a time...

Or you might be able to combat the stress caused by dieting...

But few of us will be able to fight all three of these factors that conspire to makes us regain weight lost on a diet for a significant period of time.

That’s why diets and weight loss don’t work.
Why Do We KEEP Dieting?

Weight Stigma

- Larger, or “overweight” or “obese” bodies, are seen as “less than” in society
- These are long-held beliefs based on very little other than “feelings” >>> social construct >>> discrimination
- People want to be accepted
- There are many cultural reasons we view fatness as undesirable - beauty preferences are not fixed
- People will diet even if health isn’t an issue
- What if we frame weight stigma as trauma? What is trauma-informed care?

Healthism

What is Healthism – Healthism is a belief system that sees health as the property and responsibility of an individual and ranks the personal pursuit of health above everything else, like world peace or being kind.

It ignores the impact of poverty, oppression, war, violence, luck historical atrocities, abuse and then environment from traffic, pollution to clean water and nuclear contamination and so on. It protects the status quo, leads to victim blaming and privilege, increases health inequalities and fosters internalized oppression.

Healthism judges people’s human worthy according to their health.

If health = worthiness then no wonder why we see so much stigma in our society.

- We see stigma affect people in all areas of their life, education, family, work, healthcare and media consumption.
- It has psychological and physiological effects.
Weight Stigma as Trauma

ACEs Study shows us how trauma affects our health

How would it change our approach or treatment if we began to see the oppression of larger bodies as trauma?

Felitti et al., “Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults.”
If Not Dieting, Then What??

- If diets and weight loss don’t work, how are we supposed to help people improve their health?
Health at Every Size®
Health at Every Size® (HAES®)

HAES® supports people in adopting health habits **for the sake of health** and well-being (rather than weight control).

HAES® encourages:

- Eating in a flexible manner that values pleasure and honors internal cues of hunger, satiety, and appetite.
- Finding the joy in moving one’s body and becoming more physically vital.
- Accepting and respecting the natural diversity of body sizes and shapes.
- Not using weight as an indicator of wellness or an intentional outcome of behavior change.

“ASDAH: HAES® Principles.”
5 Principles of HAES

**Weight Inclusivity:** Accept and respect the inherent diversity of body shapes and sizes and reject the idealizing or pathologizing of specific weights.

**Health Enhancement:** Support health policies that improve and equalize access to information and services, and personal practices that improve human well-being, including attention to individual physical, economic, social, spiritual, emotional, and other needs.
Respectful Care: Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socio-economic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.

Eating for Well-being: Promote flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.

Life-Enhancing Movement: Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose.
● In addition to a paradigm shift towards weight inclusive care, HAES® also has roots within a social justice movement.
● HAES® provides a framework and lens to look at how society negatively views larger bodies and promotes the “thin ideal”
● The truth is, we are fat-phobic and we assume that every person in a larger body can be thin if they just work hard enough.
HAES® Terms

Non-diet approach: Typically used to mean a HAES® approach, focus is on incorporating healthy habits rather than focusing on weight change.

Weight neutrality: Weight may be lost or gained, but it is not the focus of the health intervention. Focus on healthy habits, rather than a weight outcome, and letting weight settle where it will when someone is practicing the healthiest habits they can.

Weight inclusivity: All bodies are good bodies and should be treated with the same respectful care.
"A weight-neutral approach focuses on loving self-care and the decisions that people can make on a day to day basis that are sustainable for a lifetime. HAES is not against weight loss; it is against the pursuit of weight loss. The task is to care for the body you have, and will continue to have, whether it gains or loses weight or ages or gets cancer or runs a marathon" – Deb Burgard

Research in Support of HAES®

- Size acceptance and intuitive eating improve health for obese, female chronic dieters. (Bacon L, Stern JS, Van Loan MD, Keim NL.)
  - The health at every size approach enabled participants to maintain long-term behavior change; the diet approach did not. Encouraging size acceptance, reduction in dieting behavior, and heightened awareness and response to body signals resulted in improved health risk indicators for obese women.

- Adults with greater weight satisfaction report more positive health behaviors and have better health status regardless of BMI. (Blake CE, Hébert JR, Lee DC, Adams SA, Steck SE, Sui X, Kuk JL, Baruth M, Blair SN.)
  - Greater satisfaction with one's weight was associated with positive health behaviors and health outcomes in both men and women and across weight status groups.
Healthy Lifestyle Habits and Mortality in Overweight and Obese Individuals (Eric M. Matheson, MS, MD, Dana E. King, MS, MD and Charles J. Everett, PhD)

- Individuals who adhered to 0, 1, 2, or 3 healthy habits were 3.27 (2.36–4.54), 2.59 (2.06–3.25), 1.74 (1.51–2.02), and 1.29 (1.09–1.53), respectively, relative to individuals who adhered to all 4 healthy habits. When stratified into normal weight, overweight, and obese groups, all groups benefited from the adoption of healthy habits, with the greatest benefit seen within the obese group. Conclusions: Healthy lifestyle habits are associated with a significant decrease in mortality regardless of baseline body mass index.
Research in Support of HAES®

- Impact of Non-Diet Approaches on Attitudes, Behaviors, and Health Outcomes: A Systematic Review (Dawn Clifford PhD, RD, Amy Ozier PhD, RD, Joanna Bundros BS, Jeffrey Moore BS, Anna Kreiser, BS, Michelle Neyman Morris PhD, RD)
  - Non-diet interventions resulted in statistically significant improvements in disordered eating patterns, self-esteem, and depression. None of the interventions resulted in significant weight gain or worsening of blood pressure, blood glucose, or cholesterol, and in 2 studies biochemical measures improved significantly compared with the control or diet group.
Research in Support of HAES®

  - Compared to normal weight-fit individuals, unfit individuals had twice the risk of mortality regardless of BMI. Overweight and obese-fit individuals had similar mortality risks as normal weight-fit individuals. Furthermore, the obesity paradox may not influence fit individuals. Researchers, clinicians, and public health officials should focus on physical activity and fitness-based interventions rather than weight-loss driven approaches to reduce mortality risk.
In short, HAES® is a weight-neutral alternative to the diet and weight loss paradigm in which body size and diversity is respected, body cues such as hunger and fullness are honored, and health is viewed holistically, taking into consideration the social determinants of health, the role stigma and biases play in providing health care, and a person’s choice to pursue health.
Diet vs Diet

- Diet for weight loss versus a functional diet
- The same word but very different approaches and goals. But is there an overlap?
- Would prescribe a functional diet differently for someone with the same diagnosis if they had a BMI of 22 versus a BMI of 42?
HAES® and MNT

HAES can be applied to MNT without question. Please consider
1. Remember “healthism” and is our client presenting to us with any evidence of eating disorder or disordered eating history or behavior?
2. Is there any sort of orthorexic thinking present either from the client of the doctor?
3. Treat the whole person! Consider socio-economic factors, trauma, race, gender and access to health care.
4. Zoom out rather than in. See the whole picture.
5. Be curious, non-judgmental and provide space for exploration
6. Honor lived experiences.
7. Confront Weight-biases and our own internalized fat-phoab
Question: Would you have heard this message any differently if I wasn’t in this body?
Check Your Own Biases

**Project Implicit**

- **Gender - Career.** This IAT often reveals a relative link between family and females and between career and males.

- **Sexuality ('Gay - Straight' IAT).** This IAT requires the ability to distinguish words and symbols representing gay and straight people. It often reveals an automatic preference for straight relative to gay people.

- **Native American ('Native - White American' IAT).** This IAT requires the ability to recognize White and Native American faces in either classic or modern dress, and the names of places that are either American or Foreign in origin.

- **Asian American ('Asian - European American' IAT).** This IAT requires the ability to recognize White and Asian-American faces, and images of places that are either American or Foreign in origin.

- **Weight ('Fat - Thin' IAT).** This IAT requires the ability to distinguish faces of people who are obese and people who are thin. It often reveals an automatic preference for thin people relative to fat people.

- **Gender - Science.** This IAT often reveals a relative link between liberal arts and females and between science and males.

- **Skin-tone ('Light Skin - Dark Skin' IAT).** This IAT requires the ability to recognize light and dark-skinned faces. It often reveals an automatic preference for light-skin relative to dark-skin.

- **Weapons ('Weapons - Harmless Objects' IAT).** This IAT requires the ability to recognize White and Black faces, and images of weapons or harmless objects.
Further Reading

*Body Respect*, by Linda Bacon, PhD and Lucy Aphramor, PhD, RD

*Intuitive Eating*, by Evelyn Tribole, MS, RDN and Elyse Resch, MS, RDN

*The Intuitive Eating Workbook: Ten Principles for Nourishing a Healthy Relationship with Food*, by Evelyn Tribole, MS, RDN and Elyse Resch, MS, RDN

*Wellness Not Weight: Health at Every Size and Motivational Interviewing*, edited by Ellen Glovsky, PhD, RD, LDN (CEUs available through SkellySkills.com)

*Secrets of Feeding a Healthy Family*, by Ellyn Satter, MS, RDN, MSSW

*Secrets from the Eating Lab: The Science of Weight Loss, the Myth of Willpower, and Why You Should Never Diet Again*, by Traci Mann, PhD
Resources

Association for Size Diversity and Health
www.sizediversityandhealth.com

Intuitive Eating website
www.intuitiveeating.org

Ellyn Satter Institute
www.ellynsatterinstitute.org
Assessment Tools

Intuitive Eating Scale

Body Image Avoidance Questionnaire
Questions?