Health at Every Size®
What it is. What it isn't.

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Cigna Eating Disorder Awareness Series

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Lutz, Alexander & Associates Nutrition Therapy

Who is this person?

- University of Mississippi Alumni
- Practicing since 2012
- Lutz, Alexander & Associates Nutrition Therapy
  - Weight Inclusive Nutrition Practice - specializing in eating disorders , family feeding and HAES
  - Raleigh, Durham, Chapel Hill
- Certified Eating Disorder Registered Dietitian Supervisor
- HAES® Practitioner

“So, what do you do?”

- "Oh, I better be good tonight."
- "I bet you make such healthy dinners."
- "Sorry (about this snack). “Don’t judge me”
- "Oh, so do you put people on diets?"
- "I bet you are appalled by the school lunches. Can't you do something?"
- "Let me tell you about this great diet I just started.”

“I primarily work with people with eating disorders.”

“Oh, so you want people to eat more, not less!”

Objectives

1. Define Health at Every Size®

1. Cite at least 3 research studies that support healthcare professionals using a weight inclusive approach

1. Understand the truth about common misconceptions of HAES®

4. Name at least 3 resources a practitioner can use to strengthen his/her weight inclusive skills.

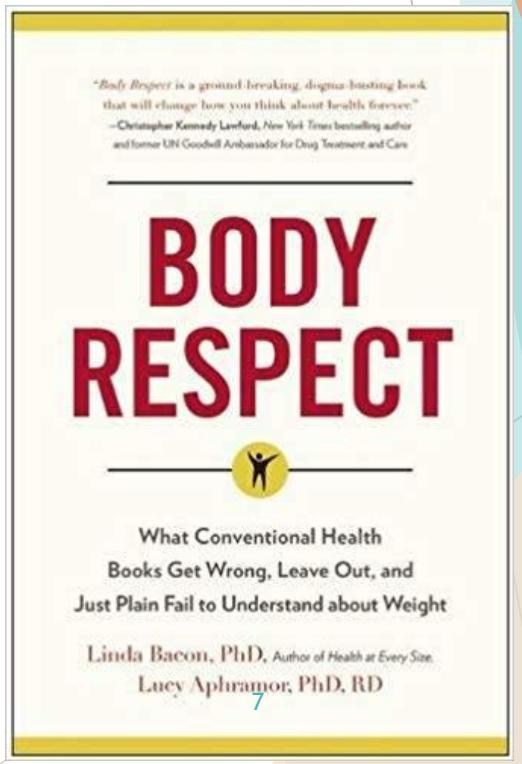
Outline

1. What is HAES®?
2. Why HAES®?
3. Research
4. What HAES® isn’t.
5. Resources
6. Questions/Discussion

A Note about Language...

- "Overweight" and "Obesity" are stigmatizing terms

- Other possible terms:
  - People in large bodies
  - Person in a larger body
  - Big
  - Fat



What is Health at Every Size®?

- An approach to health care:
  - that is an alternative to the weight-centered approach to treating clients and patients of all sizes.
  - that promotes balanced eating, life-enhancing physical activity, and respect for the diversity of body shapes and sizes.
- A movement:
  - that is rooted in social justice.
  - to promote size-acceptance, to end weight discrimination, and to lesson the cultural obsession with weight loss and thinness.

ASDAH Website: www.sizediversityandhealth.org

HAES® Principles

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

2. **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.

3. **Respectful Care**: Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socioeconomic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.

4. **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.

5. **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.

Body Diversity

- Normal diversity of body size related to genetic predisposition and environmental factors
- Genetic set point
- Studies of twins shows that genetic variation accounts for 70-80% of variation in body size
- Similar to diversity of other physical traits, including height and skin color

Reference: O'Hara and Taylor. Sage Open, April-June 2018.

Poodle Science

Why HAES®?

- Weight stigma causes harm to people's health
- The Weight Normative Paradigm:
  - Isn't evidence based
  - Doesn't work long term
  - Causes people harm
- A weight inclusive approach to healthcare is health enhancing

HAES® is evidence based, compassionate, patient centered care

Weight Bias In Health Care

- Strong implicit anti-fat bias among health professionals across multiple disciplines
- Healthcare professionals view “obese” patients as lazy, lacking in self-discipline, dishonest, unintelligent, annoying, and noncompliant with treatment
- Obese patients more likely to delay or forego routine preventative care, breast, cervical, colorectal cancer screenings
- Providers spend less time with “obese” patients”
- Association persists with controls for education, income,lack of insurance, illness burden

(Puhl RM, Heuer CA, 2009, Hebl, 2001)

Internalized Weight Stigma Causes Harm

- Those in larger bodies and who have internalized weight stigma have worse health outcomes than without weight stigma
- People with internalized weight stigma have increased risk of:
  - hypertension
  - eating disorders
  - metabolic syndrome
  - depression
  - diabetes
  - cortisol reactivity
  - weight gain

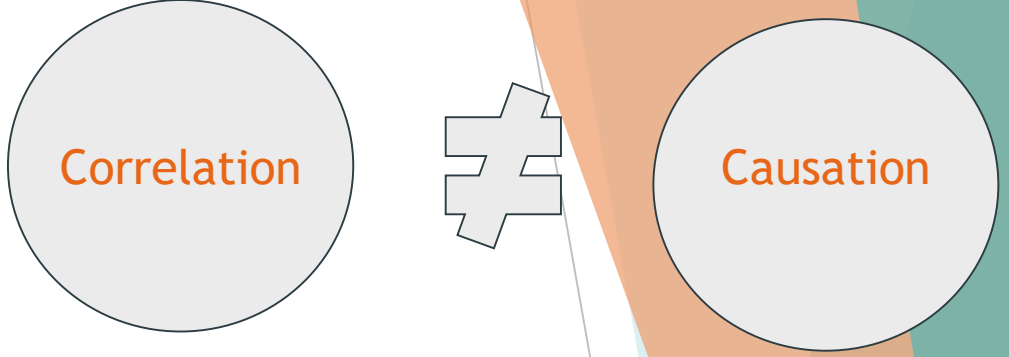
The Reality:

- Person told to lose weight, avoids going back to the doctor
- Weight recommended when go to the doctor for unrelated concerns
- Surgeries are delayed
- High Risk, Bariatric Surgery is recommended
- Person goes in for knee pain
  - fat body
  - thin body
- Person diagnosed with PCOS
  - fat body
  - thin body
- Person with long history of hip pain

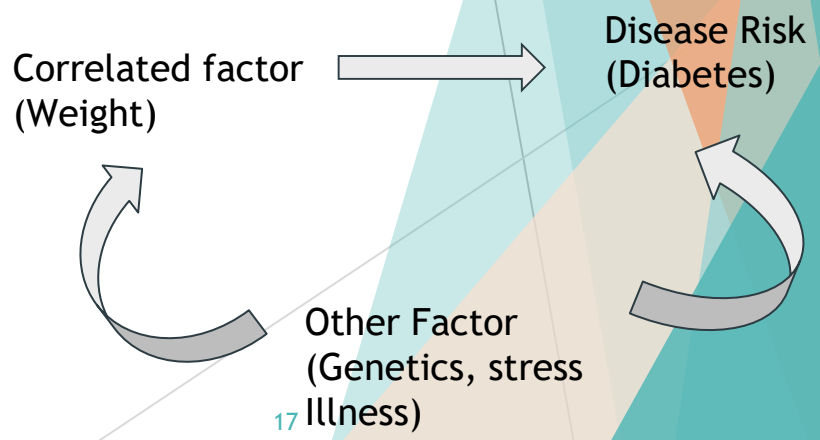
A Note About BMI...

- Equation devised in 1832 for non-medical purposes
- Dubbed “Body Mass Index” by Ancel Keys in 1972 for epidemiological purposes (NOT for individual dx)
- NIH started using to define obesity in 1985:
  - 27.8 for men, 27.3 for women (85th percentile)
- 1998 Changes:
  - “Overweight” category added
  - M/F parameters consolidated
  - BMI 25, 30—convenient, easy to remember
  - 25 million Americans instantly became “overweight”
  - "Obesity experts" on committee had ties with dieting and pharmacological industry

Weight and Health



- High BMI's are associated with: arthritis, sleep apnea, hypertension, diabetes
- Assumption that weight CAUSES these diagnoses
  - And thus, if someone loses weight than their disease or risk will improve
- Many, many other factors that could be causal
  - activity level, cardiovascular fitness
  - genetic predisposition to have a large body
  - medical conditions
  - weight stigma
  - weight cycling
  - stress and trauma
  - food insecurity



Weight and Health

- Excess weight lowers the risk of early death. (Ortega ‘12; Angeras ’12; Clark ’12; Lavie '03, ‘07)
- Overweight individuals had lowest mortality risks.
  - Moderate obesity offered no more risk than being in the normal-weight category (Flegal ‘05)
- 30 or so extra pounds had a 6% lower risk of premature death (Flegal ‘13)
- People that are obese and metabolically healthy are not at increased risk of CVD and all-cause mortality. (Hamer and Stamatakis,2012)
- Cardiorespiratory fitness and improvement of cardiorespiratory fitness lowers risk of mortality regardless of age, smoking status, body composition, and other risk factors (Wei et al., 1999)

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Diets Don’t Work Long Term

- >95% of people that lose weight gain in back
  - 5 year ‘success’ rate - 2-5%
  - ⅔ of these people gain back more

(Carson, R. 2014, Stunkard AJ, 1959, Kassirer J, 1998, Anderson JW , 2001, Wing RR, 2005, Franz MJ, 2007, Stubb, 2001)

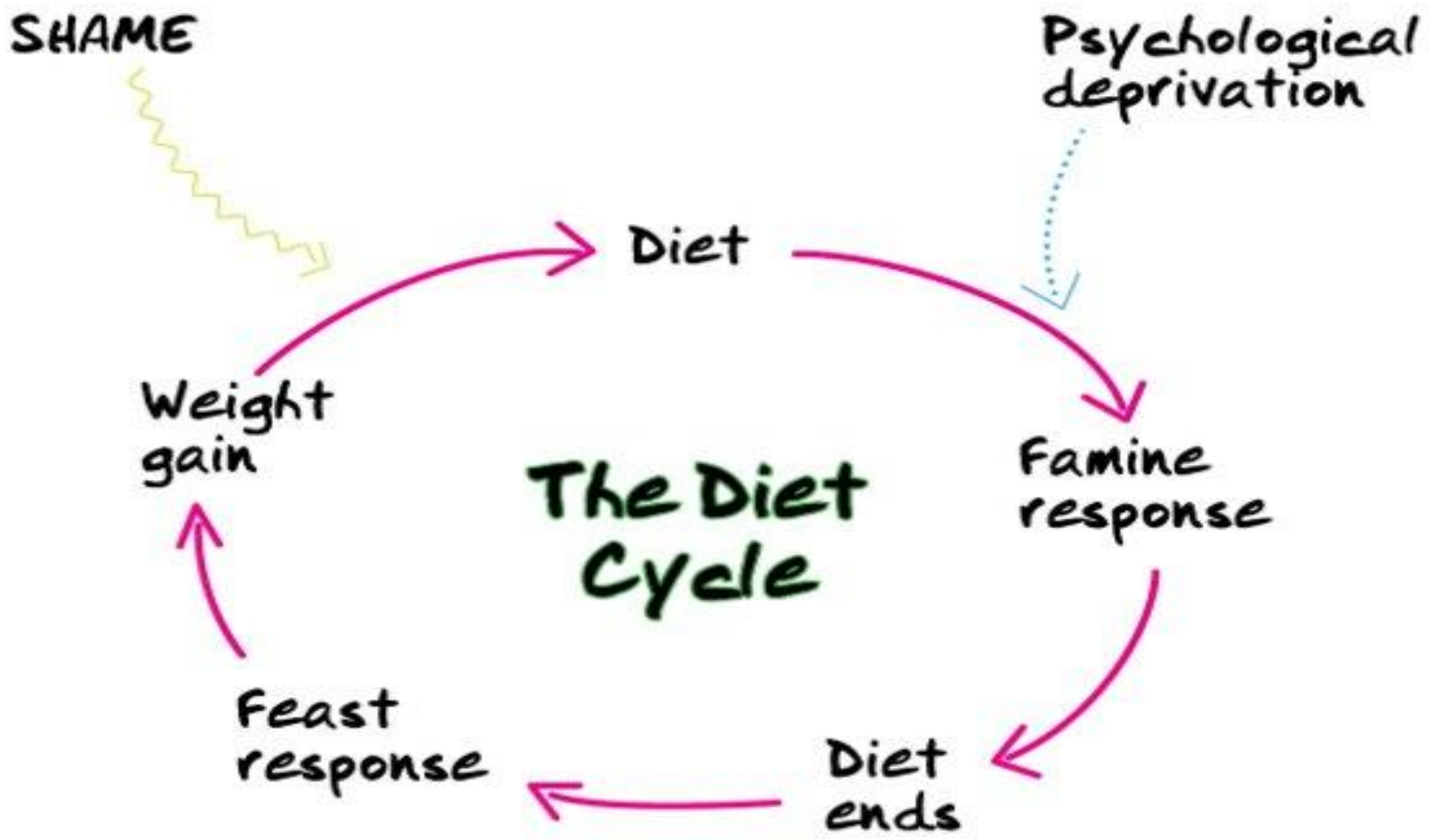
Diets Don’t Work:

- TEE remains low after sustained weight loss, favoring weight regain. (Rosenbaum et al. 2008).
- One year after weight loss, circulating hormones that mediate appetite do not revert to pre-weight loss levels. (Sumithran et. Al., 2011)

Diets Don’t Work - Feeding Practices

- Children that have restricted access to palatable foods have increased intake of those foods. (Fisher JO, Birch LL., 1999)
- Maternal restrictive feeding predicted daughters’ eating in the absence of hunger and increased change in BMI. (Birch LL, Davison 2003; Francis, Birch LL 2005)
- Parents' attitudes about overweight predict restrictive feeding practices (Musher-Eizenman et al., 2007)

Diets Don’t Work



Diets Don’t Work

"It is a remarkable fact that the central premise of the current war on fat—that turning obese and overweight people into so-called ‘normal weight’ individuals will improve their health—remains an ***untested hypothesis***."

(Campos, P. et al, 2005)

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Diets Cause People Harm

- Weight cycling has been linked to increase risk of health problems
- Individuals that perceive themselves as being overweight are at increased risk for future weight gain (Robinson, et al)
- Adolescents reporting dieting behavior more likely to exhibit binge eating, extreme weight control behaviors, and reported EDs 5 years later (n=2,516) (Neumark-Sztainer, et al 2007)

Diets Cause People Harm

- High school girls engaging in dieting at increased risk for binge eating 2 years later (Stice, et al)
- 3 year cohort study: Adolescent girls dieting at “severe” level are 18 times more likely to develop an eating disorder (Patton, et al)
- See section on Weight Stigma

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Focus on Behaviors Improves Health Outcomes

- Multiple RCTs of non-diet, intuitive eating, and other behavioral interventions have demonstrated improvements in blood pressure, lipids, health behaviors, and psychosocial outcomes
- No studies have shown adverse outcomes of these interventions

(Bacon et al., 2005, www.intuitiveeating.org)

Evidence for HAES Approach

- RCT by Bacon et al included 78 obese women with BMI >30, age 30-45
- Interventions included non-diet program (focus on self-acceptance and intuitive eating through workshops and groups) or diet program (restrict energy and fat intake, monitor weight) for 6 months, 6 months aftercare group support, and 2 year follow-up

Bacon et al J Amer Diet Assoc 2005, 105:929-936

Evidence for HAES Approach

	BP 6 mo	BP 2 yrs	LDL 6 mo	LDL 2 yrs	Wt 6 mo	Wt 2 yrs	Exercise 6 mo	Exercise 2 yrs
Diet group	Dec	No change	Dec	No change	Dec	No change	Inc	No change
HAES group	Dec	Dec	Dec	Dec	No change	No change	Inc	Inc

- HAES group showed improvement in eating disorder cognitions, self-esteem, depression
- Diet group had no sustained improvements and worsening self-esteem at follow-up

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Adapted from Bacon et al. J Amer Diet Assoc 2005, 105:929-936.

Evidence for Non-Diet, HAES Approach

- RCT 80 women age 30-45 with BMI >30
- 6 months of group meetings with weight-loss or weight-neutral approach to health, 2 year follow-up
- Weight-neutral group had no change in weight and maintained a significant decrease in LDL (10 mg/dl) at follow-up
- Weight loss group had a significant decrease in weight and no improvement in LDL at follow-up
- No change in blood pressure, glucose or other lipid parameters in either group

Mensinger et al. 2016 Oct 1; 105:364-74.

Evidence of Non-Diet, HAES Approach

Largest study to date on Intuitive Eating: 1405 women and 1195 men

- Evaluation of the Intuitive Eating assessment scale (IE-2)
- Intuitive eating scores were positively related to body appreciation, self-esteem, and satisfaction with life
- Intuitive eating scores were inversely related to eating disorder symptomatology, poor interoceptive awareness, body surveillance, body shame, body mass index, and internalization of media appearance ideals
- Intuitive eating scores also predicted psychological well-being beyond eating disorder symptomatology

Tylka et al. J Couns Psychol. Jan;60(1):137-53.

What HAES Isn't:

"Healthy at Every Size"

What HAES Isn't:

Ignoring people's health

What HAES Isn't:

Ignoring people's health

- The very purpose of HAES® is to enhance overall health and wellness in an evidence based, patient-focused way.

What HAES Isn't:

Just for fat people.

What HAES Isn't:

Just for fat people.

- No one benefits from our culture's focus on weight control and the thin ideal. People of all shapes and sizes benefit from HAES principles.

What HAES Isn't:

Telling people to do whatever they want

What HAES Isn't:

Telling people to do whatever they want

- It's a focus on individual health behaviors
  - eating for well being
  - life enhancing movement/activity

What HAES Isn’t:

Only what you see on social media

What HAES Isn’t:

Only what you see on social media

- It’s patient focused weight inclusive healthcare and a movement to reduce the harm of weight stigma

What HAES Isn't:

Anti-MNT

What HAES Isn't:

Anti-MNT

- HAES and MNT are not mutually exclusive and very compatible.
- HAES RDs use MNT daily

So, what do I do?

"There is a cultural belief that people have to be dissatisfied with their weight (or any aspect of their appearance to be motivated to improve it). This belief has not found general support in the literature. In fact, the reverse is supported: people are more likely to take care of their bodies when appreciate and hold positive feelings toward their bodies."

Tylka et al, 2014

The Weight Inclusive Dietitian's Toolbox

- ASDAH Website
- haescurriculum.org
- Intuitive Eating
- Mindful Eating
  - Michelle May
- Ellyn Satter Institute
  i. Definition of Normal Eating
  ii. Division of Responsibility in Feeding
  iii. Eating Competence Model
  iv. Macronutrients/blood sugar relationship
- Set Point Theory
- Health at Every Size and Body Respect - Linda Bacon
- Minnesota Starvation Study -- Ancel Keys
- Motivational Interviewing
- Hunger scales
- Kathy Kater Curriculum
- The Feeding Doctor
- Geneen Roth
- Health, Not Diets Newsletter - Fiona Wiler
- EDRDPro

Other Resources

Podcasts:

- Food Psych
- Love, Food
- Body Kindcast
- Dietitians Unplugged

Social Media:

- @rebeccacaritchfield
- @dietitiananna (Anna Sweeney)
- @foodpeeacdietitian (Julie Dillon)
- @chr1styharrison
- @evelyntribole
- @haes_studentdoctor
- @feministnutritionist
- @katzavrd
- @with_this_body (Maria Paredes)
- @aaronflores
- @benourished

Some tangible steps...

- Consider your own weight bias
- How do you talk about weight vs. behaviors with your clients?
- Do you comment on people's weight?
- Call out weight biased comment/jokes
- What is the language in your marketing?
- Do you discuss the risks of intentional weight loss attempts?
- Waiting room and office furniture
- Policies about weighing patients
- Do you deem certain foods off limits or encourage external cues regarding food?
- Unfollow weight focused social media
- HAES Focused Clinical Supervision

Thank you!
Questions!!

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