Why take a weight-neutral approach?

Fiona Willer, APD
Health, Not Diets

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"Obesity Epidemic" -fear and blame based rhetoric

- 'Under individual control'
  - Just eat less and move more
- Higher health care costs
  - 'my taxpayer dollars' etc
- Higher burden of disease
  - 'you brought this on yourself'
- More disability
- 'avoidable deaths'
  - 'You're abusing your family'
- Bankrupting health services
- Blame, shame, stigma, prejudice
- Etc etc

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Entrenched assumptions

- ***Obese people overeat to stay obese*** (gluttony myth)
  - 'Overeating' means eating above energy requirements. If weight is stable, by definition, they are not overeating.
  - Obese people eat about 100 calories more per day than age and sex matched 'normal' weight people. This is accounted for by greater body tissue to maintain.
- ***Obese people eat junk food to stay obese*** (junk food myth)
  - dietary quality, and specifically fruit and vegetable intake does not differ with significantly BMI (the same proportion of obese people have great, moderate and poor diets as 'normal' weight people)
- ***Eating healthy food leads automatically to weight loss*** (natural health myth)
  - Nope. See previous entry re dietary quality.

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BMI has ended up being used to measure things that it shouldn't

- Proxy for body composition
- Proxy for 'fatness'
- Proxy for health behaviours
- Proxy for fitness
- Proxy for dietary quality
- Proxy for intervention adherence

- **Let's measure those things instead!!**

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Our approach has been: 'let's make obese people smaller'

- Assumption that a 'once-fat' person will have the same magnitude of health risk as a 'never-fat' person of the same weight (this is incorrect)
- Assumption that lasting weight loss is a feasible and realistic expectation to have of obese people (it's not)
- BMI is not a good proxy for overall health, or dietary quality, or fitness – so why are we SO obsessed with it?? (it's visible, and body shape/size has moral and social currency)
- That people with higher BMIs have higher chronic disease risks means that we should be pouring efforts into developing early screening and treatment options, not blaming people for bringing it on themselves.

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So if weight can't be changed much in the long term, and in attempting to reduce BMI we are doing things that we can't say for sure aren't having an effect independently……

- It makes sense to think about BMI as a non-modifiable risk factor, and work on behaviours instead
- It is useful to think about BMI categories like age groups. The risks differ between groups, but the focus is on enhancing health outcomes within those groups, not trying to make people younger (or appear younger).

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A weight loss focus is unjust

- Insisting that larger people lose weight despite Level A evidence that they can't:
  - Unnecessarily (and unethically) delays medical care (fertility treatments, joint replacements etc) and investigations (symptoms blamed on weight, not disease process leading to missed diagnoses)
  - Diverts resources away from developing safer treatment options for larger bodies (sturdier operating tables, longer equipment, medications specifically developed and trialed in obese bodies etc) which exacerbates the risk stats.
  - Entrenches weight bias (GP clinics not having long speculum/large blood pressure cuffs/sturdy exam tables available for obese women despite this being the appropriate equipment for 1/3 of adult women)
  - Exacerbates weight stigma (thus larger people delay seeking medical help, having regular screenings etc)
  - Medications are not routinely trialed/tested for effectiveness and safety in obese people (eg birth control, chemotherapy, statins) leading to reduced/unknown effectiveness
  - Confirmation bias entrenches 'weight as problem' discourse (if a thin person has heart disease its 'bad luck' or 'genetics' but if a larger person has heart disease its 'because of their weight and thus their own fault. Can't larger people have bad luck or poor genetics??)

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Health at Every Size®

Set of philosophical principles

versus

Non-Diet Approach

(non-dieting approach/weight-neutral approach/weight-inclusive approach)

Application of principles in clinical practice or health policy

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Evidence Based Medicine (EBM)

- ''integration of best research evidence with clinical expertise and patient values'' (Sackett et al 2000)
- The most important reason for practising EBM is to improve quality of care through the identification and promotion of practices that work, and the elimination of those that are ineffective or harmful. (Gray and Pinson 2003)
- EBM promotes critical thinking. It demands that the effectiveness of clinical interventions, the accuracy and precision of diagnostic tests, and the power of prognostic markers should be scrutinised and their usefulness proven. It requires clinicians to be open minded and look for and try new methods that are scientifically proven to be effective and to discard methods shown to be ineffective or harmful. (Akobeng 2005)

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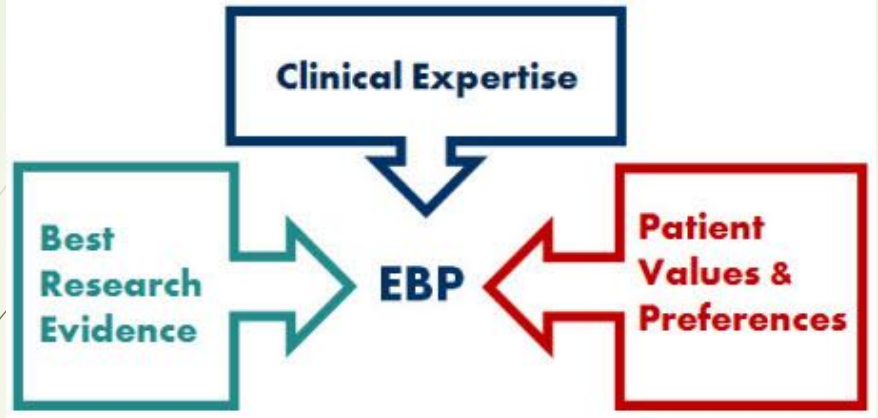

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The Non-Diet Approach and best research evidence

- First we must define the research elements that make up the Non Diet Approach (NDA)
- Then assess the benefits of these elements
- Then assess the risks/harm of these elements (safety)
- Net must be cast wide for NDA
  - HAES/NDA studies
  - Studies on individual elements which make up NDA
  - Population studies with weight neutral perspective and those which analyse behaviours separately from weight

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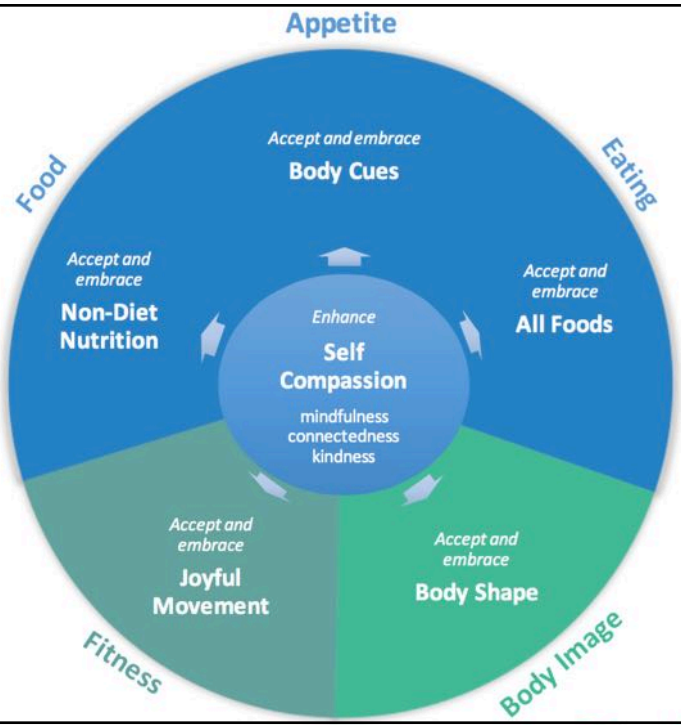

The Non-Diet Approach Model

weight neutral, client centred care

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Translating the non-diet approach into academic research

Non-diet Approach element	Academic construct
Self Compassion Experiential Learning Mindfulness	Self Compassion Theory Self-determination Theory Mindfulness
Accept and Embrace Body Cues	Dietary Restraint
Accept and Embrace All Foods	Dietary Quality & Variety
Accept and Embrace Body Shape	Body Dissatisfaction Weight Control Beliefs
Accept and Embrace Movement	Physical activity level Enjoyment of physical activity
Accept and Embrace Non-Diet Nutrition	Dietary Quality Enjoyment of food and eating

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What happens if we take a weight-neutral non-diet approach?

- Weight stability (at 5 yrs)
- Improved biochemical markers
  - Cholesterol, blood sugar, blood pressure, CRP
- Sustained healthy behaviours
- Improvement in
  - Dietary quality
  - Psychological states
  - Disordered eating patterns
  - Self esteem
  - Depression

GROUP STUDIES ONLY:
NO NEGATIVE EFFECTS

Clifford 2015 (systematic review, 16 studies met inclusion criteria), 3336 participants,

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Study populations in systematic review

Who	How many?	Researcher and year
Women with disordered eating 18-65yrs	26	Alberts 2012
Obese women 30-45yrs	78	Bacon et al 2002, 2005
Obese women 25-55yrs	62	Carol et al 2007
Obese women >20yrs	142	Ciliska 1998
Women, mean age 37yrs	87	Cole 2010
Overweight/obese women binge eaters 25-50 yrs	219	Goodrick et al 1998
Overweight, obese and healthy weight adults	102	Hendrickson 2013
Overweight/obese women, premenopausal	140	Leblanc 2012
Premenopausal women with active EDs (AN, BN, EDNOS)(mean BMI 21)	40	Marek et al 2013
Overweight/obese men and women with DM2 35-65yrs	68	Miller et al 2012
Overweight/obese women, premenopausal	144	Provencher 2007, 2009
Overweigh/obese women 18-65yrs	75	Rapoport 2000
Men and women, all weights	357	Steinhardt et al 1999
Obese women >19yrs	62	Tanco et al 1998
College females	45	Keeler et al 2013
College males and females	1689	Green et al 2012

Randomised Control Trial of HAES (Mensinger 2016)

- 6 month group intervention, 2 year follow up
- 80 obese women, randomised to weight centric or weight neutral 'healthy living program'
- Measured: BMI, BP, lipids, BGLs, weight, waist & hip circumference, distress, self-esteem, QOL, dietary risk, fruit and veg intake, intuitive eating, physical activity
- Both groups increased physical activity, fruit and veg intake, QOL and self-esteem and reduced total cholesterol and waist-to-hip ratio at 24 months
- HAES group did not have inferior results compared with the weight loss group (weight and BMI were unchanged)
- HAES group had better LDL chol & improved intuitive eating than weight loss group and had more sustained improvement in fruit and veg intake from end of program to 24 month follow up (weight loss group declined in same period although overall was still an improvement from baseline.

Self compassion and healthy behaviours

- More realistic and intrinsically motivated exercise goals (Magnus et al 2010)
- More likely to seek medical care quickly (Terry et al 2013)
- Reduces negative affective states (Leary et al 2007)
- Improves positive affective states (Neff 2003, 2007)
- Smoking reduction (Kelly et al 2010)
- Reduced alcohol misuse (Brooks et al 2012)
- Less risky sexual behavior in people with HIV/AIDS (Rose et al 2014)
- Proactive attitude towards health, benevolent self talk, motivation towards self-kindness (Terry et al 2013)

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Self compassion and disordered eating

- Less negative reaction to diet-breaking scenario in restrained eaters (Adams and Leary 2007)
- Fewer binge eating symptoms (Webb and Foreman 2013)
- Decreased social physique anxiety (Magnus et al 2010)
- Fewer body image concerns after controlling for self esteem (Wasylkiw et al 2012)
- Lower self compassion associated with higher eating disorder pathology in ED patients (Kelly et al 2013)
- Improvement in shape and weight concerns (Albertson 2012)
- High self compassion associated with low disordered eating behaviours (Geller et al 2015)
- May moderate the relationship between distress and disordered eating (Geller et al 2015)

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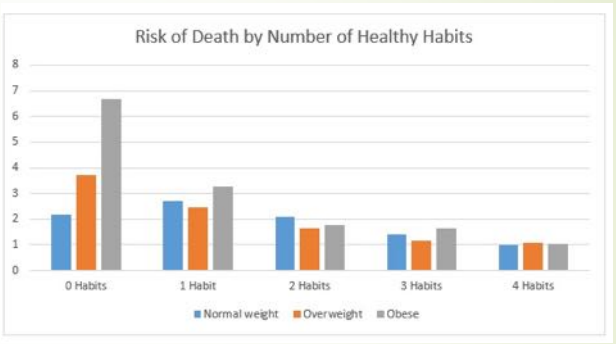
Health & Weight

- Healthy behaviours are more important than weight
- Used NHANES III data, weighted sample size of 133 million (18 mil deaths), av 170 month follow up
- Habits
  - ≥5 F+/V
  - >12 x month leisure time physical activities
  - Not smoking
  - More than 0 and up to 1 alcoholic drink/day for women and 2 for men



Matheson et al 2012

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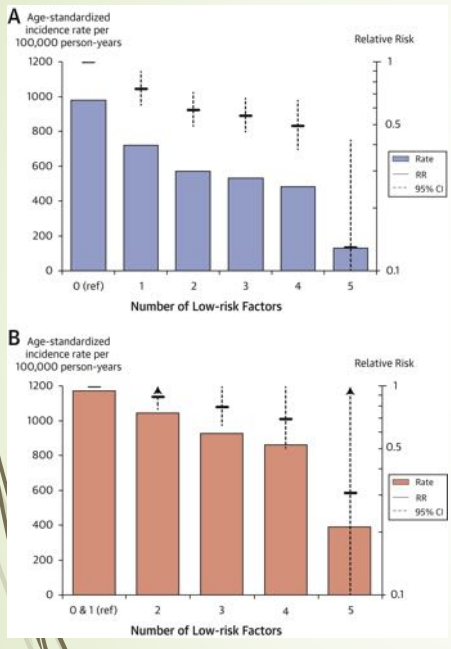

Myocardial Infarction incidence and lifestyle factors

- 20 000 men, 11 year follow up
- 5 'low risk factors'
  - High quality diet
  - Not smoking
  - 10-30g etoh/day
  - 40 mins walking/day or equiv
  - Waist < 95cm

(Åkesson et al 2014)

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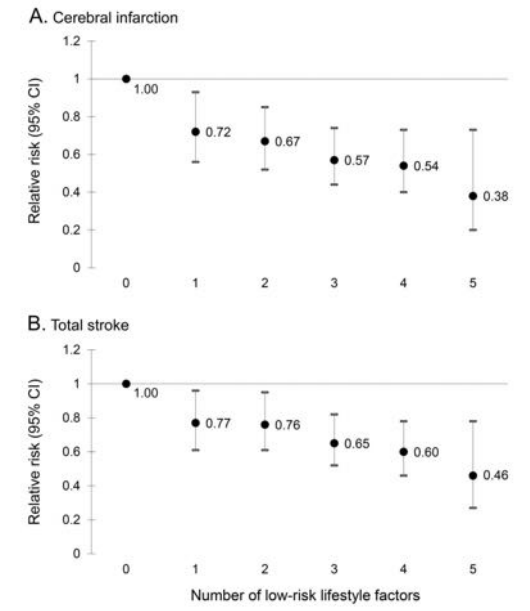

Stroke and lifestyle factors

- 31 000 women, 10.4 year follow up
- 5 'low risk factors'
  - High quality diet (in top 50%)
  - Not smoking
  - 5-15g etoh/day
  - 40 mins walking/day or equiv
  - BMI < 25kg/m2

(Larsson et al 2014)

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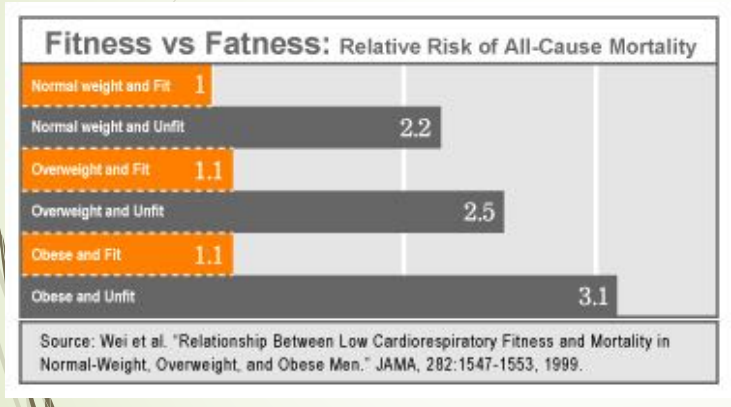
Weight loss is not necessary to improve physical health



- Studies that have actually controlled for fitness have found that it is more predictive for mortality than weight.
- This study defined 'fit' as 3-4 hrs/week of walking

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Non-directive physical activity studies

- Hsu et al 2013
  - 'The 8-week SDT-based intervention promoting Healthy at Every Size is feasible and acceptable and may result in better exercise adherence and improvements in motivational variables relative to traditional supervised exercise. These results support conducting additional research to determine the efficacy of this approach for promoting PA in sedentary, overweight women.'
- Silva et al 2010
  - [self-determination theory based interventions] providing support for autonomy, structure, and involvement will encourage individuals to develop more autonomous regulations, setting the ground to the discovery of personal meaning and enjoyment of exercise.

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Body Dissatisfaction

- 'the link between a person's weight status and a person's psychological health is accounted for by his or her level of body dissatisfaction. Thus, it appears that body dissatisfaction is one identifiable, modifiable, and underutilized factor that can be intervened on to protect against depressive symptoms.' (Bucchianeri 2014)
  - Poor self esteem
  - Depressive mood
  - Eating disorders
  - Disordered eating
  - Weight gain

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Dietary quality and health

- Having a varied core diet is more important for disease prevention and longevity than <u>not</u> eating less nutritious foods.
- Dietary quality studies often use a +ve diet score and a –ve diet score
  - +ve = AGHE type + mod etoh
  - -ve = extra foods types

Important: Junk food has NO EFFECT as long as core diet is sound

Dietary quality and longevity/mortality

- 59,000 Swedish women: 42% decreased all cause mortality for those consuming 16-17 healthy foods compared with 0-8 healthy foods. A less healthy diet defined as consumption of a high variety of red meats, refined carbohydrates and sugars, and foods high in saturated or trans fats was not directly associated with a higher overall mortality (but was assoc with higher cancer death). 100% mortality follow up (Michels and Wolk 2002)
- 7251 British adults, 39% decrease in CHD mortality and 26% reduction in all cause mortality between the 4th and 1st quartile of food variety score. A higher variety of unhealthy foods, was NOT associated with prospective risk of CHD, and cancer and all-cause mortality (Masset et al 2015)
- 36 642 men and 42 970 women in Japan, 15% reduced mortality between high and low dietary quality. Also found lower dietary quality in normal weight people but not overweight people was associated with higher total mortality, cardiovascular mortality and cancer mortality (Kurotani et al 2016)

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In a 2016 summary of studies (Kurotani et al 2016), dietary quality was found to have reduced:

- **all cause mortality by 11-42%**
- **cardiovascular mortality 17-60%**
- **cancer mortality by 11-40%**

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Prevention of DM2

- Dietary quality and physical activity can postpone diabetes development independently of weight change (Malmo Sweden 5 year follow up)
- Dietary intervention, exercise and both dietary intervention and exercise reduced the risk of diabetes development in people with impaired glucose tolerance, independent of weight status or weight change (China, 6 year follow up)
- Quoted in a systematic analysis by Hu (2007) Physical activity reduced DM2 incidence significantly in studies of adults in USA, Malta, Britain, Sweden, Finland, Japan
  - 33% reduced incidence in women who do vigorous exercise once a week vs never (Nurses Health Study, 87000 women, 8 yr follow up)
- Weight dissatisfaction in men and women, regardless of BMI, predicts type 2 diabetes risk in women (Wirth et al 2014)(table)

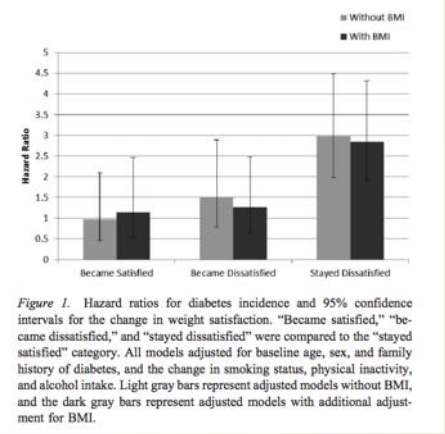

Figure 1. Hazard ratios for diabetes incidence and 95% confidence intervals for the change in weight satisfaction. "Became satisfied," "became dissatisfied," and "stayed dissatisfied" were compared to the "stayed satisfied" category. All models adjusted for baseline age, sex, and family history of diabetes, and the change in smoking status, physical inactivity, and alcohol intake. Light gray bars represent adjusted models without BMI, and the dark gray bars represent adjusted models with additional adjustment for BMI.

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Ideal candidates for Non-Diet Approach

- Chronic dieters
  - Persistent over-concern with weight and shape
  - Continual or repeated weight loss dieting/dietary restriction for two years or more
- Anyone who has had enough of dieting and regaining the weight
- Anyone who opts for a weight neutral approach when presented with the range of weight management options (EBM)
- Disordered eaters
- Bradshaw et al (2010) found:
  - Highly educated women already engaging in some healthier lifestyle choices were less likely to be non-completers in non-dieting group programs.

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What we know

- Weight loss efforts do not result in lasting weight loss or health benefits, and for some result in increased weight gain and negative psychological outcomes
- HAES is certainly safe in group settings and has positive physical and mental health outcomes (without weight loss)
- Health promoting behaviours will increase lifespan, reduce the risk of chronic disease and assist with chronic disease management
  - Fruit and vegetable intake
  - Dietary variety
  - Physical activity
  - Not smoking
  - Moderate alcohol
- Dietetic education and culture endorses traditional weight centric approaches
- Self compassion motivates and sustains health behaviours

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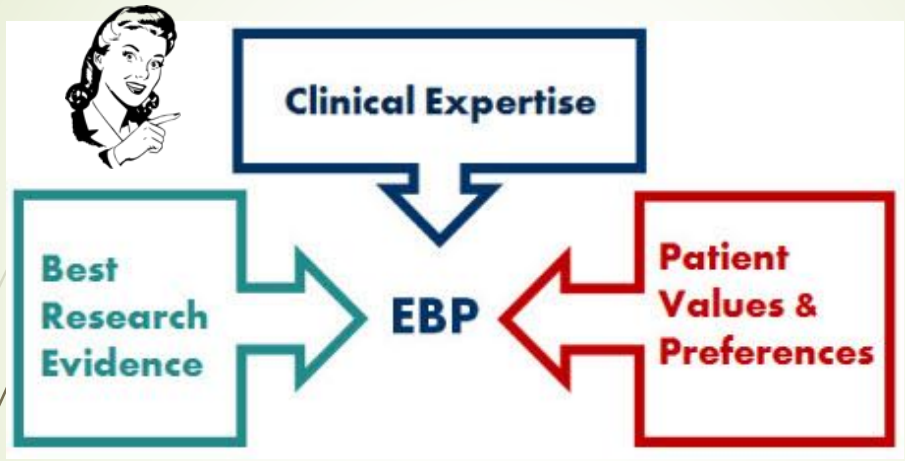

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The Non-Diet Approach in Dietetics

- HAES dietitians are a SAFE HAVEN for:
  - People of the body positivity movement
  - Eating disorder survivors
  - Chronic dieters
- Need to have adequate knowledge of the philosophical foundations AND the research AND the practice principles AND adept counselling skills
- Gaining popularity in dietitians
  - 82.4% of respondents had a positive attitude towards HAES practice by dietitians (2.6% had a negative attitude) compared with 53.8% having a positive attitude towards weight loss counselling by dietitians (29.6% had negative attitude).
  - 86% of respondents thought that HAES is a responsible way for dietitians to help overweight or obese people with weight concern (3.3% disagreed). 60.3% thought that weight loss counselling is a responsible way for dietitians to help overweight or obese people with weight concern (27.2% disagreed).
  - 58.1% of respondents thought that HAES is the most helpful way to address overweight or obese people's weight concern (8.3% disagreed). 37.5% thought that weight loss counselling is the most helpful way to address overweight and obese people's weight concern (31.7% disagreed).

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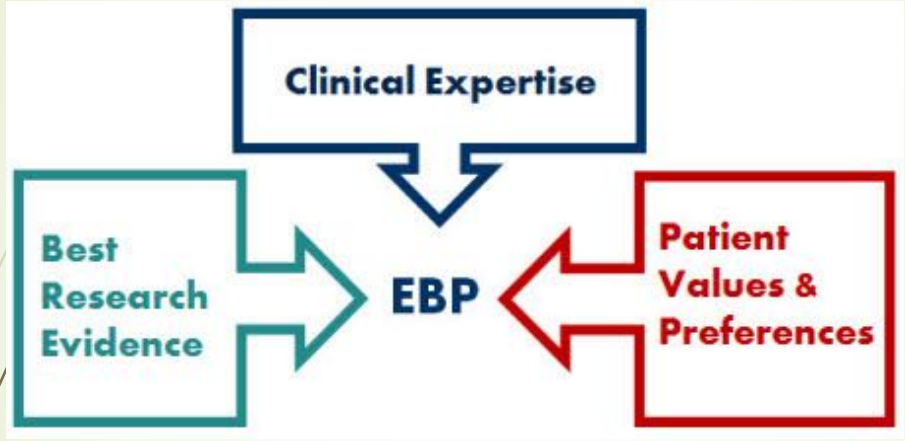

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The evidence regarding both efficacy and risks should be fully discussed with the patient in order to allow them to make an informed decision.

This approach allows a ''therapeutic alliance'' to be formed with the patient and the parents and is consistent with the fundamental principle of EBM: the integration of good evidence with clinical expertise and patient values. (Straus and Sacket 1998)

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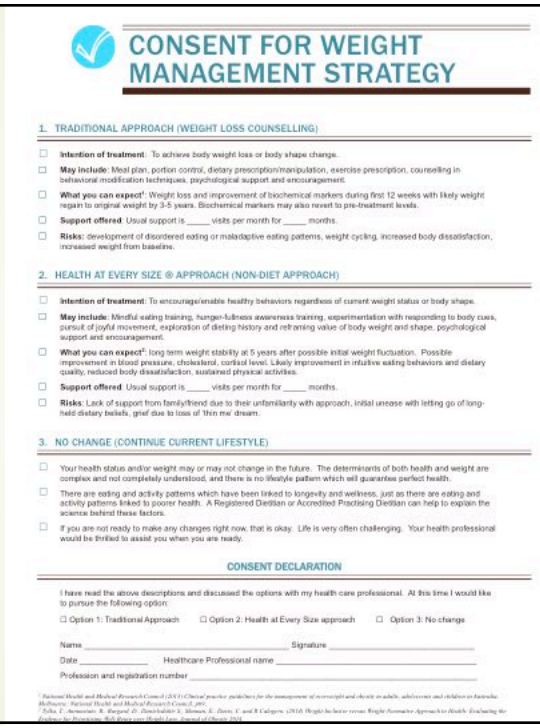

CONSENT FOR WEIGHT MANAGEMENT STRATEGY

1. TRADITIONAL APPROACH (WEIGHT LOSS COUNSELLING)

- ☐ **Intention of treatment**: To achieve body weight loss or body shape change.
- ☐ **May include**: Meal plan, portion control, dietary prescription/manipulation, exercise prescription, counselling in behavioral modification techniques, psychological support and encouragement.
- ☐ **What you can expect**[1]: Weight loss and improvement of biochemical markers during first 12 weeks with likely weight regain to original weight by 3-5 years. Biochemical markers may also revert to pre-treatment levels.
- ☐ **Support offered**: Usual support is _____ visits per month for _____ months.
- ☐ **Risks**: development of disordered eating or maladaptive eating patterns, weight cycling, increased body dissatisfaction, increased weight from baseline.

2. HEALTH AT EVERY SIZE ® APPROACH (NON-DIET APPROACH)

- ☐ **Intention of treatment**: To encourage/enable healthy behaviors regardless of current weight status or body shape.
- ☐ **May include**: Mindful eating training, hunger-fullness awareness training, experimentation with responding to body cues, pursuit of joyful movement, exploration of dieting history and reframing value of body weight and shape, psychological support and encouragement.
- ☐ **What you can expect**[2]: long term weight stability at 5 years after possible initial weight fluctuation. Possible improvement in blood pressure, cholesterol, cortisol level. Likely improvement in intuitive eating behaviors and dietary quality, reduced body dissatisfaction, sustained physical activities.
- ☐ **Support offered**: Usual support is _____ visits per month for _____ months.
- ☐ **Risks**: Lack of support from family/friend due to their unfamiliarity with approach, initial unease with letting go of long-held dietary beliefs, grief due to loss of 'thin me' dream.

3. NO CHANGE (CONTINUE CURRENT LIFESTYLE)

- ☐ Your health status and/or weight may or may not change in the future. The determinants of both health and weight are complex and not completely understood, and there is no lifestyle pattern which will guarantee perfect health.
- ☐ There are eating and activity patterns which have been linked to longevity and wellness, just as there are eating and activity patterns linked to poorer health. A Registered Dietitian or Accredited Practising Dietitian can help to explain the science behind these factors.
- ☐ If you are not ready to make any changes right now, that is okay. Life is very often challenging. Your health professional would be thrilled to assist you when you are ready.

CONSENT DECLARATION

I have read the above descriptions and discussed the options with my health care professional. At this time I would like to pursue the following option:

☐ Option 1: Traditional Approach ☐ Option 2: Health at Every Size approach ☐ Option 3: No change

Name _____ Signature _____

Date _____ Healthcare Professional name _____

Profession and registration number _____

[1] National Health and Medical Research Council (2013) Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia. Melbourne: National Health and Medical Research Council. p95.

[2] Tylka, T., Annunziato, R., Burgard, D., Daníelsdóttir, S., Shuman, E., Davis, C. and R Calogero. (2014). The weight-inclusive versus weight-normative approach to health: Evaluating the evidence for prioritizing well-being over weight. Journal of Obesity. 2014.

Consent form example

Download from www.healthnotdiets.com

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Case Studies and Discussion

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