Focusing on Health rather than Weight

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Eat Love Live

I find myself saying (again and again and again.......) if there was a diet that worked – we would all do it, everyone would be happy and someone would be very rich from it! But the reality is that diets don’t work – or not in the long term.

It interests me that the outcome everyone is looking for is weight loss – there is something far more important that is rarely mentioned .... Health! It’s sad but true that there is research that shows that people would choose weight loss in exchange for years off their life. Years that could be spent with friends, family and enjoying themselves; being happy!

And some people are not happy; not happy with their bodies, their lives, their looks; and they believe that weight loss could fix it. I also find myself repeatedly telling clients and acquaintances alike that if people are attracted to you after you have lost weight –are they really the type of people you want in your life?

Why do we believe that weight loss will solve everything? So many reasons! And no we can’t just blame the media anymore. We need to think about society as a whole and what we contribute to our society. Do we praise someone for losing weight? Do we judge people in our own minds? What are we saying inadvertently to our family, friends, and children; when we complain about our own bodies’ perceived shortcomings?

I can hear the crowd cheering as I write this – but what about the obesity epidemic? People are going to die- they need to lose weight!

Obesity in Australia

- 3 in 5 Australian adults are overweight or obese (based on BMI). That’s over 12 million people!

- 5 % more adults are overweight or obese that in 1995.

- 1 in 4 Australian children are overweight to obese.

- Over 30% more people living in outer regional and remote areas are obese than people living in major cities

- Overweight and obesity is only beaten by smoking and high blood pressure as a contributor to burden of disease

Yes as a society we are getting bigger and yes that can impact on health – but the connection is not the clear cause and effect relationship we assume. Also we have to consider why we are getting bigger, why are our habits changing for the worst? But that’s a completely different discussion!
What is influencing our eating patterns?

Some things to consider that are leading to changes in our bodies

Lifestyles have significantly changed over the past few generations:

- Male and female working full time
- Decreased time spent on food preparation
- Increased take away and convenience foods
- Traditional food preparations skills are not being passed down

Obesogenic Environment:

- Surrounding social and physical environments are more conducive to sedentary lifestyles and unhealthy food and beverage choices than they are to healthier alternatives.
- Increased fast food portion sizes
- Cheap fast food
- Reliance on transport/ cars
- Technology developments
- Increased fear of children playing outside
- Food and beverage marketing (US - $70 billion a year spent on food and beverage markets – 70% on sweets and 2% on fruit and veg (Nestle, 2002)

Healthism Environment:

- Increased media pressure on health, nutritional eating, and daily exercise.
- Increased marketing and availability of vitamin and mineral supplement and alternative therapies.
- Increased pressure on male presentation, physique and fashion sense.
- Success associated with being thin, affluent, strong willed, committed.
- Putting exercise before other commitments and food restriction seen as normal.

Dieting Isn’t Working

Identifying Diets - It is important to be able to filter some of the information we encounter in the media.

**How to assess a potential ‘diet’:**

1. Recommendations that promise a quick fix
2. Does it encourage the avoidance of certain foods or food groups?
3. Does the diet claim to be ‘new’ or ‘revolutionary’?
4. Does the diet claim to be ‘quick’ or ‘effortless’ weight loss?
5. Attribute ‘miracle’ properties to one food or product.
6. List ‘good’ or ‘bad’ foods
7. Does the diet make it difficult to eat out or eat with friends and family?
8. Requires the purchase of special product, diet supplements, pills or formulae?
9. Only mention food and nothing about activity?
10. Sound too good to be true.

*If the answer is yes to any of these statements then it probably is a ‘diet’!*

The Diet industry is big business generating approximately $58.6 billion annually in the USA alone (Bacon and Aphramor 2011). It promises quick results by developing food plans that can’t be sustained or by using supplements. Many of these programs can result in changes in the short term but are unsustainable and rapid weight gain results when normal eating recommences (Tomiyama et al 2013). One third to two thirds of all dieters regain more weight than they originally lost on their diet over the following 12 months (Bacon and Aphramor 2011). For some reason obesity research “seems to enjoy special immunity from accepted standards in clinical practice and publishing ethics” (Bacon and Aphramor 2011). Even though we know there won’t be good outcomes we keep trying something that we know will fail and will have possible detrimental effects!

Research clearly identifies that weight stigmatisation is strong in all areas of life- peer relationships, work and even health care. This automatic judgement of people we visually determine to be above their healthiest weight assumes that they are intrinsically unhealthy because of their size, is leading to an overemphasis on weight loss often without thorough evaluation of lifestyle and health (Tomiyama et al 2013 ). Similarly there is an assumption that normal weight or thin people must be healthy leading to poor health evaluation and less discussion of lifestyle interventions (Tomiyama et al 2013 ). This stigmatisation of fat actually demotivates people leading to an avoidance of health care, avoiding exercise, increased quantities of food, poor self-esteem, poor self-efficacy and a learned helplessness (Bacon and Aphramor 2011).

There has been no clear relationship between health outcomes and weight loss (Bacon and Aphramor 2011). Weight does not equal health! What the research has shown is that the change of diet to include more fibre, more fruit and vegetables and more physical activity in any form is linked with an improvement in hypertension, diabetes and cholesterol (Tomiyama et al 2013 ) even when no weight loss occurs (Bacon and Aphramor 2011). Data further supports this idea that it is the behaviours rather than the weight loss itself leading to improvements in health.

Physiologically the body fights against weight loss and fights to regain lost weight metabolically and with an altered response to food in the brain, particular in the emotional response to food.
Post weight loss people have increased appetite, increased preoccupation with food and need to maintain a significant calorie deficient to maintain the weight loss (Bacon and Aphramor 2011) due to a permanent shift in metabolic needs reflected in the levels of leptin, ghrelin and other hormones (Sumithran et al 2011). Post weight loss muscles burn 20-25% less energy daily and this is sustained up to 2 years post weight loss even when weight is regained (Sumithran et al 2011).

When investigating people who have lost weight and maintained that loss we see that some common behaviours amongst this cohort are daily weighing, calorie counting, less than half the time watching television than the rest of the population, no ‘cheat’ days, 60mins + exercise daily and overall less calories than someone the same weight who never lost weight (up to 500 calories per day less) (Sumithran et al 2011). Sounds like something only particular personality types would be able to maintain!

Repeated dieting can lead to weight cycling and overall weight gain, increased feelings of guilt about eating, rebound overeating and a sense of failure from having tried and seemingly failed. Physiologically weight cycling is more strongly correlated with morbidity and mortality than obesity (Tylka et al 2014); Weight cycling results in an increased inflammatory state contributing to development of hypertension, insulin resistance and dyslipidaemia (Bacon and Aphramor 2011).

Studies show that people with a BMI <18.5kg/m² and greater than 30kg/m² have the highest risk of illness but people with a BMI of 25-30 kg/m² have the lowest! (Bacon and Aphramor 2011). Diets also fail to address common reasons for non-hungry eating such as boredom or emotional eating which are important to consider for long term success.

We know diets are not working but until now we have had no alternative. Commonly people find diets are too complicated to follow long term, too restricting on their social life or they feel deprived and rebel. They then feel that they have failed (rather than the diet has failed) and what we do when we feel bad – we eat! And the cycle continues.

Practitioners and patients sometimes have unrealistic goals of how much weight they should lose – and this is often based on aesthetic desire rather than evidence. There is limited research to correlate large weight losses with actual health improvements and the health improvements we do see is most likely due to a change in behaviours rather than the weight loss itself. Interestingly to see sustained changes in clinical markers only 5-10% weight loss is required (Pinkney, 2001).

**Realistic Goals.**

Benefits attributable to long term 10% weight loss:

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<tr>
<th>Mortality</th>
<th>20-25% fall in total mortality</th>
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<tr>
<td></td>
<td>30-40% fall in diabetes related deaths</td>
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<td></td>
<td>40-50% fall in obesity related cancer deaths</td>
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<tr>
<th>Blood Pressure</th>
<th>fall of 10mm Hg systolic</th>
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<td>Fall of 20 mm Hg diastolic</td>
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<tr>
<th>Angina</th>
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<td>33% increase in exercise tolerance</td>
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<th>Lipids</th>
<th>10% fall in total cholesterol</th>
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<td>15% fall in LDL cholesterol</td>
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30% fall in triglycerides
8% increase in HDL cholesterol

**Diabetes**
> 50% reduction in risk of developing diabetes
30-50% fall in fasting blood glucose
15% fall in Hba1c


“Recent investigations have shown that sustained weight loss of just 3—4 kg in overweight individuals with impaired glucose tolerance resulted in 58% risk reduction for diabetes at four years.” (Pinkey, 2001).

### An Alternative approach – Focus on health, forget about the weight!

**Health at Every Size**

“**Let’s face facts.** We’ve lost the war on obesity. Fighting fat hasn’t made the fat go away. And being thinner, even if we knew how to successfully accomplish it, will not necessarily make us healthier or happier. The war on obesity has taken its toll. Extensive "collateral damage" has resulted: Food and body preoccupation, self-hatred, eating disorders, discrimination, poor health... Few of us are at peace with our bodies, whether because we're fat or because we fear becoming fat... Very simply, it acknowledges that good health can best be realised independent from considerations of size. It supports people of all sizes in addressing health directly by adopting healthy behaviours.”

An excerpt from *Health at Every Size: The Surprising Truth About Your Weight* by Linda Bacon, PhD

**Health at Every Size** is based on the simple premise that the best way to improve health is to honour your body. It supports people in adopting health habits for the sake of health and well-being (rather than weight control). Health at Every Size encourages:

- Accepting and respecting the natural diversity of body sizes and shapes.
- Eating in a flexible manner that values pleasure and honours internal cues of hunger, satiety, and appetite.
- Finding the joy in moving one’s body and becoming more physically vital.

**Health at Every Size Rejects a weight focus:**

- Weight is a consequence, not a determinate of health
- Acceptance of current body shape
- Rejects cultural expectations of ideal body shape

**Emphasis on internal vs External eating cues**

- Mindful eating, innate eating, intuitive eating
- Health supported through enjoyment of food, movement and body

**Health at Every Size (HAES) and Anti Dieting movement**

- Not synonymous with fat acceptance movement (non-diet approach as well being rather than political motivations)
• Does not deny the associations between higher weight and ill health, but strongly questions causative factors

Every person has the right to body respect, regardless of their body shape, size, colour, age, ability or health status


What does a non-diet approach look like?

Using Health Rather than Weight Focused Goals

• More tangible goals
  • Using hunger/ fullness scale
  • Food variety, trying new foods
  • Small achievable goals such as walking extra tram stop
• Sustains motivation
• Goals attained quicker

Behaviour Change Focus

• Eating behaviours – Mindful eating practices
• Activity – focus on enjoyment, listening to and responding to body cues rather than the old ‘no pain no gain’.

Stimulus control

• Eat at regular, set meal times
• Eat sitting down with appropriate crockery and cutlery
• Put away leftovers before commencing meals
• Avoid distractions such as TV and reading while eating

Reinforcement techniques

• Reward / provide positive feedback about behaviour not weight changes
• Use tangible rewards (not food) immediately on meeting goals
• Self-Monitoring
• Behavioural Contracting
• Realistic goals based on behaviour
• Social Support

Regular eating

• Regular meals and snacks to avoid getting overly hungry or feeling deprived. Assist with blood glucose level stability.

Wide variety of food- avoiding ‘food morals’

• Include food from all food groups based on the idea of eat most, moderately, least
• When having sometimes foods – sit and enjoy rather than ‘scoff’
• Avoid Labelling language when discussing food and lifestyle
Tools
- Self-monitoring
  - Check list food frequency
  - Behavioural goals
  - Non weight related goals
- Food diary
  - Hunger, satiety, thoughts about food,
- Distractions
- Mindful eating

Non Diet Approach Research

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<th>Findings</th>
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The research into Health at Every size, non-dieting approaches, and mindful eating is in its infancy and more is needed and underway – but the current findings are very promising.

“Randomised controlled trials indicate that a HAES approach is associated with statistically and clinically relevant improvements in physiological measures (eg blood pressure, blood lipids), health behaviours (eg eating and activity habits, dietary quality) and psychosocial outcomes (such as self-esteem and body image), and that HAES achieves these outcomes more successfully than weight loss treatment and…”

Bacon and Aphramor 2011

So How Does Eat Love Live Adopt a non-dieting approach to weight management

I don’t like to claim to be a Health at Every Size practitioner as I find – like in all my work – I adopt the principles into my work with clients but I am still flexible and respond to what each individual client needs and what works for them.

- We avoid using scales as much as possible – the weight changes on the scales are a reflection of many changes in the body not just body fat. The changes are inconsistent and slow.
  - Instead we focus on small changes that are in a person’s control and are easily measurable – such as trying 1 new dish per week, or walking 15mins 3 times a week.
  - The goals are always about the individual client – where they are at and what they feel they can manage.
  - Clinical indicators are also a much better indicator of health – blood glucose, cholesterol and blood pressure for example.
  - Small goals and changes help people to build their confidence to maintain changes and make more.
- We are non-judgemental in our language when listening to people and when talking about the variety of foods available (i.e. no such thing as good and bad foods).
- We aim to make people feel safe to talk about their relationship with food and their body open and honestly. There is no commentary about what people are currently doing or judgement. Most people are aware of where they are overdoing it and being able to be honest about it can be very hard – commenting in a negative way may cause them to disengage.
  - Instead we listen attentively and provide support, reassurance and containment of their difficult feelings.
- We provide information and or correct misinformation about food and nutrition information– such as carbohydrates being a bad food!
  - We provide clear, correct nutrition information.
  - We discuss with clients how they feel they may be able to incorporate any of the information provided into dietary changes – remembering that small steps can lead to much bigger ones and more self-efficacy in clients.
- If we feel it is necessary we suggest more support – for example exercise physiology, psychology, physiotherapy, ‘Step into Life’ groups, etc.
• We ensure clients have good social support also if they are making changes; I often find myself passing on articles, the names of books and websites for client to share with family and friends so they can feel like they are well supported in making changes.
• We ensure that our clients know it is ok to come back if they haven’t being able to implement anything we have discussed – that we can help them to work out why they weren’t able to change and how we can support them to move towards changes.

I tell my clients we are aiming to find the balance
  • Nutrition Knowledge
  • Intuitive Eating
  • Life

References

