

The Health at Every Size Approach: Extreme Thinking and the Middle Path

The irony underlying the media-trumpeted “obesity epidemic” is that diets go hand-in-hand with obesity. While people may believe that dieting is a health-oriented response to the problem of obesity, we now understand that people on diets do not have normal, healthy relationships with food, and are therefore destined to fail in their quest to lose weight; and will in fact likely gain more in the long run. So the diet industry, while ostensibly responding to the “obesity epidemic,” is in fact feeding it; and the only people who win in the end are those who pocket the substantial profits from the latest diet book.

The Western medical establishment generally assumes that being large is a health hazard. In their eagerness to help their patients conquer obesity, however, efforts by medical and dietetic practitioners to help may actually mask what is essentially fat prejudice. Zeal for improved health can become rigid belief that obesity is the enemy that must be defeated at all costs, the costs of course being accrued by the patient in the forms of lowered self-esteem, unhealthy adherence to unrealistic diet plans, exercise addiction, disconnect with their own bodies. Irony again: these problems can be linked to being large as well. Apparently dieting won't fix them.

The Health At Every Size (HAES) movement is the response to the destructive beliefs of the obesity/diet dyad. HAES reminds us that those costs accrued by the patient may be too high, or just as harmful in the opposite direction. In recognizing the correlations between obesity and dieting, and in reminding us that being thin does not guarantee one is healthy any more than being large guarantees ill health, HAES offers tremendous help. However, as with any social paradigm shift, the pendulum can swing to both extremes before it comes to rest in the middle. In their fight against fat prejudice, HAES believers can be as zealous and rigid as obesity critics.

Can you identify aspects of the purist, all-or-nothing mindset in yourself? What is your enemy, obesity or fat prejudice? If you are a practitioner or educator, your clients or the people you work with do not require nutritional or HAES purity from you; they need you to recognize that each of them is on his/her own path, to accept the reality of that person's path, and to meet him/her on it, gently helping guide and shape their journey to a healthier, happier place. The counsellor is not the judge of the client's shortcomings, but the pragmatic acceptor of the client's truth, even if you don't initially agree with it. Judging and condemning such people will not help you to help them. If you do not take a pragmatic, accepting approach, whatever your personal philosophy, you will lose the client, and will have failed in your goal to help.

Given what we now understand about the obesity/diet dyad, then ideally you are helping your clients go through a process, as in the HUGS program, to convince

them to stop self-defeating dieting, learn to love and accept themselves as they are, and to learn how to have a healthy relationship with food again, as well as to live a healthier, happier life. This process can help people gain improved physical and mental health, and quality of life. Diet thinking means perfectionist, all-or-nothing negative mindsets and beliefs, and one of the best ways to help your client is to replace those beliefs with something realistic and positive for their lives. Chronic dieters who come to HUGS for help are people used to living by rules arbitrarily assigned to them by the latest diet plan. They do not know how to govern their own lives to make their own decisions around issues of food and physical health. The facilitator seeks to get them off the false rules and to learn to take responsibility for their own choices.

Practitioners and educators should ask themselves: what is your personal goal for your clients or the people you work with? What do you think they need from you? What do they HAVE to do to succeed? If they HAVE to do anything, then they are being led into perfectionist, diet thinking again; and, by the way, how do you measure success? It may be difficult for dietitians in particular to avoid automatically talking about numbers of daily servings, and serving sizes, and measuring salt, fat and sugar content in everything the client eats. All of this is in aid of endorsing a healthy, balanced diet; but of course, it's still a DIET – this approach is putting the client right back on a “plan,” and missing the point of HAES altogether.

Health behavior change cannot be achieved by imposing your own rigid set of beliefs on others. You have to know what their beliefs and goals are, what their concerns are within the realities of their own lives: you need to understand “where they are coming from.” If you don't, they likely will not take your message onboard themselves, and you will fail to help them. This is true at the community health promotion level, as well as for individuals.

For example, the perennially popular public health initiative: the stop-smoking campaign. Everyone knows that smoking is bad for you, that it can cause cancer and kill. In countries with universal healthcare, treating smoking-related cancer is a public expense as well as a personal tragedy. A sensible solution, therefore, is to get people to stop smoking. Demographic reality: rates of smoking are very high among the homeless population. Follow the logic, however, of designing a public health intervention to encourage homeless people to stop smoking. Explaining to a panhandler who lives on a sidewalk grate, and who may freeze to death tomorrow night if he doesn't get assaulted for his shoes, that his smoking is the real hazard, is entirely useless. Given the lifestyle described, smoking is the least of his worries and probably the only pleasurable thing he does all day. This person's values and list of needs more likely begin with personal safety and shelter; concern for negative health behaviors is right at the bottom of the list, if it is there at all. There is no way an appeal to stop smoking will reach this individual until his other needs are met.

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By the same token, as a practitioner or educator, approaching others with purist enthusiasm for your personal philosophy and ignoring an individual's list of needs will also get you nowhere.

Case study: A recent reality television show – aimed at helping large individuals lose weight and improve their health and lives by assigning a team of professionals to help them in areas of food, exercise, and self esteem – featured a client who was an obese chronic dieter and binger. Very unhappy with herself and her home life, she was addicted to bingeing on convenience and prepared foods, and convinced that carbohydrates were the enemy. This is, of course, anathema to a dietician. The nutritionist assigned to help, rather than accepting the reality of the client's situation and misguided beliefs, and trying to gently guide her to a healthier "place," took an inflexible, rule-bound approach, imposing a great number of behavioral changes on the client all at once, requiring her to eat according to new "healthy" rules, and to give up coffee, among other things.

The result after a couple of weeks was a slightly hysterical client suffering from headaches, insomnia and constant hunger, as well as panic at being forced to eat more carbohydrates than she was comfortable with, as she truly, deeply feared carbohydrates as a food group. In fact, she stated her firm belief that carbohydrates were not necessary at all, refusing even to eat carrots as they were "high in carbs." The client was convinced she could not follow the nutritionist's plan, and worried she would fail. When she sat down to discuss her fears and concerns with the nutritionist, the practitioner was adamant that her plan be followed, that there was no room for flexibility based on the client's reality. What she said to the client was "I can't work with you if you continue to stand in your own way." This touchy-feely New Age language is in fact passive-aggressive code for "I won't work with you if you don't follow my rules." The nutritionist then refused to continue with the client, got up and walked away, leaving the client alone on camera in floods of tears.

This case study clearly illustrates the problems of rigid, purist approaches, and the futility of trying to effect health behavior change by imposition of beliefs and rules. The client's weight issue was caused to a great extent by being on diet plans, but the practitioner attempted to impose yet another plan (even if it was supposed to be healthier and based on the food groups, etc). The client learned nothing about herself from this; further, it was a plan the client could not comfortably follow. The practitioner did not acknowledge or deal with the client's personal issues and wants. Finally, the plan imposed too many changes on the client at once, completely disrupting the life she was comfortable with. This is the ultimate irony: the client has been repeatedly set up to fail by years of false diet plans, and then is set up to fail by the person to whom she turned as her last hope for help, and then is abandoned by this person when she inevitably does

fail. The client is left feeling like a complete failure again, and the practitioner has failed to help her.

At the other end of the pendulum swing, HAES practitioners may have difficulty in supporting clients who have beliefs that counter the HAES philosophy. Case example: a client who is clinically obese approaches a HAES-oriented practitioner for help with self-acceptance, but is also seriously considering some form of diet, or, more drastically, surgery to “fix” her weight problem more quickly. This person may be honestly unhappy with her appearance as a large person; and, given the cultural issues surrounding obesity and the social disadvantages that can attach to it, this unhappiness has a legitimate basis. Unfortunately, surgical intervention is gaining wider acceptance as a “solution” to weight issues. This is, of course, a social problem that the HAES movement seeks to address; but taking a pure HAES stance with the client, refusing to discuss the existence of surgery as an option, and ignoring her very real dissatisfaction with herself, will not help you to help her. She will willingly move on to a practitioner who will support her choice for a rigid diet or weight loss surgery.

Purists think you should tell people that weight loss isn't important, but this is how you lose people: they won't listen and they are gone. In another example, while being large does not mean one is not healthy, an individual may believe that some measurable health problems, such as diabetes or hypertension, could be ameliorated by weight loss. A counsellor who ignores these health concerns and adheres inflexibly to HAES philosophy will not reach this client either, and is more likely to lose him to someone (like his doctor) who will put him on a diet plan. The greatest help you can give such clients is to take an accepting approach, which will allow you the time to work with them and to gradually educate them on a healthier life-view and wean them away from harmful beliefs and behaviors.

Change can only come successfully one step at a time, and small steps at that. (In HUGS these are called “baby steps.”) You cannot simply order clients to stop being influenced by false social values surrounding beauty and self-worth. You cannot tell them to stop drinking coffee, start a new exercise program and completely change their eating habits all at once. This sets them up to fail again.

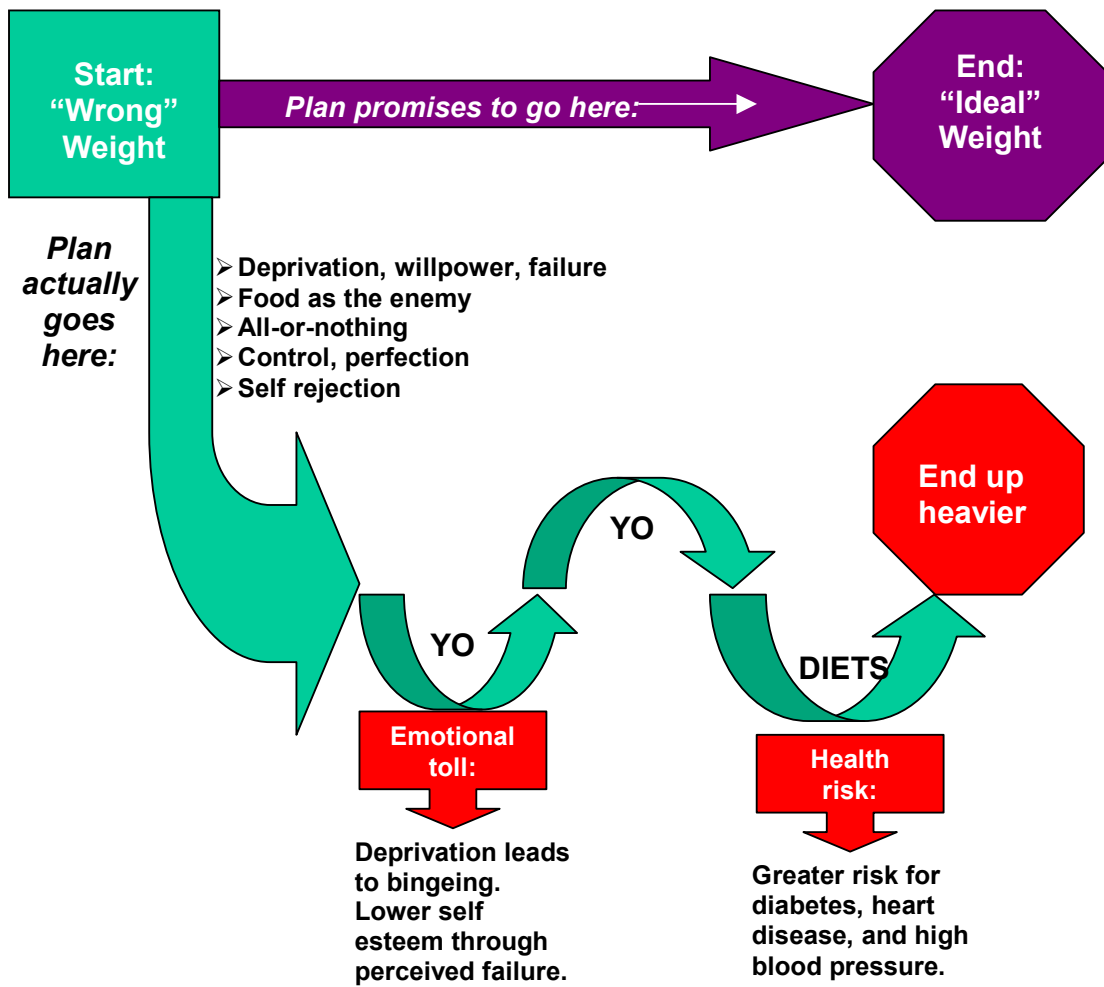
As you lead people through their individual journeys, be open to what the process also teaches you about your own beliefs, and about issues such as perfectionism, control and acceptance.

Remember that pendulum swing? An effective approach rests in the middle.

Diet Approach to Weight Management

Diet Program (restrictive eating)

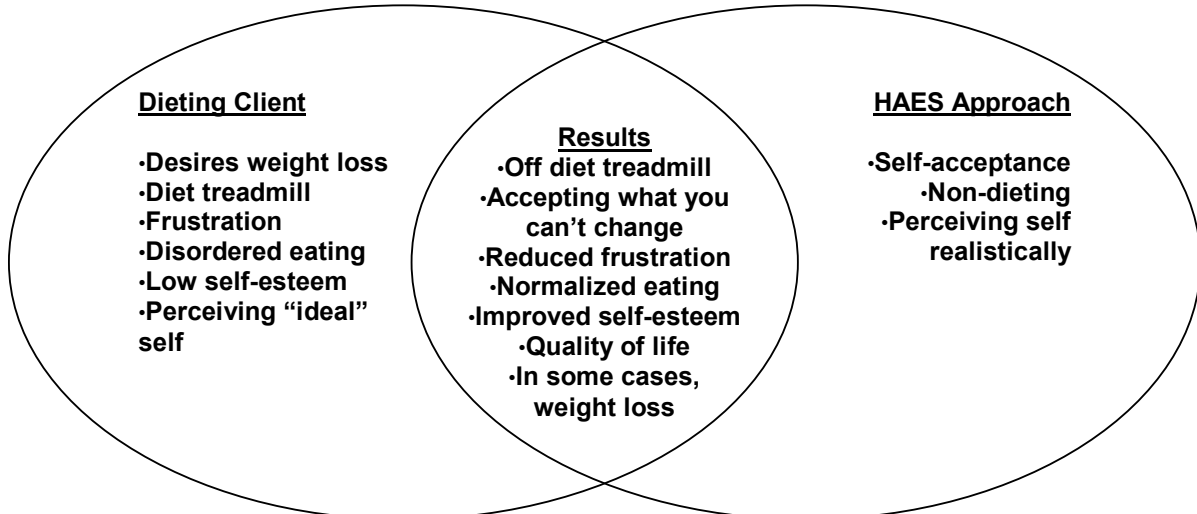
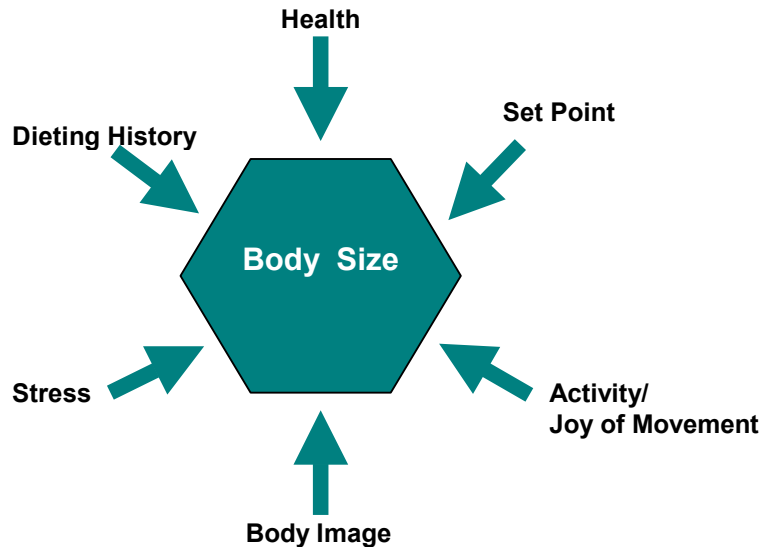
ie. Weight Watchers



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Health at Every Size Approach to Weight Management

A HAES approach, such as HUGS, changes the perception of one's body weight to what it is naturally meant to be, exploring all the issues that influence body size.



The above diagram illustrates how a dieting client (in left column) and the HAES approach (at right) combine together (in center) to help the client develop a healthier lifestyle and improved quality of life. The results show what the client and a HAES approach can build together.

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