

# INTEGRATING HAES ® PRACTICE INTO MEDICAL NUTRITION THERAPY

Fiona Willer, Accredited Practising Dietitian (Australia)  
[www.healthnotdiets.com](http://www.healthnotdiets.com)

# Learning outcomes for today

- 1. Identify areas for systems integrated HAES advocacy in clinical dietetics settings.
- 2. Recognize weight bias in the mainstream use of PESS statements and IDNT and begin to shift perspective towards weight-inclusive language.
- 3. Use practice principles of the non-diet approach to re-interpret the evidence we have for the application of medical nutrition therapy.

The Health at Every Size ® philosophy has been operationalized for the practice of dietetics (called the non-diet approach) and the tenants are available in the literature and in various books (including mine).

Learning how to take a non-diet approach can, and should, take time.

- Do I have to modify MNT?
- What do I do with my client?
- What do I say/write to the referrer?
- What do I say to my boss?
- What do I write in my notes?
- What do I say to my colleagues?

Integrating  
HAES

# Do I have to modify medical nutrition therapy?

**All conditions\* can be addressed using a non-diet approach because it is a practice framework, not a specific diet.**

Some examples:

- Heart disease and dyslipidemias
  - Encourage variety in oils, variety in fruit and vegetables, new recipes, eating to body cues
- Type 2 diabetes
  - As above plus encouraging mixed meals to ensure low/mod blood glucose response

\*more about the very unwell coming up

# What about the very ill?

- Where appetite or taste acuity is affected, either biochemically or psychologically (eg, cancer cachexia, malnutrition, anorexia nervosa) modify advice but maintain weight neutral position, the moral neutrality of food, and respect and accept their body in it's current state.
- Encouraging someone to meet or exceed protein and energy requirements in order to restore biological function is part of honoring the body. Encouraging malnourishment (body weight loss) is not.
- Foster gratitude: even when faced with extreme illness the body is doing it's best to survive.

# Interpreting evidence

- Remember that behind the term 'weight loss' in research papers is actually 'dietitian or medically designed diet and regular moderate physical activity'.
- Research diets that vary too far from established nutritional adequacy have a more difficult time getting through ethics boards, peer review, and appearing in meta-analyses.
- It can be expected that increasing the dietary quality (ie variety and enjoyment) and moving the body more will achieve improvement in illness outcomes or surrogate markers of risk in some people.



- While research findings are sometimes compelling, keep in mind the incredible drop out rates in weight loss studies and the huge variation in weight change results between individuals.
- Even if improved outcomes happen as a result of weight loss in some people we have no reliable, long term, risk free way of getting this to happen. People who lose weight with the help of a dietitian go on to gain it back, just the same as everyone else.
- By the same token, overstating HAES research is also problematic so being honest about the strengths and limitations of research and taking an openly curious approach with the individual in front of you is the best bet.



# So what do I do with my client?

- Use Nutrition Care Process (more later)
- Use assessment tools that explore behavior and attitudes towards eating, food and body shape/body image
  - Eg Intuitive Eating Scale 2, Body Image Avoidance Questionnaire, Dutch Eating Behavior Questionnaire
- Assess diet quality and explore likes/dislikes and eating pattern
- Discuss diet-disease relationship

Ask yourself

**What would I do if they had a  
BMI of 22?**

Narrow diet →

Meal plan?

**Broad diet**

Mobility problems →

Weight loss?

**Physical Therapist**

Difficulty w/ physical activity →

**Exercise Physiologist**

Problematic eating patterns →

**Explore drivers**

High cholesterol levels →

Meal  
weig

**PUFA/MUFA fat mod**

High blood sugar levels →

Meal  
weig

**PA, low GI, mod GL**

Fatigue/sleeping problems →

**Sleep assessment**

- Stay neutral, non-judgemental, curious
  - The non-diet approach allows consumption of ALL foods without judgment so your comments need to be consistent with the approach
- Gain consent (may use consent form)
  - If yes, start with building hunger/fullness awareness
  - If no, refer on if uncomfortable with using traditional approach



# 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<sup>1</sup>:** 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<sup>2</sup>:** 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 \_\_\_\_\_

Consent  
form  
example

<sup>1</sup> Tylka, T., Anunziato, R., Burgard, D., Danielsdóttir S., Shuman, E., Davis, C. and R Calogero. (2014) Weight-Inclusive versus Weight-Normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss. *Journal of Obesity* 2014.

- Use evidence based framework –how would you introduce the use of a new HPHE supplement or change to protein requirements for renal patients?
  - ie you would assess the literature, discuss with medical team and client, go ahead and then report to medical team
  - Provide evidence for practice where requested

# So what do I do with the referrer?

- Write back to them to tell them the assessment results and the intervention which has been consented to. Report on progress regularly.
- Do not be apologetic – be professional and firm
  - You are the expert here, you have conducted a thorough assessment and discussed the options with the client and the client has consented to the HAES approach. End of story.
  - Eg “Due to clients maladaptive eating behaviors and over-concern with body shape and weight, treatment will take a non-diet approach.” “The client has given consent for non-diet approach.”
  - Use Nutrition Prescription statement and PESS in the letter as well.
  - Use the terms ‘Health at Every Size’ and ‘non-diet approach’ as much as possible (builds familiarity)
- If referrers are trying to sway your practice this is an interesting insight into inter-professional power dynamics.....
- Try not to explain what it is – write as if the reader should already know
- You may lose some referrers but you’ll keep your integrity



# So what do I say to my boss?

- Offer to give an in-service about HAES and the non-diet approach.
- Provide learning materials
- Discuss when they are interested – build bridges and address the aspects they are worried about
- Be firm that HAES and the non-diet approach is not another way for people to lose weight
  - As soon as weight loss is promoted it is no longer HAES
  - HAES is not anti-weight loss, it is anti-pursuit-of-weight loss (Deb Burgard)
- Affect cultural change in the workplace if possible

# So what do I write in my notes?

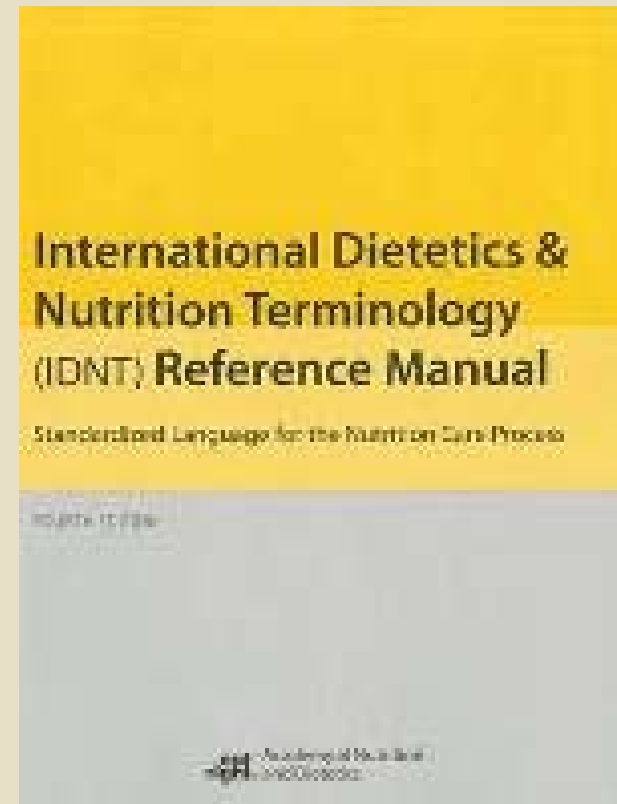
- Assessment results, including tools mentioned earlier
- Formulation of weight-inclusive Nutrition Diagnoses and PESS statements
- Include consent process or form
- Discuss progress in terms of the non-diet approach practice principles
- Mention dietary quality (ie variety) in addition to or instead of quantitative analysis of intake.

# What do I say to my colleagues?

- Be unashamedly pro-HAES (but don't be a jerk).
- See previous points for inspiration.

# Nutrition Care Process

- Nutrition Assessment
- Nutrition Diagnosis
- Nutrition Intervention
- Nutrition Monitoring  
& Evaluation



Academy of Nutrition and Dietetics (2013). International Dietetics and Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process. Chicago.

## Food/Nutrition Related History Domain

- *Food and Nutrient Intake*
- *Food and Nutrient Administration*
- *Medication and Complimentary/Alternative Medicine Use*
- *Knowledge/Beliefs/Attitudes*
- *Behaviour*
- *Factors Affecting Access to Food and Food/Nutrition-Related Supplies*
- *Physical Activity and Function*
- *Nutrition-Related Patient/Client-Centred Measures*

## Anthropometric Measurements

- *Body composition/growth/weight history*

## Biochemical Data, Medical Tests, and Procedures

- *As available and appropriate.*

## Nutrition-Focused Physical Findings

- *Discuss appetite patterns, energy/fatigue levels*

## Client History

- *Personal History*
- *Patient/Client/Family Medical/Health History*
- *Social History*

# Nutrition Assessment

NCP & IDNT

Please see the International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process for full descriptions of these terms, their alphanumeric codes, unique identifier numbers and their appropriate uses.

## **Behavioural-Environmental (NB):**

- *Food- and nutrition-related knowledge deficit*
- *Unsupported beliefs/attitudes about food- or nutrition-related topics*
- *Disordered eating pattern*
- *Undesirable food choices*
- *Physical inactivity*
- *Poor nutrition quality of life*

Intake (NI) and Clinical (NC) domains tend to be less useful for HAES practice as they focus on intake and weight status.

## **Nutrition Diagnoses**

NCP & IDNT

Please see the International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process for full descriptions of these terms, their alphanumeric codes, unique identifier numbers and their appropriate uses.

## Cause/contributing risk factors – some examples

- Pattern of chronic dieting
- Patients desire to regulate weight
- Excessive preoccupation with weight and shape
- Desire to be thin
- Intentional food restriction for weight loss
- Weight regulation/preoccupation significantly influences self-esteem
- Disordered eating pattern
- Excessive energy intake
- Physical inactivity
- Increased psychological/life stress
- Unsupported beliefs/attitudes about food, nutrition, and nutrition-related topics
- Prior exposure to incorrect information, or lack of prior exposure to nutrition-related information
- Disbelief in science-based food and nutrition information
- Eating behaviour serves a purpose other than nourishment
- Lack of value for behaviour change or competing values
- Time constraints
- Poor self-efficacy
- Altered body image

## Possible Etiologies

### NCP & IDNT

Please see the International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process for full descriptions of these terms, their alphanumeric codes, unique identifier numbers and their appropriate uses.



## Defining characteristics – some examples

- History of weight cycling >5kgs x 5
- Restrictive eating
- Failure/inability to respond to body cues of hunger/fullness
- Overeating accompanied by guilt
- Unstable/fluctuating weight
- Inflexibility with food selection
- Frequent episodes of eating past the point of comfortable fullness (>2/wk)
- Eating in private
- Avoidance of food or energy containing beverages
- Fear of foods or dysfunctional thoughts regarding food or food experiences
- Intake of energy in excess of estimated energy needs
- Intake of high caloric density or large portions of foods/beverages
- Uncertainty regarding nutrition-related recommendations
- Large portions of food (portion size more than twice than recommended)
- Avoidance of foods/food groups
- Infrequent, low duration and /or low intensity physical activity
- Frustration over lack of control

## Possible Signs and Symptoms

### NCP & IDNT

Please see the International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process for full descriptions of these terms, their alpha-numeric codes, unique identifier numbers and their appropriate uses.

- Disordered eating pattern *related to* desire to be thin *as evidenced by* inflexibility with food selection, attempts to avoid fat-containing foods, excessive guilt after overeating and fear of weight gain.
- Poor nutrition quality of life *related to* excessive preoccupation with weight and shape *as evidenced by* avoidance of carbohydrate rich foods, daily intake of ‘diet’ pills, fluctuating weight and overeating accompanied by guilt.
- Undesirable food choices *related to* disordered eating pattern *as evidenced by* estimated intake inconsistent with dietary guidelines, food and weight preoccupation and consuming large amounts of food when not feeling physically hungry.

## Sample PESS Statements

Diet paradigm:

- Obesity *related to* excessive energy intake *as evidenced by* recent weight gain of 15kgs over 6 months, intake of high caloric density foods (chocolate and cake), infrequent low intensity physical activity (walks 30 mins 1-2 times/wk)

Non-Diet Paradigm:

- Disordered eating pattern *related to* patients desire to regulate weight *as evidenced by* 20 year history of weight loss dieting and weight cycling >15kgs, Intuitive Eating Scale score of 38 (21-105), eating snack foods in private and strong belief that body weight is paramount to health

Contrasted  
PESS  
Statements

Initial Appt

Diet paradigm:

- Limited Adherence to Nutrition-Related Recommendations *related to* competing health values *as evidenced by* failure to achieve predicted weight loss, verbalised frustration with attempts to apply given meal plan, crying during consultation and recent diet history reflects sporadic attempts to comply with meal plan.

Non-Diet Paradigm:

- Poor nutrition quality of life *related to* altered body image *as evidenced by* frustration over lack of control of body shape, concerns about previous attempts to change eating behaviour and lack of familial support for non-diet approach.

Contrasted  
PESS  
Statements

Review Appt

# Use non-diet approach strategies\*

## Food and/or Nutrient Delivery Domain

- Meals and Snacks
  - Normalising Eating
  - Dealing with Buzz Foods
  - Increasing Food Variety
  - Self-Care Through Meal Planning
- Feeding Environment
  - Mindful Eating
  - Reducing Superfluous Eating

## Nutrition Education Domain

- Nutrition Education – Content
    - Discuss non-diet approach paradigm, rationale and concepts
  - Nutrition Education – Application
    - All of the strategies and guidebook worksheets are designed to fall into this category
- \* examples given (in blue) are from my book

## Nutrition Intervention strategies

Please see the International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process for full descriptions of these terms, their alphanumeric codes, unique identifier numbers and their appropriate uses.

# Non-diet approach strategies – continued

## Nutrition Counselling Domain

- Theoretical Basis/Approach
  - You may design and implement your intervention with the non-diet approach using a number of theoretical models.
    - Eg Cognitive Behavioural Theory, 'Conscious Competence' learning model
- Strategies
  - You may apply counselling strategies based on individual patient goals and your personal counselling philosophy and skill.
    - Eg Appropriate styles for the non-diet approach: Motivational Interviewing, Acceptance and Commitment Therapy (ACT), Self-Monitoring (appetite management only), Stimulus Control, Cognitive Restructuring

## Coordination of Care Domain

- Collaboration and Referral of Nutrition Care
  - Referral to other services or health professionals as appropriate

## Nutrition Intervention (continued)

Please see the International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process for full descriptions of these terms, their alphanumeric codes, unique identifier numbers and their appropriate uses.

Diet paradigm:

- **FOOD AND/OR NUTRIENT DELIVERY:** Energy reduced diet (meals and snacks)
- **NUTRITION EDUCATION:** AGHE/Healthy Eating Plate food groups (content) and AGHE serve sizes and eating frequency (application).
- **NUTRITION COUNSELLING:** *Transtheoretical Model*- preparation stage (theoretical basis) and *self monitoring* (strategy) food and activity diary and *stimulus control* (strategy) remove high sugar/high fat foods from the house.

Non-Diet Paradigm:

- **FOOD AND/OR NUTRIENT DELIVERY:** General/healthful diet
- **NUTRITION EDUCATION:** non diet approach paradigm (content) and hunger-fullness scale use (application).
- **NUTRITION COUNSELLING:** *Social Learning Theory*- expectations (theoretical basis) and *cognitive restructuring* (strategy) decenter by envisioning other perspectives and decatastrophise expected outcomes.

## Contrasted Nutrition Interventions

Please see the International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process for full descriptions of these terms, their alphanumeric codes, unique identifier numbers and their appropriate uses.



Diet paradigm:

- Recommended modified diet: energy modification. Energy intake goal of 5000 kJ/day as per AGHE recommendations for 55yr old female, no discretionary choices allowed, to elicit 0.5-1kg weight loss per week.

Non-Diet Paradigm:

- Recommended regular diet: general/healthful diet, as per non-diet approach.

Contrasted  
Nutrition  
Prescriptions

- Use terms identified in your Nutrition Assessment to guide your monitoring and evaluation
- Remember non-diet approach goals
  - Eg Fewer episodes of uncomfortable hunger/fullness, increased food variety/flexibility, decreased guilt associated with eating
- Once client has reached conscious competence in one element, add in another depending on client need
  - Don't focus on too much at once as it can be overwhelming!
- Usually takes ~6-12 months for clients to work through and internalise these skills
- Reviews as directed by client progress, usually every 2-4 weeks
- Discharge once competent with the non-diet approach principles and are calm and comfortable with the majority of their food choices
  - Stress that they are welcome to come back if they need support again as it is normal to be 'diet vulnerable' from time to time

## Monitoring and Evaluation

## Weight concerned client with type 2 diabetes

### PESS statement

Undesirable food choices *related to* prior exposure to incorrect information *as evidenced by* reported avoidance of CHO containing foods, overconcern with body shape, eating past the point of comfortable fullness (including CHO) > 2 x week, hypercholesterolemia, BSL range 4-10 mmol/l (dx DM2 2012), IES score of 32 (21-105).

### Nutrition Prescription

- Recommended regular diet: general/healthful diet, as per non-diet approach.

### Nutrition Intervention

- Consent for HAES approach given
- Non-diet approach taken

### Nutrition Monitoring and Evaluation

- Dietary quality, IES results, BSLs

### Reporting

- Letter to client's primary health care provider
- Case notes detailing non-diet approach principles covered as well as any assessment tool results (IES etc)

Putting it  
together



THANK YOU FOR  
LETTING ME SHARE  
THIS WITH YOU!

Questions?