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Guidelines for
Nutritionists & Dietitians

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NAAFA GUIDELINES FOR NUTRITIONISTS AND DIETITIANS

The Purpose of These Guidelines

NAAFA has partnered with experts in nutrition and dietetics to create an educational tool to increase awareness of an evidence-based and weight neutral approach to sustaining or improving nutritional wellbeing. Nutritionists and registered dietitians have a unique opportunity to enhance their ability to work with all clients regardless of size, and to eradicate size discrimination and weight bias. Please note that the word fat used in this document is used as a description and not as a judgment of character or physicality.

What is Size Discrimination & Weight Bias?

According to the Council of Size and Weight Discrimination, size and weight discrimination are defined as unfair difference in treatment made between people due to size or weight. It is based on prejudice, which is defined as preconceived opinion or judgment without just grounds or sufficient knowledge.

The Center for Disease Control and Prevention defines weight bias as the inclination to form unreasonable judgments based on a person's weight. Stigma is the social sign that is carried by a person who is a victim of prejudice and weight bias. The burden of discrimination, bias and stigma can reduce the quality of life and negatively impact a person's overall well being.

Societal Implications

The prevalence of weight-based discrimination has increased over the past two decades (Andreyeva, Puhl, and Brownell, 2008). The societal implications of discrimination and bias can negatively permeate the workplace, academic environments, health care settings (Rudd report, Weight Bias: A Social Justice Issue, 2012) and the fields of nutrition and dietetics (Swift et al 2012).

WORKPLACE. In a 2006 Rudd Center report, of 2400 fat people, 54% experienced weight stigma by co-workers and 43% experienced weight bias from employers and supervisors. Fat people are denied hiring and promotional opportunities (Puhl et al, 2008) and earned an average of 1-6% less than thinner peers. (Baum et al, 2004).

ACADEMIA. In academic environments, educators perceive fat students as unkempt, overly emotional and less likely to succeed (Neumark-Sztainer, 1999). Research as far back as 1966 indicated that fat students were less likely to be accepted for admission into college, despite having comparable academic performance (Canning et al). Four decades later studies still indicate that teachers have lower expectations for fat students compared to thinner peers (O'Brien et al, 2007).

HEALTH CARE. A pivotal study of 400 health care providers reported that one out of three ranked obesity as a condition that generates a negative reaction (Klein et al, 1982). They ranked obesity only behind drug addiction, alcoholism and mental illness. In the same study, health care providers associated fat patients with traits of non-compliance, dishonesty and having inadequate hygiene. This negative response to being fat was manifested again in the American Medical Association's 2013 decision labeling obesity as a disease, despite the recommendation from its own scientific advisory committee.

These less than positive perceptions could explain why fat people delay seeking health care and therefore have less than ideal health care outcomes. In fact, a survey conducted of over 500 fat women reported delayed health screenings. In addition, these women perceived their weight as a barrier to obtaining appropriate health care (Amy et al, 2006).

NUTRITION AND DIETETICS. Dietitians and dietetic students have been found to have negative attitudes towards "obese" people (Campbell & Crawford, 2000; Harvey, Summerbell, Kirk & Hill, 2002; Berryman, Dubale, Manchester & Mittelstaedt, 2006; Puhl, Wharton, Heuer, 2009). More needs to be done to educate dietitians and dietetic students about the genetic and sociocultural contributors to weight, the negative outcomes of weight-focused interventions, and the harm of stigmatization when providing care to people of size.

Negative Effects of Size Discrimination

Fat clients are often seen as having a health condition by virtue of their size alone and are then blamed for their 'condition' and viewed as lazy or gluttonous. Stigmatization and shaming are never good motivators for behavior change. In fact, stigmatizing fat individuals may actually decrease their motivation to improve nutrition and activity patterns (Myers and Rosen 1999; Puhl and Brownell 2006; Vartanian and Shaprow 2008; Vartanian and Novak 2011).

Other negative implications such as an increase in eating disorders (Haines, Neumark-Sztainer, Eisenberg & Hannan, 2006), bullying (Latner & Stunkard, 2003) and depression (Eisenberg, Neumark-Sztainer & Story, 2003) have also been associated with size discrimination and bias.

DIETING. In an effort to avoid the negative effects of size discrimination, people of all shapes and sizes turn to dieting. Interventions aimed at losing weight are often ineffective long term and can be physiologically and psychologically damaging (Bacon et al., 2002; Bacon, Stern, Van Loan, & Keim, 2005; Mann et al., 2007; Steinhardt, Bezner, & Adams, 1999; Ackard et al., 2002; Tomiyama, Ahlstrom, Mann, 2013).

Health care professionals often promote weight loss in the name of health, claiming that doing so will improve biochemical measures such as blood lipids, blood sugar, and blood pressure. However, these results are highly elusive long term, and it is well established that weight loss is not necessary to improve cardiovascular health (Gaesser, 2007; Gaesser, Angadi & Sawyer, 2011; Bacon et al., 2002; Bacon et al., 2005). Moreover, cardiorespiratory fitness is a more important predictor of cardiovascular mortality than weight and body composition (Lee, Blair, & Jackson, 1999).

Dieting is not only ineffective, but may lead to disordered eating patterns (Neumark-Sztainer, Wall, Larson, Eisenberg, Loth, 2011). Therefore, health programming aimed specifically at weight management may not be the best approach for lifelong disease prevention. In addition, an ethical argument can be made for programs that are non-judgmental and non-stigmatizing, and the public seems to prefer programs that promote lifestyle changes instead of weight loss (Thomas, Lewis, Hyde, Castle, & Komesaroff, 2010).

OPPRESSION. Focusing on weight and providing simplistic messages such as "eat less, exercise more" are certainly easier than acknowledging the underlying causes of income and health inequality in our society. Yet social determinants of health are rooted in systemic privilege and oppression and will not be addressed as long as we're distracted by prejudicial beliefs that fat individuals are necessarily unhealthy, and that individuals alone have the power to change their weight or health. This "personal responsibility" approach negates the substantial role that genes, the built environment and neurophysiology play in determining our weight (Bacon, 2010a), as well as the barriers to eating well that current food policy imposes, especially among persons with low-income.

A Weight Neutral Paradigm for Wellness

There is new evidence that Health at Every Size® (HAES®) programming may be more effective for promoting permanent dietary and physical activity behavior change than traditional weight-centered approaches (Bacon et al., 2002; Bacon et al., 2005; Provencher et al., 2007; Provencher et al., 2009; Robinson, Putnam & McKibbin, 2007; Steinhardt et al., 1999; Bacon and Aphramor, 2011; Schaefer and Magnuson, 2014). HAES approaches include dietary and physical activity recommendations that do not emphasize reaching a calorie restricted state and weight loss. Instead, HAES based interventions promote making healthful behavior changes that result in improved fitness and health regardless of weight status. Unlike dieting, HAES interventions are not associated with adverse effects.

The Health At Every Size® Principles are:

- **Weight Inclusivity:** Accept and respect the inherent diversity of body shapes and sizes and reject the idealizing or pathologizing of specific weights.
- **Recognizing 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.
- **Respectful Care:** Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socio-economic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.
- **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
- **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.

The Application of the Health at Every Size Paradigm in Nutrition and Dietetics

THE SCALE. The Health at Every Size paradigm is weight neutral. Therefore, a HAES nutrition expert discourages weighing as a method for tracking changes in health. Instead, the focus is on fostering compassionate self-care. This in turn supports the adoption of positive dietary and physical activity changes. The body will find its natural, genetically-determined weight and shape over time as one develops healthy habits.

MEASURING PORTIONS AND COUNTING CALORIES. HAES nutritionists and dietitians discourage clients from counting calories or measuring and weighing foods. Instead, clients are taught to regulate dietary intake based on internal cues such as hunger, fullness, and cravings. Research supports that individuals who eat intuitively are less likely to binge eat, have lower triglycerides, and higher HDL cholesterol than those who eat based on external cues (Polivy and Herman, 1999; Tylka, 2006; Dockendroff et al, 2012; Hawks S, Madanat H, Hawks J, Harris A., 2005).

MINDFULNESS WITH EATING. Nutrition experts who promote the HAES paradigm encourage clients to practice intuitive or mindful eating (Hammond, 2007; Mathieu J, 2009). Mindfulness allows the client to attend to body cues and how the body responds to certain foods. Mindful eating includes both the awareness of the pleasure and enjoyment of the eating experience while also attending to the physiologic responses to eating such as blood sugar, energy levels, bowel comfort, hunger and fullness cues.

MEDICAL NUTRITION THERAPY. HAES dietitians who counsel individuals in need of certain dietary restrictions to manage disease can still utilize the principles of mindful eating. For example, a client with celiac disease needs to avoid all foods containing gluten, despite cravings. A HAES dietitian can help the client navigate the grocery store to find gluten-free food items with similar tastes and textures. In addition, the HAES dietitian can promote a healthy relationship with food by supporting clients to explore internal cues and emotional responses to the necessary restriction.

There may be times when a client cannot rely on hunger and fullness cues to guide meal timing and quantity due to effects of medications or surgical procedures on satiety. Disordered eating patterns can also interfere with one's ability to rely on hunger and fullness cues. HAES dietitians can still work with these clients to explore other internal and external cues that can assist them in creating a satisfying eating experience.

Dietitians are often included as a member of the health care team in a bariatric clinic. In this setting a HAES dietitian would inform the patient of the risks involved and alternatives to surgery. Regardless of the patient's decision, the practitioner can tailor interventions to include developing mindfulness with eating, pleasurable activity and body acceptance.

JOYFUL MOVEMENT. HAES nutrition experts who also provide counseling on physical activity encourage clients to find enjoyable ways to be active and to attend to the intrinsic benefits of physical activity (mood enhancement, improved sleep patterns, increased energy, fun) instead of the extrinsic benefits of physical activity (weight loss). Research supports that individuals who are tuned in to the intrinsic benefits of physical activity are more likely to remain active long term (Newburg, Kimiecik, Durand-Bush & Doell, 2002).

CHILDREN AND WEIGHT. Nutritionists and dietitians can apply the HAES paradigm when providing education and counseling to parents and children. Babies naturally use internal cues to signal parents when they are hungry and when they've had enough. Parents can encourage their children to recognize, respect and respond to these innate cues. HAES nutritionists and dietitians encourage parents to allow the child to determine how much they eat at each feeding without pressure to eat certain foods or amounts (Satter, 1986). When provided with regular, satisfying meals and snacks children typically eat the right amount for their bodies (Johnson & Krebs, 2009; Eneli, Crum & Tylka, 2008). Variations in growth patterns among children are normal, and it's important to educate parents on body acceptance and genetic variation of shapes and sizes.

The Evidence and Ethics in Nutrition and Dietetics Practice

Given the high long-term failure rate of diets, it is unethical to continue prescribing what we know does not work (Mann et al., 2007; Bacon & Aphramor, 2011). The Code of Ethics for the Profession of Dietetics stipulates that practitioners use evidence-based principles. In addition, the code prohibits discrimination (American Dietetic Association, 2009).

Dietetic and nutrition educators, practitioners, and students must therefore examine the systems of privilege and potential conflicts of interest that influence the research agenda and public health nutrition policy in our country. For example, commodity subsidies included in the Farm Bill contribute to the plethora of nutrient poor food choices available today and influence dietary recommendations (Dietary Guidelines for Americans and MyPlate; USDA, 2012). In addition, weight-based research is often funded by the multi billion dollar diet industry.

A history of institutionalized oppression in the U.S. has led to movements advocating for civil rights for marginalized groups so that all may be supported in maximizing their potential regardless of race, class, gender, sexuality, or religion. Because of the interrelated and systemic nature of all oppressions, HAES nutritionists and dietitians believe it is time to add size to this list. It is in the public's best interest to begin shifting the focus from weight to health while also acknowledging the role of social justice in personal and community well being.

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ADDITIONAL RESOURCES

Organizations

Association for Size Diversity and Health https://www.sizediversityandhealth.org/
NAAFA https://naafa.org/
Critical Dietetics https://criticaldietetics.org/

Websites:

HAES Community https://haescommunity.com/

Project Implicit. https://implicit.harvard.edu/implicit/

Books

Big Fat Lies: The Truth About Your Weight and Your Health, Glenn A. Gaesser, PhD

Health At Every Size: The Surprising Truth About Your Weight, Linda Bacon, PhD

Talking Fat Health vs. Persuasion in the War on Our Bodies, Lonie McMichael, PhD

What's Wrong With Fat, Abgail Saguy, PhD

Additional NAAFA Guidelines

Guidelines for Fitness Professionals who serve fat clients

Guidelines for Health Care Professionals who treat fat patients

Guidelines for Therapists who treat fat clients who serve fat clients

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