

Is The “Health at Every Size” Approach Useful for Addressing Obesity?

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Obesity has been frequently referred to as a global epidemic and recently was called a “pandemic defining the largest public health challenge of the 21st century” [1]. Overweight and obesity rates have been estimated at 1.6 billion adults overweight and 400 million as obese. Meanwhile 155 million school-aged children are overweight or obese [1,2]. Being overweight or obese has been associated with a myriad of health consequences (e.g., type 2 diabetes, cardiovascular disease risk) [3].

In order to address this health concern, interventions have traditionally promoted consuming less dietary energy and expending more calories through physical activity with the direct goal to lose body weight [4]. Unfortunately traditional approaches can enforce overly restrictive eating plans and rigorous physical activity designed for immediate weight loss rather than developing healthy lifestyle habits. Moreover, the risk for promoting an unsustainable short-term solution (i.e., restrictive eating and intense exercise) carries the potential risk of contributing to a chronic dieting mentality, intense body dissatisfaction, reduced self-esteem, weight stigmatization and disordered eating [5,6]. Although the perceived benefits of diet and exercise programming designed with a weight goal as the primary marker of success are touted, in fact, 95% of people regain weight lost within 3 to 5 years [7]. A proposed alternative to a traditional, weight-based approach for addressing obesity is the Health at Every Size[®] (HAES) paradigm that focuses on promoting health-related behaviors to all individuals [8].

What is the health at every size approach?

The Health at Every Size (HAES) approach represents a growing trans-disciplinary movement that attempts to shift the focus from body weight to broader health by promoting healthy behaviors for individuals of all sizes. While the HAES[®] model resonates with many leaders in the eating disorder field, which see the harms of focusing too intently on weight and size, this approach has been slower to be adopted by obesity prevention researchers who consistently opt to include BMI as an outcome variable for measuring the success of interventions [5]. By contrast, the HAES approach focuses on promoting emotional, physical and spiritual well-being as well as an intuitive eating (i.e., listening to hunger and fullness cues for eating). Physical activity, particularly with an enjoyment motivation is encouraged. Furthermore, self-acceptance is encouraged in society and individually, as diversity of body shapes and sizes is celebrated [9]. Finally, the HAES movement works to eliminate weight stigmatization, discrimination and bias by fighting sizeism in society [10].

What are the criticisms against the HAES approach?

Critics of the HAES model argue that the association between obesity and chronic disease precludes people from being healthy at any size, particularly in the case of “extreme” obesity [11]. Some critics argue that promoting the HAES approach will lead to overeating and additional weight gain [12]. Additionally these critics often demand to see more evidence for the efficacy of the HAES approach [13,9] despite the fact that the success rate of traditional weight loss approaches is extremely low [14].

What are the arguments for the HAES approach?

HAES researchers argue that although there is an association between obesity and chronic disease, this relationship does not prove

causality. Furthermore, confounding factors (e.g., fitness, nutrition quality, socioeconomic status) are rarely considered when analyzing the relationship between weight and disease [15]. When studies describe improved health parameters following weight loss, it is more likely that the adoption of healthier behaviors is responsible for improvements in health than the weight loss itself [5]. Since long-term maintenance of weight loss has limited “success” [9], and of the pursuit of weight loss is associated with weight cycling [5] and cumulative weight gain [16], focusing on health behaviors rather than body size is important. Additionally, HAES researchers reason that since genetics result in a diversity of sizes [17,18], it is unethical to expect everyone to conform to a narrowly defined “ideal weight.”

Studies of the non-diet approach support using the HAES model in health promotion programming. A particularly noteworthy randomized clinical trial compared the effects of a HAES program and a traditional weight loss program on obese, female chronic dieters [19]. The weight loss group was instructed in eating behaviors (e.g., calorie restriction), nutrition, exercise, and social support. The HAES group was instructed in enhancing body-acceptance, eating behavior (recognizing internal cues of hunger and satiety), physical activity (for enjoyment), nutrition, and social support. A two-year follow-up of this study [20] found that participants in the HAES group had maintained their weight and sustained improvements in physiological measures (e.g., cholesterol, blood pressure), physical activity levels, depression, and self-esteem. The participants in the weight loss group did not experience any of these long-term improvements. Other studies of the non-diet approach have found similar outcomes, including improvements in physiological measures and physical activity [21], eating behaviors [22], self-esteem and depression [23].

Implications for health education

Given the body of evidence to support the efficacy of the HAES approach for improving health, the authors believe that this approach should be adopted as a mainstream “best practices” paradigm to promote health across individuals. This positive approach of helping individuals develop a healthier relationship with food, exercise and themselves will lead to greater self-acceptance, less size-related discrimination and decreased harmful behaviors (e.g., weight cycling, binge eating). Furthermore, this approach shows promise for helping children and adolescents, who are at risk for eating disorders and bullying to build self-esteem and healthy lifestyles. Although terms like obesity epidemic and obesity prevention are widely recognizable, health educators should avoid falling into the trap of narrowly focusing on

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disease prevention rather than using holistic positive health strategies to promote health and overall well-being.

Note: The authors acknowledge that "Health at Every Size" approach is a registered trademark of the Association for Size Diversity and Health.

References

1. Kraak VI, Story M (2010) A public health perspective on healthy lifestyles and public-private partnerships for global childhood obesity prevention. *J Am Diet Assoc* 110: 192-200.
2. Lobstein T, Baur L, Uauy R (2004) Obesity in children and young people: A crisis in public health. *Obes Rev* 5: 4-104.
3. Murtagh L, Ludwig DS (2011) State intervention in life-threatening childhood obesity. *JAM* 306: 206-207.
4. Aphramor L (2010) Validity of claims made in weight management research: A narrative review of dietetic articles. *Nutr J* 9: 30.
5. Bacon L, Aphramor L (2011) Weight science: Evaluating the evidence for a paradigm shift. *Nutr J* 10: 9.
6. Brown LB (2009) Teaching the "health at every size" paradigm benefits future fitness and health professionals. *J Nutr Educ Behav* 41: 144-145.
7. Ikeda J, Amy NK, Ernsberger P, Gaesser GA, Berg FM, et al. (2005) The national weight control registry: A critique. *J Nutr Educ Behav* 37: 203-205.
8. Miller WC (2005) The weight-loss-at-any-cost environment: How to thrive with a health-centered focus. *J Nutr Educ Behav* 37: S89-S94.
9. King C (2007) Health at Every Size Approach to health management. *Topics of Clinical Nutrition* 22: 272-285.
10. Provencher V, Begin C, Tremblay A, Mongeau L, Boivin S, et al. (2007) Short-term effects of a "Health-At-Every-Size" Approach on eating behaviors and appetite ratings. *Obesity (Silver Spring)* 15: 957-966.
11. Hensrud DD, Klein S (2006) Extreme obesity: A new medical crisis in the United States. *Mayo Clinic Proc* 81: S5-S10.
12. Kratina K (2003) Health at every size: Clinical applications. *Healthy Weight Journal* 17: 19-23.
13. Miller WC, Jacob AV (2001) The health at any size paradigm for obesity treatment: the scientific evidence. *Obes Rev* 2: 37-45.
14. Wing RR, Hill JO (2001) Successful weight loss maintenance. *Annu Rev Nutr* 21: 323-341.
15. Campos P, Saguy A, Ernsberger P, Oliver E, Gaesser G (2006) The epidemiology of overweight and obesity: public health crisis or moral panic? *Int J Epidemiol* 35: 55-60.
16. Mann T, Tomiyama AJ, Westling E, Lew AM, Samuels B, et al. (2007) Medicare's search for effective obesity treatments: Diets are not the answer. *Am Psychol* 62: 220-233.
17. Saguy AC, Riley KW (2005) Weighing both sides: Morality, mortality, and framing contests over obesity. *J Health Polit Policy Law* 30: 869-921.
18. Bacon L (2008) Health at every size: The surprising truth about your weight. Dallas, TX: Benbella Books.
19. Bacon L, Keim NL, Van Loan MD, Derricote M, Gale B, et al. (2002) Evaluating a 'non-diet' wellness intervention for improvement of metabolic fitness, psychological well-being and eating and activity behaviors. *Int J Obes Relat Metab Disord* 26: 854-865.
20. Bacon L, Stern JS, Van Loan MD, Keim NL (2005) Size acceptance and intuitive eating improve health for obese, female chronic dieters. *J Am Diet Assoc* 105: 929-936.
21. Rapoport L, Clark M, Wardle J (2000) Evaluation of a modified cognitive-behavioural programme for weight management. *Int J Obes Relat Metab Disord* 24: 1726-1737.
22. Provencher V, Begin C, Tremblay A, Mongeau L, Corneau L, et al. (2009) Health-at-every-size and eating behaviors: 1-year follow-up results of a size acceptance intervention. *J Am Diet Assoc* 109: 1854-1861.
23. Ciliska D (1998) Evaluation of two nondieting interventions for obese women. *West J Nurs Res* 20: 119-135.

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