



"MORTAR & PENCIL" CONCORDIA UNIVERSITY WISCONSIN SCHOOL OF PHARMACY STUDENT WRITING CLUB:

Health at Every Size®: An Overview of a Mindful Approach for Lifestyle Change

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LEARNING OBJECTIVES

- Understand the background of Health at Every Size (HAES)®.
- Learn about literature and research that support and refute HAES principles.
- Identify concerns and limitations with HAES.
- Learn how pharmacists can educate patients on HAES.

Health care professionals are searching for new methods to combat the obesity epidemic in the United States. Currently, 42.4% of the U.S. population is considered obese (Table 1).² Weight loss solutions are marketed and encouraged in many parts of everyday life, from fad diets in magazines to health care practitioners recommending weight loss. However, weight loss is not easy, and studies have shown how difficult it is to maintain significant weight loss with traditional weight-loss approaches, like calorie deficits and exercise.^{3,5} One analysis found that one-third to two-thirds of dieters regain more weight after a diet than they lost on their diets.⁶ Concerns have also been raised about the negative physical and mental impacts of an obsession with weight loss.^{4,7} Innovative approaches are needed to help patients develop a sustainable, healthy lifestyle. One such approach is the Health at Every Size (HAES®) movement. This approach is considered "weight neutral" and promotes psychological and behavioral changes. While the HAES approach

needs more research, it can be used by practitioners and pharmacists to help improve the mental and physical well-being of patients.

The Background of HAES

The concept behind HAES was first outlined in 1967, in an article published by Lew Louderback titled, "More People should be Fat!" The movement gained steam later, in 2008, when Lindo Bacon, PhD, published the book *Health at Every Size*.⁵ Since then, the Association for Size Diversity and Health (ASDAH) has further developed the approach and published a curriculum to educate health professionals about HAES. At its core, HAES is a weight-neutral approach that seeks to promote healthy behaviors without focusing on size and weight. Instead, it teaches people to eat intuitively and to find joy in physical activity. It also wants to increase acceptance for the diversity of all types of bodies, rather than focusing on the mainstream "ideal" body type.^{3,8}

The primary difference between HAES and traditional weight loss approaches is its lack of a prescribed regimen of diet and exercise and a goal of weight loss. Instead, HAES says, exercise should happen because people enjoy moving. There should be intrinsic motivation to move, which includes exercise to relieve stress and to improve sleep, self-confidence, and social interactions. The HAES diet does not restrict calories or any type of food. It implements mindful and intuitive eating. This approach encourages people to minimize distractions while eating, to check in with their bodies, and to be aware of the way food makes them feel.^{3,8} People listen to their internal cues of satiety and

choose foods based on how their mood, concentration, energy, and hunger are affected.⁹ Mindfulness is used to reduce cravings and help curb emotional eating. By responding to the body, people can naturally make healthier food choices for a longer period, rather than following a strict diet. HAES also looks to improve mental health surrounding body size and weight.^{3,8} Its premise is that by promoting self-love and body acceptance, people will feel more confident to make lifestyle changes and practice self-care.⁹ It aims to help alleviate eating disorders, reduce anxiety or guilt from dieting, and prevent weight cycling from diets and short-term weight loss.^{3,8}

Literature Supporting HAES

One point of frustration for overweight and obese patients is the way weight is traditionally discussed at health appointments. Many patients report that some providers seem to only see weight, rather than other health concerns, and patients are told that weight loss is the

TABLE 1. CDC Definitions of Obesity in Adults¹

| BMI (kg/m ²) | Category |
|--------------------------|--|
| < 18.5 | Underweight |
| 18.5 – 24.9 | Healthy weight |
| 25 – 29.9 | Overweight |
| >30 | Obesity <ul style="list-style-type: none"> • Class I: BMI 30-34.9 • Class II: BMI 35-39.9 • Class III: BMI >40 |

BMI = Body Mass Index

TABLE 2. Study Designs and Results of Literature Testing a HAES Intervention

| <i>Title of Study</i> | <i>Experimental Design and Sample Size</i> | <i>Inclusion Criteria</i> | <i>Interventions and Control</i> | <i>Measurements</i> | <i>Results</i> |
|--|--|---|---|--|---|
| Carbonneau E, Bégin C, Lemieux S, et al. A Health at every size intervention improves intuitive eating and diet quality in Canadian women ¹² | Quasi experimental N= 216 | Women who were interested in a HAES program. The most common BMI was >30 mg/kg ² . | Intervention: 13 three-hour weekly meetings and a six-hour intensive day over 16 months. Topics discussed include enjoyment of physical activity, healthy nutrition, and realistic objectives about the body Control: Waiting list | Food Frequency Questionnaire, Intuitive Eating Scale, diet quality, and HEI | The HAES group significantly increased their intuitive eating score (3.04 vs 2.79, p< 0.0001) and diet quality at t=4 months compared to control. The HEI for HAES was significantly improved at t=4 months (76.82 vs 72.12 p=0.0462), but there was no difference at t=16 months (74.93 vs 72.98, p value not given) |
| Provenber V, Bégin C, Tremblay A, et al. Short-term effects of a “health at every size” approach on eating behaviors and appetite ratings ¹³ | Randomized controlled trial N= 144 | Premenopausal women with a BMI of 25-35 kg/m ² | Interventions: 14 weekly sessions focused on general well-being, a healthy lifestyle, enjoyment of physical activity, body acceptance, and a food diary Control: Waiting list | Three Factor Eating Questionnaire and appetite sensations scales | The HAES group had increased flexible restraint (3.6 vs 2.7, p=0.42) and significantly decreased susceptibility to hunger (1.5 vs 1.9, p= 0.02), external hunger (1.7 vs 2.4 p=0.0005), and desires to eat postprandially (932 vs 1,124, p=0.02) |
| Provencher V, Bégin C, Tremblay A, et al. Health-at-every-size and eating behaviors: 1-year follow-up results of a size acceptance intervention ¹⁴ | Randomized controlled trial N= 144 | Women with a BMI of 25-35 kg/m ³ and a stable body weight for at least 2 months | Intervention: This study is a follow up study at the end of 4 months, 6 months, and 1 year post intervention of the study cited above. Control: Waiting list | Three Factor Eating Questionnaire and appetite sensations scales | The HAES group had a decrease susceptibility to hunger at 4 months (-0.9, p <0.001) and 16 months (p <0.02) and decreased situation susceptibility to disinhibition (2.5 vs 3.3, p<0.03) |
| Uljan M, Pinto AJ, de Morais Sato P, et al. Effects of a new intervention based on the health at every size management of obesity: The “health wellness in obesity” study ⁷ | Randomized controlled trial N=58 | Women between 25 and 50 years old and a BMI of 30-39.9 kg/m ² | Interventions: Thrice weekly physical activity sessions, bimonthly individual nutrition sessions, and five philosophical workshops over 7 months Control: Bi-monthly educational sessions on HAES principles | Psychological and behavioral assessments using Figure Rating Scale, BAQ, and health related to quality of life measurements (WHO-QOL-BREF) | The HAES group had significantly decreased consumption of ultra-processed foods (Pre= 32, post = 21.7 p=0.0001) and increased daily consumption of fruits (Pre= 8.8, post= 12, p=0.026) and vegetables (Pre= 13.9, post= 18.9, p=0.018). The HAES group had improved body image perception and satisfaction on the BAQ scale (p ≤ 0.05). Both groups had an increase in health-related quality of life parameters for WHO-QOL-BREF domains (p=0.03) |

BAQ = Body-Attitude Questionnaire; BMI = Body Mass Index; HAES = Health at Every Size; HEI = Healthy Eating Index

only way to prevent chronic conditions.³ While literature shows that there are correlations between weight and certain health conditions, HAES attempts to refute that health outcomes are determined by weight alone.^{4,10} Advocates for HAES often cite a Journal of the American Medical Association (JAMA) meta-analysis that suggests being slightly overweight may lead to better survival, which is known as the “obesity paradox.” This analysis studied more than 2 million subjects and found that those who were overweight and in the Grade I obesity category were not at an increased risk of all-cause mortality, and people who were overweight had significantly lower all-cause mortality than other weight groups.¹¹ Studies also suggest that weight loss may lead to endocrine changes like decreased insulin secretion, leptin signaling, energy expenditure, and satiety, while ghrelin

signaling, hunger, and energy storage increase. That is, the body may change to promote weight regain back to its baseline.⁴ By breaking down the relationship between health and weight, HAES can advocate for healthy lifestyles without a strong focus on weight loss to prevent disease.

There has also been some research to determine the effectiveness of a HAES intervention. These studies have found that women participating in HAES had improved body image perceptions and sense of self. Their eating habits changed to include more fruits and vegetables and to eat intuitively with less susceptibility to hunger. The details of these studies are outlined in Table 2. In general, the evidence shows that with intense HAES-based interventions, the women had improved diet quality and increased body satisfaction.^{7,12,13}

Concerns with HAES

Despite literature supporting HAES, some health experts have concerns about some of its principles. One debate is around whether people can truly be healthy at every size. A study in JAMA showed a correlation between higher BMI and higher rates of metabolic abnormalities.¹⁵ One article raises concerns about homeostatic changes that occur when people are chronically overweight. It discusses the body’s natural defense mechanisms against weight gain, and how these systems change as weight stays increased. The homeostatic set point of the body will shift to accommodate a heavier weight, which may have a role the difficulty of sustained weight loss. However, if lifestyle changes could be implemented early when weight begins to shift, these metabolic changes may be prevented.¹⁶

There is also a practical concern, that if people consistently eat processed food because they enjoy it, they may continue to eat those foods because HAES does not require any specific dietary changes. HAES addresses this concern, saying that, by paying attention to how food makes the body feel, people will naturally eat nutritious foods. Also, weight gain has not been significantly shown in studies conducted with a HAES intervention.⁹ Mindful eating can also help people understand their emotions and make steps to reduce binges and emotional eating. More data and studies are needed to know if these concerns are substantial.

Clinical Implications of HAES

More research is needed to maximize the clinical benefits of HAES. There is still more data needed before the approach can be broadly applied to a general population. A limitation of the current studies of HAES is the small sample sizes. Most of the participants were middle-aged white women who were in the overweight or Grade I obesity category. The interventions also involved lengthy and intense classes, which may be hard to standardize for the public, especially if there is limited access and resources. There has not been a long-term study conducted on the HAES approach. The existing studies had a trial period of 4 to 16 months and did not track physiologic outcomes like weight changes or metabolic changes.¹⁷ Furthermore, the current HAES curriculum does not implement an algorithmic approach that practitioners are familiar with, and there is no certification required to be considered a HAES informed provider.

However, the general information presented in HAES can be used by pharmacists promoting lifestyle change. It offers an approach for patients that is different from traditional recommendations. Patients may be discouraged if traditional lifestyle changes fail to achieve a certain weight or size. Pharmacists can recommend this alternative lifestyle approach and reduce the focus on weight. It can also be paired with motivational interviewing to facilitate change. The framework for motivational interviewing involves having an open discussion with the patient, discussing discrepancies between the patient's goals and their behaviors, avoiding arguments, and supporting self-efficacy and maintaining optimism.¹⁸ Studies using motivational interviewing for obesity

have also demonstrated improvements in impulsive eating and body dissatisfaction.¹⁹ The principles of HAES are similar to those in motivational interviewing. They both meet patients where they are, set goals based on patient preferences, and avoid arguments and confrontation. HAES principles could be incorporated into a non-pharmacologic approach to changing behaviors and changing people's relationship with their body. The utility of HAES with pharmacologic therapy has not been studied, but it could be used as a lifestyle change before initiating drug therapy. After people's mindsets and habits change, other add-on pharmacologic therapies to further improve health and reduce weight can be considered

Conclusion

There is promising data that HAES may be helpful to help treat eating disorders and to positively influence people's relationship with food. By promoting mindful eating and movement, people will find more joy in their lifestyles and in their body sizes. However, more research is needed to apply these concepts to public health.

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PR This article has been peer-reviewed. The contribution in reviewing is greatly appreciated!

Acknowledgements: I would like to thank Dr. Sarah Peppard and Dr. James Lokken, members of Concordia University Wisconsin faculty, who provided feedback and guidance for the article. Their time and contributions are greatly appreciated.

Conflict of interests: The author(s) declare no real or potential conflicts or financial interest in any product or service mentioned in the manuscript, including grants, equipment, medications, employment, gifts, and honoraria

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