What Is “Health at Every Size”?

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The Health at Every Size (HAES) approach to eating and weight issues differs from a conventional treatment model in its emphasis on self-acceptance and healthy day-to-day behaviours, whether weight changes or not. Letting go of the goal of weight loss has made HAES controversial in a society where the pursuit of thinness is an unquestioned prescription for health and happiness. But many of the clinicians who have evolved the HAES approach have seen the devastating consequences of the pursuit of thinness in individuals with eating disorders, and find it hypocritical to prescribe for heavier people what we diagnose as eating disordered behaviour in thin ones.

What does Health at Every Size stand for?

1) ***Enhancing health*** **-** attending to emotional, physical and spiritual well being, without focussing on weight loss or achieving a specific "ideal weight".

2) ***Size and self-acceptance*** - respecting and appreciating the wonderful diversity of body shapes, sizes and features (including one's own!), rather than pursuing an idealized weight, shape or physical feature.

3) ***The pleasure of eating well*** **-** eating based on internal cues of hunger, satiety, and appetite, individual nutritional needs and enjoyment, rather than on external food plans or diets.

4) ***The joy of movement*** **-** encouraging all physical activities for the associated pleasure and health benefits, rather than following a specific routine of regimented exercise for the primary purpose of weight- loss or management.

5) ***An end to weight bias*** **-** recognising that body shape, size and/or weight are not evidence of any particular way of eating, level of physical activity, personality, psychological issue or moral character; confirmation that there is beauty and worth in EVERY body.

(written by Ellen Shuman and Karin Kratina)

The link between health and weight

Some people feel that dropping the goal of a particular weight endpoint is not an aggressive enough treatment for high Body Mass Index (BMI), the weight/height formula used by many to determine healthy versus unhealthy weights. These people cite numerous studies linking obesity with various health problems. When examined in more detail, however, these studies show that correlations between health issues and BMI are

usually around r =.3. This means that about 9% of the outcome of whether someone has a health problem or not is somehow related to BMI (but of course a correlation does not imply causality). That means that 91% of what accounts for a health outcome has *nothing to do with BMI.* We would do well to put more effort into explaining the factors making up that 91% not related to weight. Some of these other factors might make a bigger impact on health than weight, and be easier to implement. Moreover, because so few people change their weight for more than 1-2 years, we do not know whether weight loss would in fact change people's health outcomes. We do not know that weight loss would improve long-term health, and we do not have a treatment to produce lasting weight loss for the vast majority of people.

Because of these limitations of the traditional weight loss model, many health-care workers have found the HAES approach more realistic and satisfying. The focus is on the day-to-day activities that help individuals of any size to flourish. When these activities are uncoupled from a weight loss goal, they can be assessed for their sustainability over a lifetime. The goal becomes helping individuals to make these healthy behaviours a lifelong practice. Because people are not doing them to lose weight, weight fluctuations have less impact on motivation.

A weight-neutral approach focuses on loving self-care, the decisions that people can make on a day-to-day basis that are sustainable for a lifetime. HAES is not against weight loss, it is against the *pursuit* of weight loss. The task is to care for the body you have, and will continue to have, whether it gains or loses weight or ages or gets cancer or runs a marathon.

Determining a healthy weight

The HAES model does not suggest that anyone of any weight must by definition be healthy. It does not suggest that anyone must by definition be at their own healthy weight. HAES defines health by the process of daily life rather than the outcome of weight. If people have to do things in their day-to-day life in order to achieve a particular weight that a study says would be healthier, and the things they have to do (like stomach surgery, or starving, or exercising 4 hours a day) are not compatible with loving self-care, then by definition, that is not a "healthy" weight for that individual. It would be like starving a St. Bernard because a study of dogs shows that greyhounds live longer. We are genetically like different breeds of dogs, but we can't tell what breed we are by looking. You have to tell your "breed" by the weight you turn out to be when you are living a good life. HAES points out that when people are doing this they come in a huge variety of natural weights - and that deeming any particular BMI as pathological is a political rather than a scientific act.

Finally, HAES asserts that the medical pathologizing of the majority of the American population itself harms people's health by stigmatizing them and causing discrimination in insurance, jobs, social relationships, and medical care. HAES directs medical

researchers to investigate the health consequences of stigma and discrimination based on weight, including the effects on people who are vulnerable to developing eating disorders. In this way HAES is an integral aspect of eating disorders prevention.

Assumptions we make based on weight

Are we prescribing for heavier people what we diagnose as eating disordered in thinner people? Read the following vignette with the assumption that the young woman, *Julie*, is 105 pounds, 5'5" tall. What do you see as problematic? What is your diagnosis? What would be your intervention?

> *Julie is a 17-year-old white female, above average intelligence, with concerns about her weight and loathing of her hips, thighs, and stomach. She feels hopeless about having a dating relationship unless she can lose weight, which holds the promise in her mind of making her life "perfect." She has lost 25 pounds in the last 5 months through dieting, but in the last two weeks she has regained 5 pounds, and is feeling panicky. Her mood any given day depends on whether she has lost or gained weight. She is preoccupied with what food she will be eating that day, has "healthy" and "unhealthy" food categories, and does not trust her body's hunger and satiety cues. She keeps a log of everything she eats, is currently restricting her intake to about 1200 calories/day and is particularly averse to eating dietary fat and carbohydrates. She is finding it difficult to focus mental energy on issues that are unrelated to food and weight. She avoids activities such as being seen in a swimsuit, going out with friends, and applying to be a camp counsellor, postponing them until she feels her body is more "acceptable." She has been unable to maintain the restrictive intake recently and has begun "bingeing," episodes in which she feels out of control, eats more than she feels she should, and even feeling overfull does not make her feel sated.*
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> *Julie's weight history includes seeing herself as a "chubby" child, experiencing teasing about her body, and early menarche at 10. She reports that her mother has "always struggled" with her own weight and that her father saw this as a weakness in her mother. Her weight has been unstable since puberty, and there have been two times in addition to the present when she has been amenorrheal. Repeated cycles of weight loss and regain have depleted her lean body mass to some degree, and she states she detests and avoids exercise.*

Now read the same vignette with the assumption that the young woman, *Jody*, is 195 pounds and 5'5" tall. What do you see as problematic? What is your diagnosis? What would be your intervention?

Most clinicians would view *Julie's* restrictive intake, rigidity about food, and avoidance of daily activities as evidence of an eating disorder. They might even see her binges as her body's healthy attempt to restore its natural weight. They would be pleasantly

surprised to see that Julie is not a compulsive exerciser and probably would not encourage her to move more because they want her to gain weight. On the other hand, most clinicians would view *Jody's* dieting and cognitive monitoring as desirable, and her avoidance of daily activities as understandable. They would most likely view her avoidance of exercise and her bingeing as typical problem behaviours of fatter people.

Focussing on behaviour not weight

The HAES model tries to untangle the effects of weight stereotyping. It asks us all to focus on the day-to-day self-nurturing behaviours that result in physical and mental health improvements, and to let go of the pursuit of weight loss so that our bodies can settle at the weight they do when we are living in a healthy way. It is weight neutral. We ask the individual with anorexia to trust her body to find its healthy weight when she is eating enough fuel to function well, and we ask the average and above-average weight women to do the same.

HAES builds on existing research, but more research is needed to confirm the anecdotal data that by taking the focus off of weight loss, people experience more success in consistently practicing self-nurturing activities. In theory, it is logical to expect people to take better care of a body they accept and love *now*, than one they are punishing for being imperfect. In practice, it is self-care that reinforces a sense that one's body is *worth* caring for.