

Environment, health, and safety

Health at every size

By Katie Slavin, MS, RN

Although the importance of evidence-based practice cannot be denied, traditional weight loss programs (TWLPs) have continued to be used despite decades of data discrediting their value. In response to mounting research suggesting TWLPs may actually be detrimental to health, the Health At Every Size (HAES) movement, which has grown over the past 30 years, operates under an approach of “first, do no harm.”

Research data support the notion that weight loss does not necessarily improve health or decrease mortality. In 2005, a study by epidemiologists at the Centers for Disease Control and Prevention uncovered an overstatement of the strength of the association between weight and mortality. The study also stated that this weakened association does not confirm that weight itself is the cause of mortality and cites confounders, such as physical activity, body composition, visceral adiposity, physical fitness, and dietary intake. Other confounders contributing to past associations between weight and mortality include smoking, preexisting illness, weight cycling, diet medication use, and economic status.

In both the Framingham Heart Study (1991) and a recent National Health and Nutrition Examination Survey (2005), all excess mortality associated with obesity was accounted for when the impact of weight cycling was considered. In 2007, researchers asserted that a review of scientific literature shows that weight is mostly irrelevant to health and mortality issues except at extreme levels (very high and very low) of body weight. The researchers also gave examples of studies demonstrating that blood pressure, cholesterol, and glucose levels may be treated effectively with lifestyle changes that do not result in weight loss, which suggests that weight is related to, but not necessarily the cause of, insulin insensitivity, diabetes, hypertension, and atherosclerosis.

Considering that TWLPs have a 95% to 98% failure rate in long-term (over 5 years) weight reduction, many studies suggest that TWLPs provoke weight cycling and weight gain, and increase fat-to-muscle ratios and psychological health issues. Additional research evaluating the effects of weight cycling links the practice to lower HDL levels, immunocompromised status, gallstones in men, variations in bone metabolism, certain types of cancer (kidney, lung, and breast), and increased risk of

myocardial infarction, stroke, and diabetes. Research also links dieting to perceptions of deprivation and preoccupation with food, leading to overeating, bingeing, and increased body dissatisfaction.

These studies are not limited to adults. A study in 2003 demonstrated that children who dieted gained more, not less, weight than those who did not, concluding that dieting was, in fact, counterproductive. Similarly, a study in 1996 revealed that children with greater body fat stores were less able to regulate energy intake accurately, and noted that the children of mothers who were more controlling of their children’s food intake showed less ability to self-regulate energy intake.

Multiple animal studies have linked weight cycling to abdominal obesity, hypertension, blood vessel damage, and heart disease—the same outcomes that have traditionally been blamed on obesity in humans, suggesting that hypertension and other cardiovascular pathologic conditions seen in some overweight humans may be the result of losing and gaining weight instead of the weight itself.

One study in 2002 found that study participants assigned to an HAES program group, in contrast to a TWLP intervention group, maintained long-term behavior change. Concepts of HAES were implemented at the Mercy Medical Center–North Iowa as part of their Kailo workplace health promotion program, which has resulted in numerous workplace awards and recognitions, including multiple WELCOA (Wellness Councils of America) Well Workplace Awards, since the program began in 1997. Pending further research, HAES provides an opportunity to transition from spending resources on ineffective programs that are detrimental to health and well-being to programs that actually improve overall health and quality of lives of participants.

The HAES approach focuses on the critical contribution of social, emotional, spiritual, and physical factors to health and happiness. HAES fosters size and self acceptance; increased social, pleasure-based movement for enjoyment and enhanced quality of life; and “normalized” eating by reprogramming participants to eat in response to internal body cues. Instead of weight, HAES concentrates on well-being, energy level, lipids, and glucose as avenues to improve health. More research is needed to support HAES effectiveness. ★

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