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The Efficacy of the Health At Every Size (HAES) Approach in the Treatment of Eating Disorders and Disordered Eating Patterns

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THE EFFICACY OF THE HEALTH AT EVERY SIZE (HAES) APPROACH IN THE TREATMENT OF EATING DISORDERS AND DISORDERED EATING PATTERNS

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Preface

The inspiration for this research stemmed from my insatiable interest in the concept of treating eating disorders with a non-diet approach. After witnessing weight bias in nearly every healthcare setting I have worked in, I was curious whether a culture focused on weight and diet was truly the solution to disordered eating patterns. This thesis aims to explore the evidence behind if and, ultimately, why a non-diet approach might provide long-term healing for ED patients.

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Abstract

Background: This study aims to review primary research to assess the measured physical and psychological benefits of implementing the Health at Every Size (HAES) approach in treating adults (≥18 years of age) with disordered eating behavior.

Objective: To answer the research question: What are the measured physical and psychological benefits of implementing the Health at Every Size (HAES) approach in treating adults (≥18 years old) with disordered eating behavior?

Design: This research is a scoping review of literature between January 2010 and May 2021. PubMed, Science Direct, CINAHL, and Cochrane academic databases were searched.

Participants/Setting: Participants included those 18 years or older, diagnosed with a DSM-5 recognized eating disorder or showing disordered eating pathology, less than 20% dropout rate, and sample sizes greater than or equal to 15 individuals for each study group.

Main Outcome Measure: Before research began, we hypothesized that HAES would prove to be a successful approach to treatment for patients recovering from eating disorders, and that a focus on body size and weight would exacerbate and even cause eating disorder symptoms.

Results/Conclusion: A weight-neutral approach to eating disorder recovery promotes self-compassion, supports intuitive eating practices, and protects from the harmful effects of weight-bias internalization. HAES aligned care has the desired outcome of teaching patients with disordered eating behaviors to eat for well-being and to promote flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than external factors.

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Introduction

The purpose of this study was to identify if the HAES approach is an acceptable method of treatment for those suffering from an eating disorder specified in the *Diagnostic and statistical manual of mental disorders: DSM-5* or disordered eating patterns. The research problem statement that sparked this scoping review is as follows: What are the measured physical and psychological benefits of implementing the Health at Every Size (HAES) approach in treating adults (≥18 years old) with disordered eating behavior? Our main hypothesis was that the HAES approach, with its emphasis on five principles which include weight inclusivity, respectful care, health enhancement, life enhancing movement and eating for well-being, would prove to be a successful treatment for patients recovering from eating disorders. Our secondary hypothesis was that a focus on body size and weight would exacerbate and even cause eating disorder symptoms. Each primary research article analyzed for this review included participants aged 18 years and older.

Literature Review

Weight Bias in Healthcare and Beyond

Patients in larger bodies presenting with disordered eating patterns, including those diagnosed with atypical anorexia, bulimia nervosa, binge eating disorder, or other specified feeding and eating disorders (OSFED), can experience weight bias from their treatment providers and/or eating disorder facilities. Shifting to a weight-inclusive framework can potentially lead to better outcomes, including better quality of care for larger-bodied patients, long-lasting improvements in mental, physical, and emotional health, and less patient shame within the healthcare setting (Liss & Erchull, 2015; Mensinger et al., 2018; Westermann et al., 2015). Weight-centric models can lead to pitfalls in both diagnosis and recovery by increasing patient shame, overlooking eating disorder diagnoses, and shifting the focus from health to outward appearance (Latner et al., 2014; McClure et al., 2011; Pearl & Dovidio, 2015; Persky & Eccleston, 2010). Therefore, weight-neutral care might be essential to incorporate into the treatment of disordered eating behaviors.

Healthcare professionals can carry implicit weight bias that has a propensity to affect patient outcomes, especially if the provider has a history of successful weight-loss (Pearl et al., 2017). Patient-blame is heightened when the provider and patient have different lived experiences regarding weight loss, leading to a potential for weight-related shame in the healthcare field (Pearl et al., 2017; Westermann et al., 2015). Persky & Eccleston found that medical students, when treating both "obese" and "normal weight" patients, showed significantly higher levels of negative stereotypes toward the obese patient, believing this patient was less likely to adhere to their advice, less healthy, and responsible for causing the presenting issue (2010). In this experiment, the "obese" patient's BMI was 39.9 kg/m^2, and the "normal" patient's

BMI was 21.6 kg/m^2.The normal-weight patient did not face these same stereotypes, but instead received different recommendations for the same issue (Persky & Eccleston, 2010). Medical students even reported that larger-bodied patients are frequently a target of "negative attitudes and derogatory humor" by their peers, other healthcare providers, and instructors (Puhl et al., 2014). Of note, the term "obese" used in this review is in quotations to denote its use within individual studies. "Obesity" carries social stigma that is inherently linked to shame and discrimination. Shifting the terminology from "obese" to a more neutral descriptor can initiate a shift to a more positive patient experience (Volger et al., 2011). Regardless of weight, patient health can suffer due to the internalization of weight stigma that can be expressed in a healthcare setting. This stigma may lead to body image concern, increased prevalence of anti-fat attitudes, lower self-esteem, disordered eating behaviors, and depressive symptoms for the patient (Craven & Fekete, 2019; Durso et al., 2016; Schvey & White, 2015; Webb & Hardin 2016). Even after adjusting for BMI, physical activity, and sociodemographic differences, those who experienced weight discrimination in healthcare had an increased risk of chronic medical conditions and mortality (Udo et al., 2016, Sutin et al., 2015). Creating a culture of weight-inclusivity in all levels of healthcare could help alleviate a major contributing factor of medical complications for those in larger bodies: shame and weight-related harm at the hands of healthcare professionals (Messinger et al. 2018). Health professionals promoting even flexible dietary control, which includes recommendations like limiting portion sizes and compensatory food behaviors, can be harmful for those with disordered eating patterns (Tykla et al., 2015). Flexible dietary control can potentially cause harm and lead an individual to rigid dietary control (Tylka et al., 2015). Rigid and flexible control have both led to disordered eating patterns and body image concerns, and dietary restraint led to a loss of control of eating behaviors, emotional eating, binge eating,

and ultimately a higher weight (Holmes et al., 2014; Linardon & Mitchell, 2017. In contrast, recommending and implementing the principles of intuitive eating does not promote negative weight-related outcomes (Tylka et al., 2015).

Weight-neutral approaches, like HAES, have the potential to mediate negative effects of diets on eating disorder symptomatology. Weight-related shame and guilt is associated with increased binge eating, whereas intuitive eating decreases binge eating symptomatology by serving as a protective factor against internalizing weight bias (Craven & Fekete, 2019). Latner et al. found that internalized weight bias was negatively correlated with health-related quality of life (2014). However, those with low internalized weight bias, even with the same variance in BMI as the high internalized weight bias group, did not have physical health impairment (Latner et al., 2014). BMI alone does not have an impact on health-related quality of life. Instead, holding negative weight-related beliefs about the self has a greater impact on health-related quality of life than the ratio of weight to height (Latner et al., 2014). Further, presenting weight status as a variable the individual can control can be detrimental to mental health (Liss & Erchull, 2015).

BMI and Its Potential Harm

In a movement spanning from the 1970s through the mid-1990s, BMI became the standard measure of weight and health (Fletcher, 2014). BMI is currently used as a measure of health in most healthcare and research settings due to its ease of calculation and low cost (Dodgen, 2017). However, a focus on BMI as an indicator of health for larger bodied individuals could lead to harm. Using BMI in this way ignores that nearly half of overweight individuals, ~26% of obese individuals, and ~16% of obesity type 2 and 3 individuals are cardiometabolically healthy (Tomiyama et al., 2016). Yet 30% of the “normal weight” population are

cardiometabolically unhealthy, leading to missed diagnoses and delayed healthcare (Tomiyama et al., 2016). One study of more than 29,000 diverse men and women found that exercise capacity was a strong indicator of mortality and health, whereas BMI had limited significance in predicting these outcomes (McAuley et al., 2016). This study upheld the findings of the Veterans Exercise Testing Study, which found that exercise capacity—not obesity–was a better predictor of mortality. In fact, obese men with high exercise capacity had better health outcomes than their normal weight counterparts (McAuley et al., 2010). Improving fitness might be a more important and evidence-based health goal rather than decreasing BMI (Lavie et al. 2015). Relying on BMI as an indicator of health can also lead to a lack of care, especially for those with eating disorders presenting in larger bodies. When individuals already experience implicit weight bias, classifying them as overweight or obese based on their BMI can lead to anxiety, depression, and lessened overall health (Hilbert et al., 2013). Furthermore, clinical use of BMI carries a positive association with an increase in body-related guilt, shame, healthcare-related stress, avoidance of healthcare, binge eating disorder, and other eating disorder pathologies (Kelley et al., 2016; Mesinger et al., 2018; Spoor & Madanat 2016). In counteracting this harm, however, self-compassion can mediate the negative effects of weight bias and its association with BMI (Kelly et al., 2014).

Self-compassion, a healthy response to feelings of upset or inadequacy, is a potential mediator for the harm of internalized shame and body dissatisfaction (Kelly et al., 2016). Tykla et al. found that self-compassion helps protect women from the "thin ideal" imposed by cultural messages (2015). These compassion practices can take a variety of shapes, from group classes to a daily mindfulness practice. In one study of women who engaged in self-compassionate behaviors, the participants were less likely to experience negative attitudes towards eating or

weight-related shame after engaging in body observation in a mirror (Liss & Erchull, 2015). When self-compassion levels are low, however, body image flexibility and intuitive eating suffer, leading to a potential increase in disordered eating pathology (Webb & Hardin, 2016).

The DSM-5 and Eating Disorders

According to the DSM-5, a patient presenting with Anorexia Nervosa must meet the following criteria: (1) Restriction of food intake that leads to weight loss or a failure to gain weight, resulting in "significantly low body weight" for the individual's age, sex, and height, (2) Fear of becoming fat or gaining weight, (3) A distorted view of themselves and of their condition (DSM-5). A patient presenting with Bulimia Nervosa must meet the following criteria: (1) Repeated episodes of binge eating, (2) Loss of control—the patient must feel out of while eating and unable to stop themselves or control how much they eat, (3) Use of compensatory behaviors to avoid weight gain (e.g. self-induced vomiting; misuse of laxatives, diuretics, and/or enemas; and excessive exercise), (4) Both the binge eating and compensatory behaviors occur at least once a week for three months, (5) The person's weight and/or body shape has a significant impact on the way the person views themselves (DSM-5). Binge Eating Disorder criteria include: (1) Recurrent and persistent episodes of binge eating, (2) Binge eating episodes are associated with three (or more) of the following: eating much more rapidly than normal, eating to the point of discomfort, eating large amounts of food when not feeling physically hungry, eating alone due to embarrassment of food quantity, experiencing self-disgust, depression, or guilt after overeating, (3) Marked distress regarding binge eating, (4) Absence of regular compensatory behaviors. Other Specified Feeding and Eating Disorders, or OSFED, is a term in the DSM-5 used to diagnose disordered eating behaviors that do not completely fit into another eating disorder category. Examples of OSFEDs include Atypical Anorexia Nervosa and Night Eating

Syndrome (DSM-5). Although no longer part of the classification of eating disorders in the DSM-5, BMI is still frequently used to classify both health-status and eating disorders (DSM-5). Despite the continuing use of BMI in healthcare settings, the decision to remove BMI from the criteria for diagnosis can help shift the treatment and management of disordered eating away from stigmatizing language and toward weight-inclusivity.

Health At Every Size

An increasingly common method for treating eating disorders is the incorporation of HAES principles. The HAES movement was created in the late 1980s and early 1990s to take the focus off weight as an indicator of health. HAES does not advocate that every person is healthy no matter their body size. Rather, HAES (1) encourages body acceptance, (2) supports adopting intuitive eating practices, and (3) prioritizes moving for enjoyment rather than rigid exercise programs (Bacon & Aphramor, 2011). The HAES approach can be used to treat individuals of all sizes and sociocultural backgrounds.

Building on the foundation of HAES, a growing body of evidence supports that the principles of intuitive eating can be used to treat disordered eating patterns. Eating disorders can present in a variety of bodies, making weight-neutral treatment an approach worth considering. In a study conducted by Denny et al., healthcare providers shifting their focus from weight-centric approach to a weight neutral approach promoted healthy behavior changes, regardless of weight change (2013). Traditional eating disorder treatment focuses on dissonance-based interventions, which work to encourage individuals experiencing negative thoughts and behaviors to counter those with positive actions (*Cognitive Dissonance and Attentional Biases Related to Body Dissatisfaction - Full Text View*). However, individuals who are at risk of eating disorders might benefit from non-diet approaches that promote intuitive eating and increase

interoceptive awareness (DeVille et al., 2021). Dieting has been proven largely ineffective, as more frequent self-weighing and calorie counting is associated with increased eating disorder symptoms, and disordered eating has been extensively associated with low intuitive eating and interoceptive awareness (Ainley & Tsakiris, 2013; Cristoph et al., 2021; Denny et al., 2013; Herbert et al., 2013; Madden et al., 2012). Intuitive eating, self-compassion, body appreciation, and body trust—the cornerstones of the HAES philosophy—are essential in the treatment of eating disorders (Bardone-Cone et al., 2019; Denny et al., 2013; Iannantuono & Tylka, 2012; Kelly et al., 2014; Koller et al., 2020; Liss & Erchull, 2015; Tylka et al., 2015). Hudson et al. showed that implementing dissonance-based programs led to a significant increase in body appreciation and significant decreases in body dissatisfaction, sociocultural influence, disordered eating, eating disorder symptoms, depressive symptoms, and negative affect (2021). Lessening psychological distress is crucial for the success of weight-neutral approaches (Cloutier-Bergeron et al., 2019). Depression, low self-esteem, and low quality of life can work against the HAES approach and lead to less improved outcomes (Cloutier-Bergeron et al., 2019). However, one study showed that HAES interventions increase intuitive eating behaviors and lessen depressive symptoms, disinhibition, and susceptibility to hunger. (Bégin et al., 2018). Women were also less affected by food, eating, and weight preoccupation, even at 1 year follow up (Bégin et al., 2018). HAES' greatest benefits come from increasing intuitive eating, appearance and weight-related body esteem, and eating disinhibition (Bégin et al., 2018; Mensinger et al., 2016). Not identifying foods as "good" or "bad" or diets as "success" or "fail" is a key mechanism in the protection against disordered eating patterns (Linardon & Mitchell, 2017).

Search Procedures

An electronic search of the literature was performed for this scoping review between September 2020 and August 2021 using PubMed, Science Direct, CINAHL, and Cochrane academic databases. Search terms included the key words: Health at Every Size, Eating Disorders, Intuitive Eating, Weight Bias, Healthcare, Binge Eating Disorder, Anorexia Nervosa, OSFED, Access to Care, Food Insecurity, and Atypical Anorexia Nervosa. Inclusion criteria included participants that were 18 years or older, diagnosed with a DSM-5 recognized eating disorder or showing disordered eating pathology, less than 20% dropout rate, sample sizes greater than or equal to 15 individuals for each study group, and publication range between January 2010 to May 2021. Exclusion criteria included studies consisting of children and adolescents under 18 years of age, fewer than 15 individuals in each study group, more than 20% dropout rate, studies by the same author similar in content, articles not in English, and publications prior to January 2010. Study design preferences included Randomized Controlled Trials (Class A), Cohort Studies (Class B), Non-Randomized Clinical Studies (Class C), and Cross-Sectional Studies (Class D). The primary author conducted a quality assessment of each article using the Academy of Nutrition and Dietetics Evidence Analysis Library quality criteria checklist for primary research (Academy of Nutrition and Dietetics, 2016).

Discussion and Limitations

Utilizing the intuitive eating principles is the end goal in the treatment of all eating disorders and disordered eating patterns. Incorporating HAES into the treatment plan of these individuals has the potential to bolster recovery even further, especially in those presenting in larger bodies. Adopting self-compassionate and body appreciative behaviors, cornerstones of the HAES movement, are pivotal in mediating the effects of weight-focused cultural messages (Kelly et al., 2016). Utilizing treatment plans which encourage these behaviors promotes lasting

eating disorder recovery (Koller et al., 2020). Not only are these treatments effective, but they are also long-lasting. At a 5-year follow up, one study found that intuitive eating remained effective at lowering the prevalence of a higher weight, dieting and disordered weight control behaviors, and binge eating among both men and women (Christoph et al., 2021).

Several confounding variables such as inadequate insurance coverage, access to care, lack of racial and gender diversity within the clinical staff when treating BIPOC, LGBTQ+ and other minorities impact the success and overall care of eating disorder treatment. Studies conducted on the eating disorder population are typically conducted on college-age white women. Further HAES research is needed to include a more diverse cohort.

Future Research

Although it was the goal of this review to provide evidence that HAES is impactful in the treatment of disordered eating, there remains much work to be done to incorporate HAES as the preferred treatment modality in this setting. Evidence is lacking for HAES in the treatment of eating disorders in most populations beyond white, college-aged women. Future studies should focus on diverse patient populations across all socioeconomic backgrounds such as people of color, those without college educations, those who do not identify as female, and populations that span across many ages and cultural backgrounds. Taylor et al. found that women of color showed evidence of binge eating disorder and bulimia nervosa more often than anorexia nervosa (2013). In addition, cultural differences may be protective of eating disorder development in certain populations, like Caribbean Blacks (Taylor et al., 2013). These potential differences in the manifestation of disordered eating need further investigation in not only identification, but also treatment that is culturally appropriate and accounts for possible trauma specific to women of color (Gordon et al., 2010). In addition, some evidence shows food insecurity could be

positively correlated with eating disorder pathology (Becker et al., 2019; Barry et al., 2021; Coffino et al., 2020; Tester et al., 2016). HAES does not address the issue of food insecurity. Research is needed to assess an appropriate, weight-neutral approach to treating patients without access to adequate healthcare, food, or mental health resources. In addition, evaluating the prevalence of eating disorders in food deserts where healthcare is limited is a vital step in assessing the efficacy of HAES and other weight-neutral approaches. Once learned, HAES can be incorporated into any treatment plan implemented by healthcare professionals, particularly but not limited to Registered Dietitians. Further research is needed to evaluate whether the HAES non-diet approach to healthcare could help in preventing disordered eating patterns before they begin. Although HAES aligned care is being implemented by some eating disorder practitioners, HAES is not a mainstream standard of practice for other patient populations.

Conclusion

HAES aligned care has the desired outcome of teaching patients with disordered eating behaviors to eat for well-being and to promote flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control. Increasing the HAES framework in clinical care is essential in combatting the weight biased and potentially harmful messages that exist within most westernized cultures. Although more research is necessary, weight-neutral approaches appear to have beneficial health outcomes, like decreased shame, higher quality healthcare for larger-bodied patients, and improvements in mental and physical well-being. This weight-neutral approach shows no evidence of harm in providing care for those with disordered eating. Using a HAES aligned model for treatment of disordered eating behaviors appears to be an efficacious, long-lasting, and safe approach to care for all patients.

Glossary

Intuitive Eating: Intuitive eating is considered a self-care eating practice, integrating thoughts, emotions, and instinct to guide eating behaviors. It was created in 1995 by two dietitians: Evelyn Tribole and Elyse Resch. It has 10 basic principles, which act as a framework to help in attuning to physical sensations that arise from within the body to get both biological and psychological needs met. Intuitive eating and HAES align to bring peace and neutrality to body size and food (Tribole, 2019).

Rigid Dietary Control: All or nothing dieting that categorizes "good" or "bad" foods and encourages adopting strict food rules.

Flexible Dietary Control: A more relaxed form of dietary control where food is restricted in certain aspects and with an emphasis on moderation.

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