Myths About HAES®

I've heard a lot of myths about HAES, which can make it really confusing if you're trying to sort through ideas. So I've named and answered a few of the common ones here.

Everyone is healthy whatever their weight.

C'mon, you know that can't be true! HAES isn't suggesting that everyone everywhere is healthy. What it does say is that the best way to promote wellbeing is to remove the focus from weight and shift to promoting health-gain and respect*. That way, everyone everywhere has the best chance of being as healthy as they can be right now in the body they've got.

There's no link between weight and health.

Where did you hear this? Certainly not from HAES, as we're clear the research demonstrates there can indeed be a link between weight and health. For example, type 2 diabetes is more common in people with higher body weight, and osteoporosis is more common in those of lower weight. A few things, first, association does not mean causation. And the truth can complicate our understanding. For example, knowing that fatter people with type 2 diabetes live longer than thinner people with the condition raises issues for weight loss as a treatment.

You meant high weight right? Okay, I'll come to that, but let's not forget the links between lower weight and increased risk of poor health or mortality. I mean, did you know that folk in BMI category 25-30 tend to live longer that those in BMI range 20-25. I'm just sayin', you might want to look again at the truisms you've been relying on.

Yes, HAES categorically recognizes the link between higher weight and some diseases. Consider Flegal's[1] study showing that fatness above BMI 30 was linked with 25 814 excess deaths in the U.S. in 2000. (Underweight was linked with even more - 33 746). To make these figures useful we need to ask **why** the link exists – too often it's assumed fatness **causes** the increased risk, but unless this is backed by evidence it's an assumption, not science. Flegal encourages us all to be good scientists by pointing out that these analyses do not identify any hidden contributing factors – that job type, diet, physical activity and disparities in medical care may all play a role.

I'm using the term respect in a very broad way to bridge both the dignity of individuals and ways of being that help build a fair society.

[1] Excess deaths associated with underweight, overweight and obesity *Flegal* et al., JAMA (2005) 293 (15) 1861-1867.

(If you want more science read on : Flegal also reminds us that the analyses model the effects as if all people classed as "obese " (sic) were classed as normal weight. In reality, in any population people will always be a range of weights from lighter to heavier rather than everyone being in the middle. Using this more plausible scenario of expecting a distribution of weights in a population would yield a lower numbers of excess deaths.)

As well as the examples given above, the pathways linking higher weight and illness could be to do with the ways in which living with stigma makes its mark on our lives and metabolism. This happens through the direct impact of stress on our metabolism, with stress leading to high cortisol leading to high blood pressure and other changes. If we belong to a stigmatized group we're less likely to have access to good jobs, a decent income, wholesome food and so on, this is another more indirect pathway that stigma impacts our metabolism.

We could go on. And, as we keep on asking "but why?" in the name of good science – and equal rights – the list of confounding variables grows. Maybe the links between higher body weight and illness are in part due to discrepancies in rates of body dissatisfaction; by disproportionate use of slimming drugs; by high rates of weight fluctuation which is linked to death from all-causes; by missed diagnoses; delayed appointments.

Type 2 diabetes is one of the diseases most strongly linked to body weight. But it could be diabetes leading to fatness, rather than the other way round: diabetes leads to insulin resistance which leads to weight gain.

Diabetes is increasing because people are too fat.

Let's recap. There is a link between type 2 diabetes and fatness, but this doesn't mean fatness causes diabetes. Fatness confers protection in terms of longevity for people with diabetes.

If it's not fatness that's causing diabetes though, what could it be? To answer this question we need to turn to research that looks at lifestyle, fatness and other variables. There was a large Canadian study that did just this. It found those living more often in poverty over the twelve year study had a 41% greater chance of developing type 2 diabetes. Taking fatness and lack of physical activity into account reduced this greater risk from 41% to 36%, a reduction of only 12% of the original poverty-related risk.

Traditional explanations of diabetes focus on genetic and lifestyle causes only, but as we see here, more thorough research shows evidence that type 2 diabetes is primarily a disease of material and social deprivation associated with poverty and marginalization. In which case the best way to intervene to prevent and treat diabetes would be to promote compassionate self-care, build fair societies and have good science.

It doesn't matter what you weigh.

Pretty much, at least in terms of self-care. For the vast majority of people HAES shows that compassionate self-care is the best way forward in terms of us looking after ourselves. (We'd want to make sure that people at either end of the statistical extremes of body weight were treated with due attention). This centres on us thinking about ways to support our wellbeing, rather than support weight management, and is suitable for people of all shapes, sizes and weights.

That said, it's important we remember the realities of size stigma, and that we remain sensitive to the ways in which the experience of living in larger body is different than that of others whose bodies are smaller and deemed normal or acceptable. Advancing size equality doesn't mean being "weight blind" – very large people may have particular needs, and size stigma and thinness privilege are alive and kicking.

It's not possible to separate health off into a check list of health behaviours. Thinking about wellbeing necessarily involves thinking how we treat others and how we get treated in the world.

HAES promotes binge eating by saying it's ok to have your cake and eat it.

Like you, I'm concerned by the distress people experience when they feel out of control round food. That's why I support people in legitimising foods, tuning in and eating to appetite. This approach to eating helps people regain a sense of agency over their eating behaviours. People who approach eating in this way are much less likely binge eat than people trying to follow rules.

The traditional approach of cognitive restraint and weight control promotes binge eating by increasing people's disconnect from their bodies and perpetuating judgments about size.

HAES says it doesn't matter what you eat.

Come again? HAES advocates seek to increase people's opportunity to optimize their enjoyment of meals and life!

What we eat or don't eat can make a huge difference to how we feel on a day-to-day basis and also impact our long-term health. But the best way to help people eat to nourish themselves is not to scare, bully, lecture or give rules to follow. It's to help us build a healthy relationship with our food and bodies.

This means learning how to listen to our bodies and value our experiences so we eat in way that nourishes us, physically, psychologically and in other ways too.

HAES ignores the science.

Far from it. HAES challenges poor standards in science; we can only challenge something if we've engaged with it. Having done this, we do dismiss a lot of mainstream assumptions because they are just that, assumptions, and not supported by scientific findings.

You can click here to see what I mean about assumptions in weight science: http://www.nutritionj.com/content/9/1/30

I wrote the article with the aim of highlighting some serious quality issues - with real consequences for people's welfare - and then I brought them to the attention of the British Dietetics Association with a view to getting things changed. That was a while ago, and the Association's decision to do nothing seems inconsistent with the stated commitment to robust research and publication ethics.

I think it could make sense for some people. But what about people who are really fat?

Want to improve the health of fat people? Spend an hour a day in fat rights advocacy. Address thinness privilege. The best thing we can do for population health is build fair societies. Want to support people in looking after themselves generally? Help them develop a sense of agency and self-worth. Struggling with food? Body respect. Compassion. Mindful eating.

Ok, as a starting point let's consider a fat person who has been asked to see me, a dietitian. Firstly, I'd want to know is there a health problem or something they are concerned about? If not, chances are I'd be wasting their time or worse still scaremongering.

What if all wasn't well, maybe they struggle with self-acceptance or are insulin resistant or have poor mobility? My approach would be more or less the same regardless of a person's weight. I'd want to hear their story. We'd work out what treatment was available for any difficulty identified that wanted support with – relying on science, not conjecture. The "more or less" bit depends on what people want to talk about. And it's really important we tell the truth in a way that helps people make sense of what's going for them, explaining how the personal, political and psycho-physiological all interact. What I mean by this is, it's not good enough to leave someone thinking that getting "5 a day" is the best thing they can do for their health when we know health behaviours count for so little of health outcomes.

In case you're still worrying about their weight: Let's say they are above their setpoint weight, for whatever reason. The evidence suggests that following a HAES approach will improve health and lead to weight stability. The evidence shows that the pursuit of weight loss is likely to be harmful to health and any

possible benefits are simply too small to recommend it. Moreover, even if the pursuit of weight loss was shown to lead to reliable personal health improvement, it increases size stigma and is therefore unethical. Stigma reduces wellbeing at a population level. The pursuit of wellbeing through self-care and equality is the safe and reliable choice.

Especially when there is a link between higher body weight and health, the last thing that person needs is the damage of self-hatred and the risk of weight gain that go hand in hand with efforts to slim.

Aren't you sacrificing weight loss in the small percentage of people who would lose weight with a conventional approach by using HAES as a one-size-fits-all?

Let's say we have a hundred people attending diabetic clinic. Bill sees a dietitian for weight loss and sure enough loses weight. At six months he's eating more regularly and enjoying cooking for his family, is more active and his HbA_1C has improved. This suggests Bill was above his set-point, likely did not have a dieting history and benefited from taking time to think about what he was eating and receive some nutrition education. For every Bill, there are innumerable patients who are well-versed in nutrition and preoccupied with diet. These are the people whose have long histories of dieting, who go to bed calibrating their self-worth in terms of the scales, who wake up fearing food and dreading the day ahead. Despite tenacious efforts to follow the dietitian's advice they oscillate around their set-point from one period of "being good" to the next. Their blood glucose is poorly controlled, their mood and self-efficacy low. This history tells us that a weight-loss target is ineffective and harmful, and it follows it would be unethical to recommend this.

Now we switch our focus from weight loss to health-gain. Bill changes his lifestyle, gains health - and loses weight. The other ninety-nine patients are offered a way out of the diet roller coaster. The literature shows longterm improvements in health behaviours, physiological and psychological measures in chronic dieters that are independent of weight change and arise from moving away from weight-loss targets. In addition, Bill and his fellow patients all get the message that respect is independent of health, size or fitness and learn that health is more than health behaviours.

What about when someone's weight is causing them joint pain?

People of all shapes and sizes get joint pain. But we don't all get taken seriously, or get the proper diagnosis and treatment we need. Some people will delay presenting because self-care is hard for them, and/or because they've been shamed and humiliated in healthcare in the past. Maybe the encounter increases pain through increasing stress. Maybe the knee exercises someone was told to download are not suitable for people with bigger bodies and so not relevant?

All things being equal, when pain is suspected to be weight-related the last thing you need is to risk weight gain. The ethical response is high quality dignified treatment including, if needed, helping someone stop battling their bodyself and protect themselves from oppression.

... and people who have difficulty breathing? Surely it's simply unkind not to help larger patients with pulmonary disease lose weight?

You're getting the picture. Perpetuating this idea there's a proven safe way of "helping people lose weight" is a dangerous and irresponsible fantasy.

It's weight loss that's lethal for lung patients. Check out the science. All the rest is stereotype.

> "Risk of COPD-related death increased with weight loss but not with weight gain. In subjects with mild-to-moderate COPD, the effect of weight change was the same irrespective of initial weight. In subjects with severe COPD, there was a significant risk ratio modification between effect of baseline BMI and weight change: in the BMI <25 best survival was seen in those who gained weight. For BMI >25 best survival was seen in stable weight[2]. "

. . . So what about morbidity and respiratory disease then?

… does weight loss improve quality of life in lung patients? Good question. If you're about to recommend weight reduction you'll want to answer that.

Still I'm confused. The question would seem to imply that you've got a safe and reliable treatment. And forgotten that bit we covered earlier about a weight-centred approach leading to size stigma.

It's true that weight-reduction has shockingly poor outcomes, and though this raises all sorts of ethical issues, it's not the key point. The fact is that promoting weight loss increases stigma which contravenes human rights. End of. Surely?

What happened to the term "weight-neutral"?

I prefer "weight-equitable" to reflect the fact that people of different sizes may well require different medical treatment for the same outcomes and come to us with different experiences. This difference is something we'll want to be aware of. So being weight-neutral isn't the most effective framing, in the same way that being gender blind, or race neutral, works against social justice. Another term could be "weight aware", and some researchers use "weight inclusive."

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[2] Prognostic value of weight change in chronic obstructive pulmonary disease: results from the Copenhagen City Heart Study. Eur Respir J 2002; 20: 539–544

Is HAES practice the same as a wellness approach? *

A wellness approach can be thought of as an approach promoting wellness rather than weight loss. Typically, you'll find mention of size acceptance, intuitive or mindful eating, and joyful movement.

The Association for Size Diversity and Health, ASDAH, are copyright holders for the HAES trademark. ASDAH define HAES as 'grounded in social justice'. So, to my reasoning, it follows that the HAES term doesn't describe any wellness approach, just those grounded in social justice. In other words, HAES can be thought of as a wellness approach grounded in social justice.

Does this mean teaching self-acceptance, intuitive eating and active embodiment is redundant? Of course not. It means that we keep health behaviours in perspective and help people make sense of how the context of our lives impacts choice, opportunity and outcomes in interlinked ways. Here's an example. Many people have heard of "white coat syndrome" which explains a sudden rise in blood pressure when we're waiting to have blood pressure checked. The blood pressure-stress link is an obvious case where there's more to it than diet, exercise and self-acceptance, though these three can also impact outcomes. Wider factors, such as stress, are too often off-radar when it comes to the health conversation. As a result people can end up feel confused or even guilty for poor health outcomes.

Making room for non-behavioural factors helps keep the bigger picture in perspective, reducing judgement and enhancing a sense of agency as people are better able to make sense of their experiences. It also makes for more accurate science, and ensures we're working within ethical codes requiring fully up-to-date and evidence-based practice.

* You'll no doubt come across instances where there is confusion between a wellness approach and a HAES approach: just calling an approach HAES doesn't make it so! One such example is in the 2011 paper I wrote with Linda Bacon. We said the RCTs showed the effectiveness of a HAES approach but it would be more accurate to say they showed the effectiveness of a wellness approach. This doesn't negate their effectiveness: the research still strongly finds in support of size acceptance, intuitive eating and active embodiment only not in programmes known to be grounded in social justice. In fact, the seed of confusion is sown early on where we give an inaccurate definition of HAES, one that misses out the bigger picture. If I was to rewrite this now I'd say something like:

> "the primary intent [of HAES practice] is to build a society where every body (and explicitly including people of all sizes) is respected and to promote wellbeing for all by advancing social justice and fostering compassionate self-care".