

Moving towards a weight-neutral approach to obesity management

Devyn E. Parsons^{a,°}, BSc

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[°] Corresponding author: devyn.e.parsons@alumni.ubc.ca

^a MD Student 2019, Faculty of Medicine, University of British Columbia, Vancouver, BC

abstract

Obesity is a leading public health challenge in the world today, due to its high prevalence and role as a risk factor for many health conditions, including cardiovascular disease, diabetes, and certain cancers. The substantial health risks to individuals and immense costs to the healthcare system posed by obesity could be diminished by successful management and prevention of obesity.¹ However, there continues to be a lack of effective obesity treatment or prevention strategies,² and obesity remains immensely stigmatized despite its prevalence.^{3,4,5,6} This commentary aims to discuss the inefficacy and adverse effects of traditional obesity care, the stigma carried by obesity, and the potential of a novel approach to obesity management known as Health at Every Size.

weight-based stigma and healthcare

Individuals with obesity face weight-based prejudice and discrimination in workplaces, educational institutions, interpersonal relationships, and the media.³ Even in medical settings, individuals with obesity are faced with stigma and discrimination. Higher patient body mass index (BMI) is associated with lower physician ratings of respect,⁴ and physicians report spending less time with patients with obesity, but ordering more tests,⁵ which suggests poorer patient outcomes and increased costs to the healthcare system.

Increased understanding of the complex etiology and refractory nature of obesity does not decrease stigmatization. A study of healthcare professionals specializing in obesity found significant implicit weight-based biases, and associations between obesity and laziness, stupidity, and worthlessness.⁶

effects of stigma on health and obesity

Weight stigmatization is a significant risk factor for depression, anxiety, low self-esteem, and body dissatisfaction, even

when controlled for BMI.⁷ In turn, lower body satisfaction is associated with binge eating, physical inactivity, and less healthy diets.⁸

Weight stigmatization may contribute to the development and maintenance of obesity. Exposure to weight-based teasing in youths is related to lower levels of physical activity and higher levels of unhealthy eating behaviours.⁷ Exposure to weight stigmatization in the form of apparent exclusion from a research activity on the basis of body size resulted in elevated cortisol levels in women who perceived themselves as overweight. This finding suggests weight-stigmatization may play a role in the pathogenesis of obesity, as cortisol stimulates appetite and abdominal fat deposition.⁹ Accordingly, individuals who report exposure to weight-based discrimination are more likely to become or remain obese at follow-up.¹⁰

inefficacy of traditional obesity interventions

The primary goal of traditional obesity management is to achieve weight loss via decreased caloric intake and increased physical activity.⁴ The 2015 guidelines for management of obesity in adults provided by the Canadian Task Force on Preventative Health Care continue to recommend this

approach,¹¹ despite the persistent increase in obesity prevalence of 66% in the United States within the context of this approach.³

A review of long-term outcomes of calorie-restrictive approaches to obesity treatment found that one-to-two thirds of dieters regain more weight than they lost on their diets.¹² Weight regain consists mostly of fat and does not replace bone and lean mass lost during the previous weight loss. Weight loss may therefore have adverse health effects such as increased risk of osteoporosis, in addition to being difficult to achieve and maintain. Individuals that successfully maintain weight loss generally must maintain high levels of restraint and physical activity.² This likely contributes to

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observed low rates of successful weight loss maintenance.

Traditional approaches to obesity management view physical activity as a tool for weight loss, which may impair perception of physical activity as having intrinsic value for health promotion.¹³ However, considerable evidence demonstrates health benefits of physical activity independent of weight loss. Several studies have demonstrated that accounting for physical fitness greatly reduces or even eliminates the widely cited link between obesity and increased mortality.¹⁴ Individuals who are obese but physically fit have been found to have lower mortality risk than individuals who are normal weight but physically unfit.¹⁵ In youth with obesity, exercise training improves insulin action, independent of changes in body weight or composition.¹⁶ There is thus evidence to support the value of increased physical activity in individuals with obesity regardless of weight loss outcomes. Furthermore, the emphasis of traditional obesity care on weight loss rather than intrinsic benefits of physical activity may result in decreased adherence to exercise programs, as patients may see failure to lose weight as an indicator that the program is not beneficial.¹

Current approaches to treating obesity have the potential to worsen weight-based stigma by conceptualizing obesity solely as a matter of caloric excess and physical inactivity. Within this paradigm, individuals are implied to be personally responsible for their obesity.² A study of obesity-related attitudes found that women assigned to a non-dieting program promoting eating when hungry and making healthy food choices reported significantly less negativity

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about obesity and less internalization of appearance standards than women in the traditional caloric-restriction dieting condition.¹⁷ This suggests that non-dieting approaches may have psychological benefits not present in calorically restrictive approaches.

Health at Every Size: a novel approach to obesity care

If traditional weight-targeted approaches to obesity care are both ineffective and potentially harmful or stigmatizing, what should healthcare practitioners do for patients with obesity? Evidence is accumulating in support of a holistic and weight-neutral approach to obesity management known as Health at Every Size (HAES). HAES promotes a healthier lifestyle at the individual's existing size, rather than focusing on weight loss as a primary goal.¹⁸

There are three major components to the HAES approach. The first component is to encourage size acceptance, self-acceptance, and appreciation for the natural diversity of human bodies.¹⁸ The second component is to promote increased physical activity for pleasure and intrinsic health benefits, without emphasis on calorie burning or weight loss.¹⁸ The third component is to normalize eating by encouraging patients to listen to internal hunger and satiety cues, and by reducing food-related anxiety through avoiding restrictive dieting.¹⁸

A review of six randomized controlled trials (RCTs) comparing HAES to waitlist controls or diet-based approaches found that a HAES approach was associated with improvements in physiological measures including blood pressure and blood lipids, health behaviours including physical activity and eating disorder pathology, and psychological outcomes including self-esteem and body image. None of the trials detected adverse changes in any measured variable after treatment with a HAES approach. Attrition was significantly lower in the HAES group compared to control group across five of the six RCTs.¹⁹ This is important given the poor retention rates

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of current obesity treatment methods.² Additionally, a recent RCT assessing changes in patterns of dietary intake in a HAES approach versus social support and waitlist control groups found a significant decrease in hunger and total daily energy intake in the HAES group compared to both control groups.²⁰ As previously discussed, non-dieting programs may also have psychological benefits through reduced anti-obesity attitudes and reduced internalization of appearance standards compared to dieting programs.¹⁷ It should be noted that none of the RCTs investigating HAES had large sample sizes, and only one RCT compared HAES to a more traditional diet-based method of obesity treatment.¹⁹ More research is required to establish the efficacy of a HAES approach over traditional obesity treatment methods. There has also been concern that a HAES approach may increase excessive food consumption and weight gain.² Although not observed in the existing literature, this possibility cannot yet be dismissed given the previously noted limitations of current HAES research.

If additional research confirms the efficacy of HAES for obesity care, this approach can be implemented on a public health level through the use of weight-neutral language in anti-obesity campaigns, public education on intrinsic health

benefits of physical activity, and inclusion of HAES and anti-weight bias training in medical school.²

From a clinical perspective, physicians can implement a HAES approach through self-education and discussions with their patients about advantages and disadvantages of HAES compared to traditional obesity care. Physicians should avoid admonishing their patients to lose weight, and focus instead on fostering positive health changes by encouraging their patients to accept, love, and care for themselves and their bodies through physical activity and a nutritious diet. Physicians should discuss the benefits of physical activity independent of weight loss with their patients, and help patients devise ways in which to incorporate pleasurable physical activity into their lives. Finally, physicians should discuss with their patients the limited efficacy and adverse effects of dieting, as well as strategies for more intuitive approaches to eating in accordance with internal body cues.¹⁸

Physicians should avoid admonishing their patients to lose weight, and focus instead on fostering positive health changes by encouraging their patients to accept, love, and care for themselves and their bodies through physical activity and a nutritious diet.

conclusion

Traditional approaches to obesity management recommend caloric-restriction and increased physical activity to achieve weight loss. These approaches have low success rates, with few individuals achieving and maintaining weight loss.² Additionally, traditional approaches to obesity management may pose health risks associated with weight regain and may perpetuate weight-based stigma.^{2,17} Physical activity has tremendous health benefits independent of weight-loss, and should thus be encouraged in patients as a health-promoter in its own right.¹³⁻¹⁶ A HAES approach to obesity management promotes healthy lifestyle choices at the individual's current weight, rather than targeting weight loss as a goal.¹⁸ Preliminary research shows promise for this approach in terms of physiological measures, health behaviours, and psychological outcomes.^{19,20} Evidence thus suggests that a weight-neutral approach including promotion of physical activity and a nutritious diet may offer a promising new direction for obesity management.

disclosures

The author does not have any conflicts of interest to disclose.

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