Health at Every Size

A Compassionate, Effective Approach for Helping Individuals With Weight-Related Concerns—Part II

by Jon Robison, PhD, MS, Kelly Putnam, MA, and Laura McKibbin, LISW

Editor's Note—It seems that everyone in the health care and business communities is talking about the "obesity epidemic," particularly what has caused the rise in overweight and obesity and what should be done to reduce the incidence and prevalence of the epidemic. Robison, Putnam, and McKibbin take a different approach to this public health issue and in this article suggest alternative interventions for overweight workers. After reading the two parts of this article (April and May 2007), review the references for accuracy, timeliness, and scientific rigor, discuss the ideas with colleagues, and then send your comments to the Journal. We will publish letters to the editor to stimulate discussion about best practices in addressing obesity and overweight for the benefit of both employees and employers. I look forward to receiving your comments.—J. W.

The underlying goal of traditional approaches to weight and health is for individuals to be smaller (i.e., lose weight). Little evidence exists supporting the efficacy of such approaches and concern is mounting that they may be violating the primary health care directive of "first, do no harm." Furthermore, as discussed in Part I of this article, which appeared in the April issue, traditional assumptions about the relationship of increased weight to poor health and premature death and the relationship of weight loss to improved health have been seriously questioned recently. An effective, compassionate alternative is available for individuals with weight-related concerns.

The rationale behind this approach first emerged in the 1970s when feminist activists began exposing the way in which women were being targeted, in contrast to men, regarding weight and health issues. Two major scientific reviews published in 1979 questioned the effectiveness and social appropriateness of traditional weight-loss treatment (Stunkard & Penick, 1979; Wooley, Wooley, & Dyrenforth, 1979).

Since then, numerous books and articles have been published challenging the basic assumptions of the biomedical emphasis on weight loss. From the combined work of many women and men from a variety of fields, the Non-Diet/Size Acceptance Movement was born. During the past 30 years, this movement has grown in popularity and developed into what is referred to by increasingly more of those involved as Health At Every Size (HAES). The basic conceptual framework of the HAES philosophy includes belief in:

- The naturally existing diversity in body shapes and sizes.
- The ineffectiveness and dangers of dieting for weight loss.
- The importance of relaxed eating in response to internal body cues.
- The critical contribution of social, emotional, spiritual, and physical factors to health and happiness.

The Table contrasts the underlying assumptions of traditional weight management approaches with those of HAES (Robison, 1997).

WHAT IS A HEALTHY WEIGHT?

HAES suggests that an appropriate "healthy weight" for an individual cannot be determined by the numbers on a scale, an ideal height/weight chart, body mass index, or body fat percentages. Rather, HAES defines a healthy weight as the weight at which individuals settle as they move toward a more fulfilling and meaningful lifestyle—one that includes eating in an unrestrained manner guided by internal cues and participating in enjoyable, reasonable, and sustainable levels of physical activity. The HAES philosophy does not suggest that all

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Table

Comparison of the Traditional Weight-Loss Paradigm With Health At Every Size

Traditional Weight-Loss Paradigm	*Health At Every Size*
Everyone needs to be thin for good health and happiness.	Thin is not intrinsically healthy and beautiful, nor is fat intrinsically unhealthy and unappealing.
Individuals who are not thin are "overweight" because they have no will power, eat too much, and do not move enough.	Individuals naturally have different body shapes and sizes and different preferences for food and physical activity.
Everyone can be thin, happy, and healthy by dieting.	Dieting usually leads to weight gain, decreased self-esteem, and increased risk for disordered eating. Health and happiness involve a dynamic interaction among mental, social, spiritual, and physical considerations.

Major Foci of Health At Every Size

Size Acceptance and Self-Acceptance

Affirmation and reinforcement of human beauty and worth regardless of differences in weight, physical size, and shape.

Physical Activity

Support for increasing social, pleasure-based movement for enjoyment and enhanced quality of life. Calorie burning and weight loss are not the goals of the activity.

Normalized Eating

Support for discarding externally imposed rules and regimens for eating and attaining a more peaceful relationship with food by relearning to eat in response to internal body cues.

individuals are currently at a weight that is the healthiest for their circumstances. It strongly purports that, over time, the movement toward a healthier lifestyle will, for most individuals, produce a weight that is healthy for them. Focusing on weight, as in traditional approaches, is most likely to produce weight cycling and, with time, increased weight. Although this conceptualization is often labeled "radical," it is congruent with the concluding statement of the National Institutes of Health Consensus Conference on Obesity (1992) that focusing on approaches that can produce health benefits independently of weight loss may be the best way to improve the physical and psychological health of Americans wanting to lose weight.

Removing the focus on weight does not imply ignoring health risks and problems. On the contrary, when larger individuals present with health problems, health professionals should consider and offer the same approaches they would for thin individuals with similar presenting problems. In the case of thin individuals with essential hypertension, for example, conventional approaches suggest changes in diet, increases in aerobic physical activity, and management of stress followed by medication if necessary. Larger individuals presenting with the same diagnosis are told to lose weight, despite all that is known about the most likely consequences of this recommendation. Because no effective intervention is available to accomplish this goal, it is likely the individuals will experience another failed attempt at weight loss. With the almost inevitable weight regain and subsequent weight cycling, the result may be an exacerbation of the original presenting complaint. Research suggests that larger individuals often postpone important health care when they have been repeatedly admonished about their weight (Amy, Aalborg, Lyons, & Keranen, 2006).

HEALTHIER AT EVERY WEIGHT

HAES supports a "holistic" view of health promoting that one feel good about oneself, eat well and in a natural, relaxed way, and be comfortably active (Burgard & Lyons, 1994). The Sidebar outlines the major foci for helping individuals with eating and weight-related struggles from the HAES perspective. These are elaborated on in the text that follows. In all situations, the goal for health professionals is to assist individuals in living healthier, more fulfilled lives by honoring and caring for the bodies they currently have.

Size Acceptance and Self-Acceptance

The focus on self-acceptance and size acceptance is seen as primary. Body dissatisfaction and hatred are rampant, particularly among women in the United States. Self-acceptance is an affirmation that just as human worth is not based on race, color, or creed, it also is not dependent on body weight, shape, or size. The obsession with thinness has spawned what may be the last culturally accepted prejudice against individuals who do not measure up to unrealistic societal standards of body shape and size. Like racism, sexism, anti-Semitism, and homophobia, according to Goodman (1995) this weightism is based on visible cues, defines a large group of individuals within

a narrow range of negative characteristics and behaviors, elevates the status of one group of individuals at the expense of another, and serves as a vehicle for bigots' anxieties, frustrations, and resentments.

The result of this prejudice is widespread social, economic, and educational discrimination against larger individuals (Gortmaker, Must, Perrin, Sobol, & Dietz, 1993; Roehling, 2002; Rothbloom, 1994; Solovay, 2000). As with all forms of prejudice, however, not just the persecuted group suffers. Women of all sizes and increasing numbers of men suffer from the demands of unreasonable expectations that play havoc with their self-esteem and promote disordered eating and exercise behavior. As a cornerstone of HAES, self-acceptance involves honoring the natural diversity in the human form and challenging cultural weight prejudice. Health professionals must confront their own prejudices and learn strategies to empower clients to do the same. Materials have been developed to assist health professionals in understanding and combating their own weight prejudice, including many books written by larger female health professionals who have struggled with the pain of growing up in a thin-obsessed culture (Bernell, 2000; Bruno, 1996; Erdman, 1995, 1997; Goodman, 1995; Wann, 1998).

Physical Activity: To Move, Not Change the Body

Physical activity is widely recognized as an important element in health, yet most Americans of all sizes remain sedentary. HAES focuses on promoting social, playful, and pleasurable movement including not only jogging, cycling, and exercise classes but also activities connected with everyday living such as walking and gardening. Movement is encouraged for enjoyment, camaraderie, and improved quality of life, not calorie burning and weight loss. This approach is seen as critical to success, because exercise has not been shown to be any more effective for weight loss than has dieting. Weight loss is often promised by health professionals and expected by exercisers as a result of program participation. However, minimal weight loss is usually achieved, leading to frustration, cessation, and the forfeiture of the numerous health benefits often accompanying these programs.

HAES supports reasonable and sustainable physical activity. The traditional, structured, sports-oriented approach to movement does not work for many individuals and has likely frightened many more away from being physically active. The emphasis in HAES is on helping individuals find movement that is fun and that fits their circumstances. In addition, HAES acknowledges the prevalence of sedentary living in U.S. society as largely a cultural phenomenon that cannot be significantly impacted without addressing cultural barriers. This is especially true for larger individuals, many of whom are deterred from engaging in physical activity as a result of the ridicule and humiliation they have endured as a regular, ongoing part of their lives (Garner & Wooley, 1991). For many such individuals, discovering movement in a size-friendly environment can be a means of beginning to rediscover and reconnect to the bodies they have been taught to hate and ignore (Lyons, 1995). Resources are available to health professionals and clients alike for understanding and working through these issues (Kratina, King, & Hayes, 2003; Lyons & Burgard, 2000; Rice, 2001).

Normal Eating: Making Peace With Food

The externally focused, restrictive methods used by diet programs rarely succeed in helping individuals become healthy eaters. Strong evidence exists that humans are capable of regulating caloric intake according to internal hunger, appetite, and satiety signals (Davis, 1928; Johnson & Birch, 1994) and that chronic food restriction such as dieting interferes with this process and actually increases the likelihood of overeating (Polivy, 1996).

HAES endorses internally directed, "normal" (intuitive and mindful) eating as an important component of healthy weight and good health for individuals of all shapes and sizes. HAES refutes the concept of "good" and "bad" foods and discourages the use of externally focused eating strategies such as counting calories, carbohydrates, and fat grams. Instead, all foods are legalized and the focus is on reducing anxiety about eating. Individuals relearn how to eat in response to physiological hunger and satiety cues by paying attention to and trusting their bodies' signals about what, when, and how much to eat (Hirschmann & Munter, 1995; Satter, 1999).

Individuals who normalize their eating may or may not see changes in their weight. However, research has clearly demonstrated that this eating style can improve health by reducing the anxiety, guilt, preoccupation with food, bingeing, weight cycling, and weight gain commonly associated with restricted eating (Bacon et al., 2002; Bacon, Stern, Van Loan, & Keim, 2005; Ciliska, 1990; Omichinski & Harrison, 1995; Rosen, Orosan, & Reiter, 1995; Roughan, Seddon, & Vernon-Roberts, 1990).

HAES recognizes that individuals' struggles with food- and weight-related issues are often symptomatic of underlying distress that cannot be relieved merely by delivering nutrition information and advice. Trying to assist individuals with these kinds of issues while not doing harm in the process necessitates a compassionate, truly holistic approach including attention to the social, emotional, spiritual, and physiological aspects of food.

SHOW ME THE DATA

Given the tremendous vested interests supporting the status quo regarding issues of weight and health, it is not surprising that the HAES movement has many critics. Critics have particularly pointed to a lack of data supporting the effectiveness of HAES approaches. These same individuals continue to promote traditional approaches despite the almost complete lack of research supporting their efficacy.

Given a lack of funding (i.e., difficulty finding in-

Health At Every Size (HAES) in Practice

Self-acceptance

- Avoid admonitions to lose weight
- Positive change comes from self-acceptance and self-love, not from self-loathing
- Respect for diversity is for everyone
- Difficult to teach without doing one's own work

Pleasurable physical activity

- Fat does not necessarily mean unfit
- Do not associate physical activity with weight loss or calorie burning
- Physical activity as "caretaking"—"to move the body, not change the body"
- Encourage physical activity, not just exercise

Internally directed eating

- Listening to appetite, hunger, and satiety cues
- Can be relearned by teaching awareness
- No "good" or "bad" foods
- Food nourishes the body, mind, and spirit

Health vs. weight-centered care

- Avoid size-related assumptions
- Discuss weight and body image concerns with individuals of all sizes
- Focus on things such as well-being, energy level, lipids, and glucose rather than weight
- Provide concrete reasons not to diet while offering the HAES alternative

Health vs. weight-centered outcomes

- Improved quality of life and self-acceptance
- Amelioration of health problems and decreased reliance on medications
- Increased participation in and pleasure from physical activity
- Increased use of internally directed eating style and decreased obsession with food

terest groups to support research that does not include weight-loss products or services), limited research has been conducted directly comparing HAES approaches with traditional programs. However, as discussed in the April issue, numerous studies exist supporting the efficacy of approaches that can improve health independent of weight change. These studies conclusively show that risk factors traditionally labeled as weight related (e.g., elevated blood pressure, cholesterol, or glucose) can be ameliorated and often normalized in individuals considered to be obese with interventions that have little, if any, effect on body weight.

A study comparing the efficacy of a HAES approach with that of a state-of-the-art, traditional, behavioral weight-loss intervention was recently reported (Bacon et al., 2002, 2005). Both groups received 6 months of weekly intervention, followed by 6 months of monthly aftercare support and another year with no intervention. Participants in both groups experienced similar physiological and psychological benefits during a 6-month period, including improvements in metabolic fitness, eating behavior, depression, self-esteem, and energy expenditure. However, almost half of the diet group participants dropped out, and most of the health benefits they gained in the first 6 months had evaporated by the end of 2 years. In stark contrast, almost all of the initial benefits were maintained by the HAES group in the absence of any significant weight loss. Although perhaps surprising to some, these results are precisely what HAES supporters have been predicting for years. Focusing on health is effective for helping individuals improve their health, whereas focusing on weight is not. Bacon (2002) found that HAES, unlike the diet approach, allowed participants to maintain long-term behavior change.

RESHAPING THE PRACTICE

Nurses and other health professionals are likely to need some retraining to shift the focus of their work from weight loss to assisting individuals to be healthier at their current weight. This training must incorporate deep introspection regarding personal prejudices and struggles surrounding weight and eating. Research clearly demonstrates that a strong bias against fatness exists on the part of health professionals (Brown, 2006; Teachman & Brownell, 2001).

The training must also help practitioners identify individuals whose psychological issues make it appropriate to refer them for additional support. It also must include a broadened understanding of how complex sociocultural issues such as addiction, poverty, abuse, isolation, and oppression often underlie individuals' behavioral struggles. Although this has not been a major part of traditional training for many health professionals, trying to assist individuals without an understanding of the bigger context of their lives is likely to result in a continued lack of effectiveness and diminished credibility for health professionals. The Sidebar provides an at-a-glance reference for nurses wishing to incorporate the tenets of HAES into their work.

By breaking the endless cycle of weight loss and regain, the HAES approach can help stop the wasting of valuable resources resulting from the cultural obsession with thinness. The goal is to help individuals improve the quality of their lives regardless of their weight. The end result will be a less judgmental and more truly diverse culture and individuals leading happier, healthier, and more fulfilled lives by honoring and caring for the bodies they currently have. Because occupational health nurses have so much individual, day-to-day contact with employees, they can play a major role in trans-

forming the current, ineffective, weight-centered focus to a more effective and compassionate health-centered one.

HAES AT THE WORKPLACE: THE "HEALTH FOR EVERY BODY" PROGRAM

Weight management programs have long been a hallmark of occupational health and wellness promotion. However, the pressure on worksite health practitioners to do something about the U.S. "obesity epidemic" has intensified in recent years.

The HAES-inspired "Health for Every Body" (HFEB) program offers an alternative to traditional worksite weight-loss interventions, which, thus far, not only have been ineffective in addressing issues of weight and body image, but also have likely caused harm to many of the individuals involved and in the end have made these problems worse (point 3 below). HFEB was developed and implemented as part of the larger Kailo employee wellness initiative at a medical center where nearly 90% of the employees are women.

Given the current "war on obesity" climate, articulating to organizational leadership and employees why a worksite health and wellness initiative should reconsider offering weight-loss programs is the first step in adopting a HAES-friendly model. Kailo practitioners narrowed the somewhat complex HAES philosophy down to a few talking points to succinctly build the case for an alternative approach:

1. *Lack of efficacy.* Trying to lose weight through exercise, food restriction, and behavior modification is associated with a 90% to 95% failure rate. Despite these near impossible odds, more individuals are dieting than ever before. This begs the question: In what other world is a failure rate of 90% to 95% considered an acceptable outcome? Given the current emphasis on "evidence-based" practices in health care, the scientific validation is clearly lacking for continuing traditional weight management strategies.

2. *Poor investment.* Most occupational health programs do not suffer from overfunding. Given the budgetary challenges facing many worksite health practitioners, all programs and services must be evaluated based on their investment potential. Is a health promotion program for which the likely outcome is that half of the participants drop out and 90% to 95% are unsuccessful a wise use of scarce resources?

Dr. Dee Edington, Director of the Health Management Research Center at the University of Michigan, feels that money spent on weight loss is money down the drain, and that no diet program works beyond 2 years (Grossman, 2004).

3. *Iatrogenic effects.* Berg (2001) provides compelling evidence that promoting weight loss is not just ineffective; it can be unintentionally, yet seriously harmful. Berg links the culture's obsession with weight and thinness to (1) a dramatic twofold increase in eating disorders in the past decade; (2) a 55% prevalence of overweight adults (up from just 25% in 1970); (3) an estimated 80% prevalence of dysfunctional eating behaviors such as chronic dieting, undereating, overeating, good food–bad food thinking, and fear of food among women; and (4) size prejudice and discrimination. Increased body hatred and decreased mental health and well-being could be added to this list.

The Six Tenets of "Health for Every Body"

- Education—to provide the latest scientific research on weight and health not typically covered in the mainstream media.
- Normal eating—to teach participants how to (1) eat in response to internal, rather than external, cues; (2) refrain from dieting (restricting foods); and (3) avoid "dieter's mentality," which includes good food–bad food thinking, fear of food, chronic dieting, and starving–bingeing cycles.
- Movement for pleasure—to de-emphasize weight loss and body sculpting as the primary goals of physical activity and emphasize pleasure, feeling good, and increased energy.
- Self-acceptance—to encourage participants to work on issues of body hatred from the "inside-out."
- Social support—to recognize the role of relationships in addressing issues of weight and health and to build a supportive network of HFEB-friendly health professionals in the community.
- Size tolerance—to advocate for the fair and equal treatment of individuals of all shapes and sizes.

THE HFEB PROGRAM

Although Kailo has had a HAES philosophy since the program's inception in 1998, in 2004 the staff decided to devote an entire year of marketing and programming efforts to its promotion. This decision was prompted by increased pressure on the hospital's wellness program to do something about the "obesity epidemic."

Using HAES principles, the HFEB program was built around six tenets (Sidebar). The 2004 program featured the following:

- Kailo Breaks (Lunch 'n' Learns) featured national experts in the HAES movement. Speakers included Glenn Gaesser, PhD, author of *Big Fat Lies: The Truth About Your Weight and Your Health*; Pat Lyons, MA, coauthor of *Great Shape: The First Fitness Guide for Large Women*; Jon Robison, PhD, MS, coeditor of the Health At Every Size journal; Kathy Kater, LICSW, author of *Real Kids Come in All Sizes*; and Marilyn Wann, author of *Fat! So?*. Subsequently, one HAES speaker was featured each year.
- HFEB: The Workshop—a 6-week intensive work-

shop facilitated by a licensed independent social worker focusing on a more in-depth exploration of the six HFEB tenets. It was offered twice in 2004 and annually thereafter.

- Kailo for One—a licensed independent social worker on Kailo staff is available to work with employees individually on issues of weight and health from a HAES perspective.
- HFEB marketing included a logo design and calendar, brochure, T-shirt, and water bottle giveaways.
- HFEB Intranet page includes a full description of the HFEB approach and provides employees with more information about the concept, quizzes, a suggested reading list, and website referrals.
- HFEB self-study materials including books, videotapes, DVDs, audiocassettes, and workbooks available through the Kailo library on HAES-related topics.
- Gentle Fitness—a HFEB-friendly exercise class focusing on yoga, stretching, and relaxation.

HFEB: THE STUDY

In addition to a yearlong focus on HFEB programming for the entire worksite population, Kailo recruited 61 of the medical center employees to participate in a 12-month study determining how exposure to the HFEB approach might impact health outcomes. A summary of the study is provided below. Although no control group was possible due to the real-life setting of the program, the results remain of interest due to their similarity to those described previously from the research conducted by Bacon, after which the intervention was modeled (Bacon et al., 2002, 2005).

Recruitment/Selection

Sixty-one (60 female and 1 male) subjects were recruited via e-mail and Kailo Break announcements.

Intervention

Participants met with a study leader to review the menu of HFEB opportunities they could choose to engage in during the course of 2004 (e.g., Kailo Breaks, workshops, Gentle Fitness classes, Kailo for One, and self-study). Participants were given a diary in which to record their thoughts and track attendance in programs. They were invited to special sessions with each of the national HAES experts throughout 2004. Study leaders met quarterly with participants as a group to answer questions, address concerns, discuss how they were thinking and feeling about the HFEB program, and foster relationships between group members.

Results

Overall, the HFEB participants demonstrated both clinically and statistically significant improvement in body dissatisfaction, depressive symptomology, and disordered eating. Participants also appeared to have an increase in physical activity, but results in this category were not statistically significant. Pre- and post-program data were collected from 41 participants using the following standardized tools:

Beck Depression Inventory II (BDI II). The BDI II measures the presence of depressive symptomology. Scores of 14 to 19 indicate mild depression, 20 to 28 indicate moderate depression, and 29 to 63 indicate severe depression. Of all the pre- and post-program measurements collected from the HFEB participants, depression scores improved the most. This is not surprising given the relationship among poor body image, failed dieting, and decreases in emotional well-being. Twenty-seven participants had pre-program BDI II scores indicating they were not depressed; 14 participants were depressed. None of those not depressed became depressed, and 11 of the 14 scored less than 14 post-program. Overall, the HFEB participant group had a 41% improvement in their BDI II scores (pre-program mean, 9.7; post-program mean, 5.8).

Reducing depression is no small matter. In fact, its prevalence and high employer-paid health and lost productivity costs make depression one of the most significant untapped opportunities in worksite health promotion. The Health Enhancement Research Organization study estimated a depressed employee generates $1,508.90 more in annual health care claims than a non-depressed worker (Goetzel et al., 1998). Kessler et al. (1999) estimated the salary-equivalent loss in productivity due to depression at $182 to $395 per month per employee.

With the use of these estimates, by-proxy cost savings were calculated for each HFEB participant whose BDI II score was reduced to 13 or less—a score associated with "minimal" symptomology for depression (Beck, Steer, & Brown, 1996). The medical center's total estimated cost savings associated with the reduction of depressive symptomology during the HFEB study year was $54,613.90 when 11 (the number of participants no longer depressed) was multiplied by $1,508.90 (the reduction in annual health care claims) and $288 (the average per month in regained productivity). Adjusted for inflation in 2007, the estimated savings was $58,834.70 (www.bls.gov/cpi).

These results suggest that one of the major benefits of using a HAES approach with weight issues in the workplace may be a reduction in employee depression. More traditional weight management approaches have been associated with a decline in mental well-being (Seligman, 1993).

Body Image Avoidance Questionnaire (BIAQ). The BIAQ measures body dissatisfaction by asking individuals to rate the frequency of their avoidance of activities due to body dissatisfaction. Research indicates the average score in samples of patients with eating disorders is 40, and the average woman has a score of 30 to 31.5. As a group, the HFEB participants' scores improved by 22% (pre-program mean, 30.439; post-program mean, 23.707).

Three-Factor Eating Inventory (EI). The EI measures disordered eating in three categories: (1) cognitive restraint (i.e., the amount of time and energy one spends thinking about food); (2) disinhibition (i.e., one's tendency to overeat in the presence of a disinhibitor such as alcohol, low mood, or stress); and (3) hunger (i.e., the individual's perception of hunger throughout the day). As

IN SUMMARY

Health at Every Size

A Compassionate, Effective Approach for Helping Individuals With Weight-Related Concerns—Part II

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1. The underlying goal of traditional approaches to weight and health is for individuals to be smaller (i.e., lose weight). Little evidence exists supporting the efficacy of such approaches and concern is mounting that they may be causing harm.

2. An effective, compassionate approach to issues of weight and health—Health At Every Size (HAES)—acknowledges the naturally existing diversity in body shapes and sizes, the ineffectiveness and dangers of dieting for weight loss, the importance of relaxed eating in response to internal body clues, and the critical contribution of social, emotional, spiritual, and physical factors to health and happiness.

3. Occupational health nurses can use the HAES approach at the worksite to assist employees with effectively addressing their weight-related concerns.

a group, the HFEB participants had a 17% improvement in cognitive restraint scores, meaning they spent less time and energy thinking about food; a 23% improvement in disinhibition scores, meaning they overate less; and a 37% improvement in hunger scores, meaning they reported feeling hungry less often throughout the day.

Stanford 7-Day Physical Activity Recall (PAR). The PAR measures the frequency and intensity of an individual's physical activity. Participants' post-program scores were compared with their pre-program scores to obtain a percentage improvement. As a group, the HFEB participants had a 7% improvement. Although this was not found to be statistically significant, even small improvements in physical activity can be highly significant to health and well-being on an individual basis.

A 2007 HFEB UPDATE

Kailo continues to be committed to promoting the HAES philosophy through the employee health and wellness program. Although resistance occasionally surfaces and traditional weight-loss strategies are still being used in other areas of the hospital, the leadership at the medical center continues to allow space for an alternative approach in addressing what is an emotionally charged and complex health issue for its employees. Occupational health professionals involved in helping employees with their weight-related concerns should encourage size acceptance, reduced dieting, and increased awareness of and response to body signals (Bacon, 2005).

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