Hello,

Due to the COVID-19 outbreak and our transition to virtual care, The Central Coast Treatment Center has been serving clients across numerous counties in California. Because this means our clients are being medically monitored by providers we do not necessarily have a working relationship with, I am writing to share some basic education pertaining to the eating disorder population. If you are not already familiar with us, The Central Coast Treatment Center offers both intensive outpatient and partial hospitalization programs for the treatment of eating, exercise, and body image disorders out of San Luis Obispo. We serve clients of all ages, genders, and sizes. My intention with this letter is to open the door for further communication between our offices so that we can coordinate the best, most respectful care for our clients. Please share this letter with any members of your team that provide direct client care.

As you may know, eating disorders come in all shapes and sizes; it is impossible to tell by someone's appearance (or weight) if they have an eating disorder. Pair this with the emotionally-charged concept of "weight control" – the desire, with or without perceived medical urgency, to change body weight – makes for an uncomfortable conversation for patient and provider alike. If a client with an eating disorder is to have their weight monitored, it is crucial that a blind weight is taken – meaning the client is not given their weight (orally or in written documents) nor feedback about their weight trajectory ("up or down" or, even worse, "good or bad.") There are several reasons for this. The first being that a focus on weight perpetuates shame and disordered behaviors. It allows room for weight bias to dictate care, consciously or otherwise. Furthermore, weight in and of itself is not an indication of health, well-being, or Recovery status. To focus on the number on the scale is to tell a client with an eating disorder "you are your weight." It can cause harm and it contradicts Recovery goals.

My guess is that the above statement: "weight is not an indication of health," strikes a chord of discomfort. As health care providers, we are taught the opposite. We are taught "obesity kills" and told that weight can be "fixed" through dedicated calorie counting and commitment to daily exercise. Many of us have even dedicated entire careers to combat the so-called "obesity epidemic." For a thorough overview of the medicalization of "obesity" and the harm that weight stigma causes, I highly recommend the newly released book *Anti-Diet: Reclaim Your Time, Well-being, and Happiness Through Intuitive Eating* by Christy Harrison, MPH, RD.

In the scope of this letter, I would like to summarize the basic principles of Health at Every Size (HAES.) To be clear, the HAES philosophy does not translate to Health at *any* size and fully recognizes the correlation between weight and illnesses such as cardiovascular disease and diabetes. Despite this correlation, to medically treat "obesity" with diet prescriptions is not evidence-based health care. A shocking majority (somewhere between 95-98% by most studies) of all diets fail to produce sustained weight loss. Those who do manage to sustain weight loss for more than five years have been shown to do so by engaging in dangerous and disordered eating

behaviors– behaviors that may meet clinical criteria for a diagnosis of an eating disorder, and are often missed or overlooked by health care professionals, if not praised as "healthy." Not only do diets fail, they actually lead to weight gain via sometimes irreversible damage to the metabolism. (Additionally, this weight gain, often called "weight cycling," is independently correlated to cardiovascular disease, diabetes, and other illnesses, and often not controlled for in weight studies.) Perhaps most importantly (or maybe I am just biased by my work) diets, whether sought willingly or prescribed by a health care professional, are arguably the number one risk factor in the development of eating disorders. Surely any other medical intervention with this failure rate and risk of harm would not pass as evidenced-based care.

What HAES offers is another way to treat clients of all sizes in a way that does not equate weight with health, risk causing emotional and physiologic harm, or diminish a client's value to the number on the scale. To accept HAES principles is to embrace size diversity while rejecting the idealizing or pathologizing of particular weights or shapes. It allows for health enhancement and respectful care with consideration of physical, economic, social, spiritual, and emotional needs – not just dietary and physical activity needs. For a lengthier explanation of HAES and a deeper dive into the science supporting it, I recommend the following books: *Health At Every Size: The Surprising Truth About Your Weight* by Lindo Bacon, Ph.D., and *Body Respect: What Conventional Health Books Get Wrong, Leave Out, and Just Plain Fail to Understand About Weight* by Lindo Bacon, Ph.D. and Lucy Aphramore, Ph.D., RD.

More simply put, here are some key actions your team can implement to provide HAES minded care:

1. Do not focus on weight or offer unsolicited weight loss advice. Assess health risk using other indicators like lab work and vitals. Try to address symptoms such as pain, immobility, digestive concerns, etc. without assuming weight is the culprit. For clients in a larger body, it may be helpful to first ask yourself, "What would I recommend if a client in a thin body had these same concerns?"

2. Do not encourage weight loss through dietary restriction. Not only is restriction an ineffective and potentially dangerous intervention, but it will also likely create guilt and shame when it fails. (People don't fail diets, diets fail them.) This guilt may make it less likely for the client to return for follow up care or continued treatment.

3. Do not assume clients in larger bodies are consuming sufficient energy. Symptoms of malnutrition, nutritional deficiencies, amenorrhea, or digestive upset can be the result of restrictive eating (or a full-blown eating disorder) and are often missed in clients in larger bodies.

4. Do ask open-ended questions related to eating and activity habits. Do encourage dietary variety and joyful movement.

5. Do refer to an eating disorder treatment facility if there is any suspicion of inadequate intake, binge and purge behavior, or excessive exercise.

The shame and harm caused by weight centered care and the alternative offered by the Health at Every Size Principles are relevant to all clients, eating disorder diagnosis or not. The eating disorder population, however, presents with a unique challenge in that their disorders are easily, and more often than not unintentionally, invalidated by friends and family, media influences, and medical professionals. It is ubiquitous with the disorder for my clients, regardless of shape or size, to feel they are "not sick enough." This thought is as dangerous as it is incorrect and often stands in the way of the appropriate treatment. My hope is that all clients with eating disorders receive care that does not reinforce this thought and I believe removing the focus on weight from the center of that care is one step in the right direction. Open communication between care providers is the next step.

Please know that the team at Central Coast Treatment Centers is here to support you, your team, and your clients with any eating, exercise, or body image concerns. Our website offers more information related to eating disorders that is appropriate for both clients and medical providers. Our intake assessment process is free and will determine the appropriate level of care for the client, if needed. Lastly, for an in-depth medical overview of eating disorders, I'll leave you with one final book recommendation: *Sick Enough: A Guide to The Medical Complications of Eating Disorders* by Jennifer L. Gaudiani, MD, CEDS, FAED.

Respectfully,

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