

Ethical Considerations of Behavioral Weight Loss Programs for Obese Clients

with Binge Eating Disorder

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Introduction

Binge Eating Disorder (BED), as defined by the DSM V, is a disorder characterized by recurrent episodes of binge eating within a discrete period of time in which one experiences feelings of being out of control while consuming an amount of food that is larger than what most people would eat in a similar period of time (American Psychological Association [APA], 2013). Though the disorder occurs in both normal-weight and overweight individuals, it is more strongly associated with the development of obesity (APA, 2013). In the United States, BED is equally prevalent across non-Latino whites, Latinos, Asians, and African-Americans and the disorder additionally occurs with similar frequencies across most industrialized countries (APA, 2013). An important note about prevalence as it relates to the current paper is the fact obese individuals with BED more commonly seek weight loss programs compared with obese individuals who do not have BED (APA, 2013).

In the 1990's binge eating was first recognized as a formal diagnosis (Thoma, Pilecki, & McKay, 2015). Prior to 1992, individuals with this type of behavior were labeled as emotional overeaters, compulsive overeaters, and food addicts (Thoma et al., 2015). Additionally, the DSM V was the first version of the DSM that included BED as its own disorder, and separate from EDNOS (Thoma et al., 2015). This recognition legitimized the disorder and allowed people to access care under their insurance plans for treatment.

Given the recentness of BED's recognition as a mental health disorder, treatment history and approaches are relatively new. However, as with all eating disorders, BED is generally treated through an integrative approach including psychological interventions, medication, and

ETHICS OF WEIGHT LOSS FOR BED

nutrition therapy (Mayo Clinic Staff, 2015). There is, however, a dichotomy in the way BED is currently treated as it relates to weight loss (Wilson, Wilfrey, Agras, & Bryson, 2010).

In a more traditional paradigm, the goals of treatment are to reduce eating binges and in the cases of clients who are obese, lose weight (Mayo Clinic Staff, 2015; Wilson et al., 2010). The most common psychological treatment is cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT), with interventions targeted at maladaptive cognition and behavior associated with binge eating and an aim to reconstruct one's rigid thinking about body shape and weight (Shea, Cachelin, Gutierrez, Wang, & Phimphsone, 2015). Medication management has generally included Topamax and various anti-depressants, particularly the Selective Serotonin Reuptake Inhibitors (SSRI's) (Mayo Clinic Staff, 2015). Within the last year, the Food and Drug Administration (FDA) expanded the use of an Attention Deficit Disorder medication, lisdexamfetamine dimesylate (Vyvanse), to include the treatment of BED (FDA, 2015). If a history of failed attempts to lose weight has been reported, the medication and CBT treatments are often paired with behavioral weight loss (BWL) programs (Mayo Clinic Staff, 2015). BWL interventions are widely used to treat obesity, including binge eating disorder, via caloric restriction, improved nutrition, motivational interviewing, and rigorous physical activity (Mayo Clinic Staff, 2015; Wilson et al., 2010). This last component of treatment is recommended once the disorder has been treated for an extended period of time, as dieting may trigger more binge-eating episodes (Mayo Clinic Staff, 2015).

While these traditional methods continue in their use, new and emerging data suggest that a Health at Every Size (HAES) model may be more effective for the treatment of BED and differs in its decision to forgo BWL programs (Bacon, Stern, van Loan, & Keim, 2005; Wilson et al., 2010). HAES is a public health movement that promotes size and self-acceptance,

ETHICS OF WEIGHT LOSS FOR BED

encourages pleasurable physical activity, eating well, and ending societal weight bias (Bacon et al., 2005). Rather than focusing on weight loss, it redirects focus to overall health behavior and intuitive eating instead of weight as the key measure of health (Bacon et al., 2005). The intervention is valuable for BED treatment, as it shifts a self-defeating focus on weight to an empowering focus on health promoting activity (Bacon et al., 2005). Additionally, eating disorder treatment facilities adopting a HAES philosophy in their treatment models claim that it is the continual fear of being “overweight” that may prevent full recovery and/or the cessation of trying to control weight (Bacon et al., 2005).

Given the conventional treatment modalities that include BWL interventions and the fact the American Medical Association (AMA) and the Center for Disease Control (CDC) now recognize obesity as a disease, while at the same time there is a rise in the advocacy against weight stigma through the HAES philosophy, an interesting dilemma arises regarding the ethical implications of promoting weight loss (Bacon et al., 2005; Martinez, 2013; Wilson et al., 2010). While both traditional and HAES treatments have shown short-term effectiveness in the treatment of BED, the new rise in awareness of weight stigmatization in the healthcare industry question whether BWL interventions are ethical (Hand, Robinson & Creel, 2013; Wilson et al., 2015). The present paper will address the following dilemma: as a mental health counselor on a treatment team for an obese client with BED, is it ethical to endorse BWL programs? The decision process is evaluated by considering the ACA Code of Ethics as it relates to treatment effectiveness and evidence-based medicine, client dignity and non-discrimination, and informed consent and values (ACA, 2005).

Treatment Effectiveness & Evidence-Based Practice

ETHICS OF WEIGHT LOSS FOR BED

Counselors are ethically bound to promote efficacious treatment plans with reasonable levels of success (ACA, 2005). Additionally, they have a professional responsibility to base interventions and treatment goals in theories supported by a sound scientific foundation (ACA, 2005). Therefore, a first consideration for BWL programs is whether weight loss is likely achievable and how its effectiveness has been evaluated. Literature demonstrates that health-based educational efforts to reduce body weight have been largely unsuccessful in terms of reducing the prevalence of obesity, increasing physical activity, or altering dietary patterns of the American diet (Hawks, 2000). Additionally, research on the effectiveness of non-surgical weight loss treatments, regardless of modality, have failed to reveal a consistently effective treatment approach (Tomiya, Mann, Vinas, Hunger, DeJager, & Taylor, 2010). In fact, 95% of people who lose weight through dieting, exercise, or other treatment modalities, regain the weight loss within a year (Bacon et al., 2005). In addition to the questionable efficacy of weight loss treatments in general, many professional organizations that study treatment interventions for eating disorders recognize that those with BED have an even greater difficulty sticking to a traditional BWL program (ANAD, 2015). This statement might suggest that the 5% effectiveness previously mentioned would not apply to those with a history of BED.

In evaluating whether 5% effectiveness warrants endorsement of BWL, it's helpful to turn to the ethical decision making process of conversion therapy for gays/lesbians, particularly since both BWL and conversion therapy assume that the individual is in part choosing to have their 'condition,' and that change is in their full control (Cramer, Golom, LoPresto, & Kirkley, 2008; Hawks, 2000). The criteria for empirically supported treatments (ESTs), as determined by the APA, can be used to evaluate the evidence (Cramer et al., 2008). For starters, BWL programs need to have at least two rigorous randomized control trials demonstrating

ETHICS OF WEIGHT LOSS FOR BED

effectiveness over placebo or other proven treatments (Cramer et al., 2008). However, despite showing short-term effectiveness, BWL programs are not as effective as CBT or IPT in the short-term, and they have yet to show long-term success (Wilson et al., 2010). Therefore, BWL has been relatively untested due to the fact weight loss interventions have yet to produce sustained results in order to test for long-term health benefits (Bacon & Aphramor, 2011). With such limited empirical efficacy, BWL programs would not meet the criteria for Category 1 ESTs as defined by the APA (Cramer et al., 2008).

In addition to having rigorous, consistent benefits in literature, another consideration when evaluating the effectiveness of BWL programs is whether the results of weight loss equate to better health. In order for a clinician to promote BWL in addition to healthy behavior change, there must be scientific evidence that suggests weight loss, specifically, leads to healthier outcomes than health behavior change alone. However, it has yet to be proven whether obese individuals who lose weight have lower disease incidence in rigorous, random controlled trials (Bacon & Aphramor, 2011; Williamson, Pamuk, Thun, Flanders, Byers, & Heath, 1999). Williamson et al. (1999) studied 43,457 overweight, non-smokers regarding weight change and health status and found that initial health status mediated all associations between intentional weight loss and longevity, suggesting that weight loss was only associated with health status when individuals already had better health markers. Additionally, while intentional weight loss's effectiveness at increasing health is unsupported, it *is* clear that health indicators can be improved by lifestyle changes, regardless of weight loss (Bacon et al., 2005). A counselor must decide whether the pure association between chronic disease and weight is strong enough to warrant BWL programs in light of evidence suggesting lifestyle changes, independent of weight, can promote health in BED clients in non-discriminatory, and more efficacious, ways. If making

ETHICS OF WEIGHT LOSS FOR BED

this decision by using the APA's guidelines for ESTs, a counselor would not accept this association as sufficient justification for supporting BWL programs (Cramer et al., 2008).

Client Dignity & Non-Discrimination

A second key consideration in whether to promote BWL programs for obese clients with BED is the fact a counselor needs to consider their responsibilities to ensure the dignity and welfare of their clients (ACA, 2005). A counselor is also required to avoid participation in any type of discrimination in addition to engaging in advocacy efforts at the individual, institutional, and societal levels for increased quality of life for their clients (ACA, 2005). Before examining the ACA ethics code in these areas, it's important to understand the origins of weight stigma. Weight bias is thought to stem from racism (Hand, Robinson, & Creel, 2013). The prevalence of obesity is 44.1% in African Americans, the highest prevalence rate of all races and ethnicities in the US and it is, therefore, not likely coincidental that obese individuals are seen as 'stupid, ugly, and lazy' much as African Americans have been similarly, and unjustly, labeled by racist individuals (Hand, Robinson, & Creel, 2013). Because of this parallel, it's important to assess the health costs of discrimination on obese clients and to ensure that, as a counselor, added discrimination is avoided.

Individuals with BED already have a higher prevalence of shame, self-loathing, and low self-esteem (APA, 2013; ANAD, 2015). Therefore, helping these clients preserve dignity and respect is paramount (ANAD, 2015). With the aforementioned 95% of individuals failing to sustain weight loss post BWL programs, a counselor should assess the implications for a client's dignity if weight loss is not achieved through such programs (Bacon et al., 2005). An ethical counselor must consider that encouraging weight loss without proven efficacy in treatment

ETHICS OF WEIGHT LOSS FOR BED

promotes the societal values of thinness for the sake of the concept alone with little clinical justification (Bessenoff & Sherman, 2000).

Similarly, endorsing BWL programs suggests the element of control that a client has over their weight status and increases perceived individual responsibility felt by the client (Cramer et al., 2008). However, weight is influenced by a myriad of external factors including genetics, social environment (access to safe walking trails, bike routes, and parks), and prejudice (Abbate, Daga, Gramaglia, Amianto, Marzola, & Fassino, 2010; Beety, 2013). By emphasizing the internal locus of control above external factors, failure to meet weight loss goals can lead to low self-esteem and further body disgust in a population with an already higher risk for body dissatisfaction and low self-esteem (Abbate, Daga, Gramaglia, Amianto, Marzola, & Fassino, 2010). Similarly, by failing to recognize the external factors, a message is communicated that an obese individual should work harder to be a different size and/or shape (Beety, 2013).

This last point brings us to then consider whether BWL programs, in addition to decreasing clients' dignity, also promote discrimination. When looking specifically at discriminatory practice, it's necessary to assess whether traditional practice of promoting BWL programs for obese clients with BED but not non-obese clients with BED is a discriminatory practice in and of itself (Wilson et al., 2010). To begin, BMI is the indicator used to establish whether one's weight status is classified as obese or not, yet BMI fails to accurately determine health status or body composition, and is therefore a poor method for determining whether BWL would improve a client's health (Martinez, 2013). Therefore, promoting weight loss for an obese client with BED but not for a non-obese client with BED, with no other indication of health status, promotes stigmatization, and consequently, discriminatory treatment that is harmful on both an individual and societal level (Hand, Robinson, & Creel, 2013). In this way, a counselor

ETHICS OF WEIGHT LOSS FOR BED

should assess whether it's more ethical to promote one effective, health promoting and efficacious treatment technique for all clients with the same diagnosis of BED. Additionally, with eating disorder treatment often including group therapy, the potential for attention brought to differences in the utilization of BWL programs according to weight alone may be apparent when group members discuss their treatment process (Maxwell, Tasca, Ritchie, Balfour, & Bissada, 2014). This added social attention may further perpetuate weight stigmatization.

In addition to discriminatory practice, discriminatory attitudes must also be evaluated. Health professionals, even those who specialize in working with clients who are obese and/or have BED, are not immune to implicit weight bias (Hand, Robinson, & Creel, 2013). More specifically, counselors generally have more negative reactions toward overweight clients compared to thin clients (Bessenoff & Sherman, 2000). With prejudice extending to even those assumed to be the most sensitive to this bias, in that this group of clinicians have chosen to specialize in working with the obese population, a greater care must be taken that both implicit and explicit prejudice does not impact the therapeutic relationship (Hand, Robinson & Creel, 2013). Additionally, this weight stigma is almost seen as acceptable with the new designation of obesity as a global epidemic, allowing clinicians to practice prejudice without being seen as politically incorrect when contrasted with racial or gender bias, for example (Hand, Robinson & Creel, 2013). Most ethics codes for all types of practitioners promote fair treatment of all clients regardless of race, ethnicity, socioeconomic status, or gender (ACA, 2005). However, heightened weight stigmatization has yet to be included. Understanding that weight can be as much a part of one's identity as socioeconomic status and just as marginalized as race, an ethical clinician would assume responsibility for not promoting one weight over another (Hand, Robinson & Creel, 2013). Therefore, when considering BWL for an obese client with BED, it's

ETHICS OF WEIGHT LOSS FOR BED

important to consider whether doing so would lead to further marginalization and whether a lower body weight would be implicitly communicated to have greater value, violating principles of non-discrimination for marginalized individuals (ACA, 2005; Cramer et al., 2008).

Having such implicit attitudes can clearly lead to discrimination and stigmas and devastate the therapeutic alliance (Hand, Robinson, & Creel, 2013). Applying therapist and counselor characteristics necessary for ethical cultural competency, including: 1) awareness of oneself as a cultural being with biases, stereotypes, and assumptions; and 2) awareness of the views of culturally diverse clients, to the ethics of promoting BWL programs can be a helpful reference for understanding impact of personal biases, in part shaped by society, in the therapeutic relationship (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007). The greatest danger is the invisibility of the weight bias that prevents clinicians from realizing and addressing their roles in potentiating psychological stress for obese clients with BED and the impact of increased shame and self-loathing (Bessenoff & Sherman, 2000, Sue et al., 2007).

Overall, with the potential for discrimination, an ethical counselor should make sure that they disengage from the social norm of weight bias and take the required steps to promote changes at the individual and societal levels to promote quality of life and equal treatment of all clients of all sizes (ACA, 2005; Beety, 2013). A counselor must thus consider whether promoting BWL programs inherently invalidates all efforts to advocate for their already marginalized clients.

Informed Consent: Limitations of Treatment and Counselor & Client Values

A last few areas of the ACA ethics code that directly relate to the decision to promote BWL programs for obese clients with BED are that of informed consent in addition to client and counselor values (ACA, 2005). The ACA code of ethics states that counselors must explicitly

ETHICS OF WEIGHT LOSS FOR BED

explain the nature of all services provided including the orientation of the counselor, goals, and the potential limitations and risks of treatment (ACA, 2005). Informed consent therefore provides a structure to allow counselor and client collaboration about treatment recommendations and their risks. Given the scant evidence of BWL programs explored earlier, an ethical counselor must inform all clients of its limited effectiveness (Wilson et al., 2010).

A key component of the ethical decision making process is detailing all of the potential consequences of a recommendation (Koocher & Keith-Spiegel, 2008). A first consequence to consider in deciding whether to promote BWL programs is that of physical harm. While increased physical activity can provide many health benefits to an otherwise sedentary person, dieting often contributes to weight cycling that has poor health implications (Tomiya et al., 2010). Also, obese individuals who are 'fit' have lower risk of mortality than thin individuals who are sedentary (Schloegl, Percik, Hortsman, Vlringer, & Stumvoll, M, 2011). While it appears that the evidence suggests that therapeutic techniques to encourage physical activity would be health promoting, it's important to acknowledge these benefits can also exist without a BWL program.

An additional consequence for dieting within BWL programs is that food restriction decreases circulating leptin which leads to increase desire for highly palatable foods while increasing the reinforcement value of food, proving to be a further trigger for those with BED (Schloegl et al., 2011). Caloric restriction and caloric tracking have also been seen to increase cortisol production and perceived stress, two factors known to increase weight gain (Tomiya et al., 2010). Such consequences of treatment don't only fail to lead to weight loss, but they may also exacerbate binge-eating symptoms (Schloegl et al., 2011).

ETHICS OF WEIGHT LOSS FOR BED

In addition to treatment limitations and consequences, a counselor is also required to disclose their own views of weight loss (ACA, 2005). Every client has the right to choose whether to enter a therapeutic relationship with a counselor, and whether a counselor believes in health as defined by BMI or according to HAES philosophies should be discussed unambiguously to allow the client to make an informed decision (Bacon et al., 2005; Martinez, 2013). When counselor and client views of BWL programs differ, for example when a client wants to lose weight while the counselor does not support BWL programs as an efficacious treatment strategy, another ethical predicament arises. It is a counselor's responsibility to meet the preferences and needs of the client independent of the biases of the counselor (Koocher & Keith-Spiegel, 2008). However, it's important to realize that client values do not form in a vacuum and are therefore created within a society promoting the thin ideal (Bessenoff & Sherman, 2000). A counselor must then understand the many factors that shape a client's weight loss goals. Knowing the origins of weight stigma in racism, an extension of Clark & Clark's (1947) study on the societal influence of internalized self-hatred of African American children, can be made to obese clients with BED, in that they, too, have negative self-images shaped by repeated, societal messages. In this way, while a client's goals warrant consideration, it's ethically necessary to expose the societal influences in their formation in order to truly differentiate client core values from prejudiced, societal expectations.

Conclusion

In conclusion, implications for treatment effectiveness, client dignity, and informed consent raise a logical question: should mental health professionals continue promoting BWL programs for obese clients with BED? In order to answer the question, a clinician can utilize the present paper to view the dilemma through several ethical lenses. Additionally, referencing

ETHICS OF WEIGHT LOSS FOR BED

literature on the evidence of conversion therapy for gays/lesbians and the relationship between racism and weight stigmatization can provide a helpful framework for viewing such a dilemma (Cramer et al., 2008; Hand, Robinson, & Creel, 2013). In coming to a decision, the present paper explicitly follows a suggested decision making process, laying out the ethical principles to consider, the need to assess personal bias, the evaluation of the rights and vulnerabilities of clients, alternative decisions, and the consequences of those decisions (Koocher & Keith-Spiegel, 2008).

The importance of this paper cannot be understated as BWL programs are still seen to be a viable treatment for obese clients with BED, and there are clear ethical considerations that must be brought to awareness at the very least (Mayo clinic staff, 2015; Wilson et al., 2010). In a time when social justice is at the forefront of many advocacy efforts and weight stigmatization has yet to be explicitly stated under many ethics codes' non-discrimination clauses, a competent counselor must consider the limited effectiveness of such treatment considerations in addition to the potential for discrimination and its far-reaching psychological, physical, and social consequences (Hand, Robinson, & Creel, 2013).

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