

## **THE “CHILDHOOD OBESITY EPIDEMIC”**

### **What is The Real Problem and What Can We Do About It?**

**By Dr. Jon Robison**

#### **Foreword**

**By Radley Balko**

A recent report in the British Journal of Developmental Psychology says that girls as young as five years old are beginning to have problems with body image. The authors concluded that the girls "felt 'paranoid' about their weight - partly because of the Government's anti-obesity message," according to the *London Telegraph*. Girls as young as eight are being diagnosed with eating disorders. The situation is no different in the United States. If we crunch the available data on eating disorders (with data from the National Institute of Mental Health) versus the number of children who have Type II Diabetes (the most common ailment associated with childhood obesity -- data comes from the Center for Disease Control) we find that the average child today is somewhere between 222 and 1,097 times more likely to have an eating disorder than Type II Diabetes.

Why in the world would a state like Arkansas, then, boast about how it forces each of its public school students to stand on a scale, then sends notes home parents about the child's Body Mass Index?

Why are lawmakers in New York, Georgia, and Texas considering similar proposals? Because, obesity is the outrage *du jour* of late. Body image and eating disorders are *passé*. If policies enacted to fight obesity make adolescents and teens more likely to develop eating disorders, well, that's a consequence of how some health activists and media outlets have arranged priorities.

The unfortunate policies don't stop there. Why did Texas attempt to ban elementary students from bringing cupcakes to school, even to celebrate a birthday? Why have some lawmakers proposed allowing teachers to rifle through lunchboxes and seize *contraband* such as Snickers bars and Pixie Sticks?

The answer of course is hysteria. We're in the midst of a moral panic over obesity. We're told that we've been getting fatter for thirty years, and that this thickening of our waistlines portends a coming healthcare catastrophe. Yet over that same period of time, our life expectancy has risen to all-time highs, while cancer, heart disease, and stroke have dropped off dramatically.

Of course, when we're talking about children, the rhetoric only heightens. "We need to do something -- for the children," is a refrain so common in American politics, it's become cliché. Invariably, "for the children" means taking control away from parents, and handing it over to panicked bureaucrats and health activists. "For the children" means *act now*. It means do what at first blush seems obvious; to do what *feels right*, consequences and real world implications be damned.

Nutrition activists and self-appointed public health advocates are beating down the doors of Congress, and they want action—any action. At an obesity conference in June 2004, the president of largest public health organization in the country -- the Robert Wood Johnson Foundation -- acknowledged that the real-world consequences of obesity weren't yet known, but that, nevertheless, "we must act ahead of the science." That's a rather remarkable charge. Act blindly, and rashly. Whether or not a given policy is practical, survives an analysis of its costs and benefits, or effects unintended consequences, then, isn't important. Our children are getting big, anti-obesity crusaders say. And if their parents aren't satisfactorily monitoring their own children's diet and exercise, it's time for the state to step in. In this important paper, Dr. Jon

Robison calls for a "timeout" from all of the hysteria. He calmly and lucidly scours and summarizes the body of academic work on childhood obesity, and comes to a few conclusions most Americans might find surprising, or at least contrary to conventional wisdom.

First, Dr. Robison explains, there's really no good way to define "childhood obesity." The BMI is problematic enough for adults, but it's even more impractical when used on children, who grow and physically mature at different rates at different ages. It's not really even possible to define what is a "normal" weight for a given child at a given age and a given height. Children's growth habits just aren't unpredictable enough to draw such broad conclusions.

Second, the data is far from conclusive that overweight or obese children grow up to be overweight, obese, or unhealthy adults. This is the most common reason why advocates and policymakers often call for government action.

Third, it's likely that the real scope of the child obesity "epidemic" has been exaggerated by the government, public health activists and the media. Dr. Robison notes that between eighty-five and ninety percent of American children are of acceptable weight. The trend seems to hold in Britain too, where activists have been particularly alarmist and reactionary about the problem.

Fourth, Dr. Robison also debunks the common assumption that our kids are not only eating more today, they're eating more of the wrong kinds of food. He cites published, peer-reviewed research showing that energy intake among children is actually on a downward slope, as is the number of calories kids consume from fat.

Next, Dr. Robison questions claims (often put forth by advocates for the food industry), that today's kids are plumper because they

don't move as much as they did in the past. While the evidence on just how active today's kids are is conflicting, Dr. Robison points to several studies that find no direct correlation between, for example, TV viewing habits and childhood obesity. Dr. Robison then examines and dismantles the panoply of proposals aimed at reducing the collective weight of America's kids. He concludes that most place too much emphasis on restricting options, focus too fixedly on thinness, and create unhealthy relationships between children and food (designating "good" and "bad" foods).

Ultimately, Dr. Robison suggests we inculcate in kids a healthier approach to food, one that emphasizes the inherent risks and fallibility of dieting, accepts the fact that we human beings come in a wide variety of sizes and shapes, encourages pleasurable, sustainable physical activity, and fosters normal eating patterns based on our internal cues of hunger appetite and satiety.

The media is always eager to bite on a crisis. See the rash of shark attack reports several summers ago (actual attacks were down), or the kidnapping reports from three summers back (those were down, too). The CDC's now-discredited claim that 400,000 Americans die each year due to obesity was swallowed whole by journalists and health professionals across the country, with very little skepticism. They also bit on a story a decade ago that put the number at 300,000. These statistics weren't without their critics. It's just that those critics didn't make the news. Of course, the critics were ultimately vindicated -- the agency recently revised its figure down to 115,000, or 25,000 when you discount for lives saved from the health benefits of modest overweight. That means the original figure was off by a factor of fifteen. Perhaps we've finally reached the point where the obesity panic is the "norm" in newsrooms, and its critics are the kind of "man bites dog" story journalists clamor for. If that's the case, Dr. Robison's thorough refutation of the conventional wisdom on childhood obesity ought

to provide ample grist for the next round of stories on America's battle with the bulge.

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### **What is The Real Problem and What Can We Do About It?**

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It would be very difficult to overstate the urgency that U.S. government and health officials have placed on the dangers posed by obesity. The rhetoric reached a new zenith in 2003, when Surgeon General Richard Carmona warned that obesity was, for Americans, “a greater threat than weapons of mass destruction” from which nothing short of a “cultural transformation” could save us.

At the same time, nothing in the field of healthcare has been more conclusively proven than the abject failure of traditional approaches to obesity. Over the last hundred years, the medical establishment has prescribed a plethora of often dangerous and sometimes lethal treatments to promote weight loss in “the name of health.

Tragically, heightened fears elicited by recent government proclamations about the “obesity epidemic” in children are driving caring, concerned parents to allow their children to be subjected to these same dangers also “in the name of health.” While the continued use of such failed and potentially dangerous treatments on adults is deplorable, their extension to non-consenting minors is tantamount to criminal.

It is bad enough that larger children are regularly singled out and teased by other children and sometimes even by teachers. Now we are asking schools to weigh children and send notes home to parents when these children are deemed to have a “weight problem.” Both children and adolescents are faced with constant

haranguing about the dangers of fat and an overload of media images of often grossly underweight celebrity role models.

Growing efforts by the “food police” to promote “healthy eating” have led to organized searches through children’s lunch boxes, prohibition of cupcakes from birthday parties and confiscation of other “contraband” foods. Taken together these types of measures threaten to do irreparable damage to both the physiological and psychological health of our children. They are already exacting a heavy toll in terms of self-esteem, eating habits and body image. The time is long past due for us to critically examine the premises on which the ‘childhood obesity crisis’ is built and adopt approaches that will help our children without harming them.

### **What Is “Childhood Obesity?”**

There is, in actuality, currently no widely accepted definition for “childhood obesity”. The U.S. Centers for Disease Control recommend using the Body Mass Index, (weight in kilograms divided by height in meters squared) to determine “overweight” in children.

Current guidelines propose that children be considered overweight if they fall at or above the 95th percentile and “at risk” of becoming overweight if they fall between the 85th and 95th percentiles. The use of BMI to measure weight and related health status has come into widespread use largely due to the difficulty of accurately measuring body fat in nonclinical environments. Unfortunately there are significant problems with its use, particularly with respect to children.

The first problem is that the most commonly used growth charts published in 2000 are based on a previous, slimmer population of children. While children have been growing taller and heavier and maturing earlier for over a century, the growth charts do not reflect

these changes, therefore, instead of 5% of children plotting at or above the 95th percentile (cutoff for overweight) 15% of children currently do. This tells us that the population as a whole is getting larger, but it tells us nothing of importance about the health of individual children. Even in adults, while the BMI provides reasonable estimates of average body fat for large populations of people, it is relatively inaccurate when applied to individuals.

Results from a number of studies indicate that the relationship between body fat and BMI in children is even more tenuous. (8, 9) In an article in the Journal of Pediatrics that evaluated this relationship, the authors concluded that “the available data do not show that BMI adequately reflects body fat mass in children and adolescents.” Additionally, children of different ethnic origins such as Mexican and Navajo tend to have shorter, denser body builds, which causes them to weigh more and plot higher on the BMI curves even though body fat is not elevated.

### **What Is Normal Growth and Development for Children?**

What is rarely discussed but most critical to understand when considering children’s growth and bodyweight is that the designation of the 95th percentile as a cutoff point for determining whether a child is overweight is a relatively arbitrary one.

Children’s weights like many human biological measurements are distributed according to a symmetrical bell-shaped curve (also called a *normal* distribution). For any age and gender, most children will weigh an average amount, with fewer children weighing considerably higher or lower than the average. Growth percentiles simply represent the cumulative percentages on the bell-shaped curve. This means, for instance, that the weights of 15% of children plot at the 15th percentile or below and the weights of 95% of children plot at the 95th percentile or below.

The important point is that, even though some groups of children may be by definition *unusual* in the sense that they are growing above or below the average, their growth may be at the same time quite *normal*.

Determining for children what is normal or abnormal growth should not be dependant on the percentile at which they are growing, but on the integrity or consistency of their growth over time. A thorough and illuminating exploration of what does and does not constitute normal, healthy growth for children can be found in child feeding expert Ellyn Satter's new book – “Your Child's Weight: Helping Without Harming”.

The bottom line is that many children tracking consistently at very high or very low percentiles may be demonstrating good abilities to regulate their food intake and to grow normally and predictably. On the other hand, if children, regardless of their BMI, are making abrupt shifts in their percentiles, either up or down, this may be a sign of abnormal growth which needs to be addressed.

With all of the hype and fear surrounding the “childhood obesity epidemic”, almost everyone has jumped on the bandwagon of assuming that large children are abnormal and in need of treatment. Yet, as Satter so eloquently explains: Despite all the exposure, the messages are still *wrong*. In truth, a child growing at the upper percentile is highly likely to be just fine. What is critical is how *consistent* his growth has been over time. At all times, a child's growth *must* be interpreted in the context of *that child's own history*. It cannot be interpreted on the basis of an arbitrary cutoff.”

## **Do Fat Children Become Fat Adults?**

The concern about high BMIs in children is based on the traditional “wisdom” that children who track at or above the 95th



percentile will inevitably end up as fat adults. This, however, is not supported by the available scientific evidence. In fact, according to a review of 17 studies that followed groups of children for decades the general tendency is actually towards slimming. The authors found that 75% of infants and toddlers, 60-70% of preschoolers and 50-60% of school-age children actually slim down by the time they reach adulthood. Furthermore, only 5-20% of obese adults were obese as children.

A more recent study following more than one thousand British families concluded similarly that there was “little tracking from childhood overweight to adulthood obesity and that “being thin in childhood offered no protection against adult fatness.” Only 21% of 3,000 obese adults questioned in 1946 had been obese at age 11, and 79% of obese 36-year-olds first became obese as adults.

Doctor David Klurfeld, Chairman of the Department on Nutrition and Food Science at Wayne State University and Editor in Chief of the American Journal of Clinical Nutrition summed up the reality of this seeming paradox: “It is intuitive that fat children will grow up to be fat adults, but the facts don’t always support intuition.”

### **Do Fat Children grow to be Unhealthy Adults?**

The focus on controlling children’s weight is, of course, based on the premise that without intervention, they will grow up fat, resulting in increased risk for disease and premature mortality. In fact, the relationship between increased weight and premature mortality has been seriously questioned. Most epidemiological studies do not show a strong correlation between weight and mortality except at the extremes of the bell-shaped curve.

Furthermore, Blair et. al, have shown that, when fitness is taken into consideration, fatness has little bearing on mortality for either men or women. In addition, the most recent research shows that the impact of overweight and obesity have been greatly exaggerated, with most fat people having little or no extra risk over their thinner counterparts.

When it comes to fat children and adult health risk, the relationship appears to be just as tenuous. The recent study of a thousand British families the authors concluded that there was “no excess adult health risk from childhood or teenage overweight.”

Furthermore, in the review of 17 studies that examined the tracking of obesity from childhood to adulthood mentioned above, children whose fatness persisted into adulthood had no more disease risk than adults who had never been fat. In fact, fat adult women who were also fat as children actually had *lower* triglycerides and total cholesterol.

With respect to the relationship between increasing weight and health, it is informative to note that for more than a century, increasing body weight has been strongly associated with *increased* life expectancy. Additionally, as the weight of the population has steadily increased over the past 50 years, mortality from so-called obesity-related diseases, such as heart disease and cancer has consistently *declined*. In spite of repeated frantic warnings about impending dire consequences, there is no data to support the fears that larger body sizes in children will suddenly begin correlating with decreased life expectancy.

### **What is The Real Scope of the Problem?**

There is little disagreement that the United States population, including both adults and children has gotten heavier since the 1950s. Though the problem for our children has been framed by

the government and the health establishment as an “epidemic” of gargantuan proportions, the actual picture is considerably less frightening. Even with the significant increases over the past fifty years, only about 15% of children between 6 and 19 years old and 10% of children between 2 to 5 years old are considered overweight, according to the relatively arbitrary and questionable cutoff points that have been described. This, of course means that 85% and 95% respectively in these age groups are not overweight.

Further more, the latest research looking at weight changes between 2,000 and 2,002 failed to find any increase in the weight of children over that period of time.

Interestingly, the accuracy of similar frantic pronouncements concerning childhood obesity from Great Britain has also recently been called into question. In analyzing data from the Health Survey for England 2003, researchers from the Social Issues Research Center concluded that “there have been no significant changes in the average weights of children over nearly a decade. This can be taken as evidence that there has been no ‘epidemic’ of weight gain, since an epidemic would certainly have affected average weights.” They decry as inappropriate “sensationalist claims and the quite unjustified use of terms such as ‘epidemic or ‘exponential rise’ to describe the current situation and conclude with a stern warning that would seem to apply equally well in our country.

We do no service to the people at risk of obesity-related morbidities in our society by ‘hyping’ their plight, exaggerating their numbers or diverting limited educational, medical and financial resources away from where the problems really lie.”

**Have Our Children Gotten Fatter from Eating Too Much of the Wrong Food?**

Childhood obesity has been portrayed as fundamentally an energy imbalance problem based on increased calories in and decreased calories out. Traditional wisdom informs us that our children are getting fat because they eat too much of the wrong (fattening) foods and move too little. Once again, in spite of the widespread acceptance and intuitive appeal of this claim, the research does not indicate an increase in caloric intake among children. In fact, in the 30 plus years between 1965 and 1996, national data show a *decrease* of 17% in total energy intake in children and adolescents as well as a general downward trend in the percentage of calories from fat. In a recent extensive review of the literature, Rolland-Cachera and Bellisle conclude that children are now: “Taller and heavier than in the past, in spite of relatively stable or falling energy intakes...It is often suggested that high energy or high fat intakes predispose to obesity. No clear evidence for this emerges from epidemiological studies conducted in children.”

With the resurrection of low-carbohydrate mania in recent years in the United States many anti-obesity, childhood nutrition initiatives have focused on trying to reduce and/or eliminate various sources of sugar from children's diets. Soft drinks and foods with added sugars (sweets) have been particularly singled out as contributing significantly to the obesity problem. This has led numerous school systems to restrict or ban soda on their grounds. Other schools have prohibited the consumption of sweets during birthday parties, and still others have actually searched children's lunches and confiscated foods considered to be “unhealthy.”

Unfortunately, the science supporting the indictment of sugary foods in the etiology of obesity is virtually nonexistent. A large recent study that followed some 12,000 children and adolescents from 1 to 19 years old failed to find an increase in the consumption of carbonated beverages from 1978 to 1998 in any age group.

Furthermore, most studies *do not* show a positive relationship between sugar intake and obesity in children, instead indicating a high intake among all BMI categories. Paradoxically, in one recent study, there was actually an inverse relationship between weight and soda drinking; teenagers who drank the most soda were actually the skinniest. Contrary to popular opinion, the research overwhelmingly suggests that sweeteners have little affect on the nutrients children and teens receive or on the quality of their diet.

### **Have Our Children Gotten Fatter from Moving Too Little?**

The other side of the energy equation, “calories out,” has also been widely promoted as a major contributor to the childhood “obesity epidemic.” Much of the blame to date has been directed at the influence of technology; particularly televisions, computers and video games. The assumption is that because children are spending more time involved in these types of activities, they are spending less time being physically active, thereby becoming *couch potatoes* and gaining weight. As before, though this assumption seems to make intuitive sense, the research to back it up is equivocal at best.

Most of the studies to date have looked at the relationship between television viewing, physical activity and weight. Though there are some conflicting data, in general the findings suggest little relationship between the time children spend watching television and that amount of physical activity in which they engage.

Writing in the journal *Pediatric Exercise Science* in 2002, Marshall et al conclude their review of the relevant literature by saying: One hypothesis is that involvement in sedentary behavior limits the time available for participation in health-enhancing physical activity. Most data do not support this hypothesis and cross sectional and prospective data between TV viewing and adiposity show weak and inconsistent associations.”

In 2004, a meta-analysis of 52 previous studies re-examined the relationship between television, physical activity and body fatness in children between the ages of 3 and 18. Published in the prestigious International Journal of Obesity, the research reaches the same conclusion saying: “A statistically significant relationship exists between TV viewing and body fatness among children, but it is likely to be too small to be of substantial clinical relevance.” In fact, even the ubiquitous conclusion that children are watching increasing amounts of television has recently been challenged. In an article in the Journal of The Royal Society of Health in 2004, the authors conclude: “Although more children and youth have greater access to TVs than in previous generations, the amount of TV watched per head has not changed for 40 years....Indeed, measures of ‘couch potato-ism’, such as TV viewing, may be inappropriate markers of inactivity.”

To summarize, in spite of ongoing proclamations about supposed decreases in children’s daily physical activity and energy expenditure promoting the “epidemic” of childhood obesity, there is little scientific support for a causal relationship. The state of the art in this regard is summed up in an article in the Proceedings of The Nutrition Society: ...No definite conclusions are justified about the levels of physical activity of children, or whether these are sufficient to maintain and promote health.”

### **Are Current Approaches Helping Our Children?**

In spite of the lack of scientific support that the “obesity epidemic” in children is primarily the result of poor eating and sedentary lifestyle, anti-obesity initiatives have focused primarily on getting fat children to decrease their energy intake and increase their energy expenditure with the ultimate goal of losing weight. Not surprisingly, as has been the case with their parents for decades, these efforts have been decidedly unsuccessful. One of the largest school-based prevention programs was the Child Adolescent

Trial for Cardiovascular Health (CATCH) study, sponsored by the National Institutes of Health. This highly-funded study involved thousands of elementary school children in more than 50 different schools in 4 states. In spite of a combination of food service modifications, enhanced physical education, increased health curriculum and additional family education, the three year Trial produced no changes in overweight, blood pressure or cholesterol levels.

A review of the literature on the efficacy of such interventions conducted by Lorrene Ritchie and colleagues at the University of California, Berkeley, concluded that: “There is little evidence so far that school-based programs have had a major or lasting impact on BMI or body adiposity.” Even when programs do manage to reduce caloric intake and/or increase caloric expenditure during school hours, research suggests that children compensate for the changes once they are out of school, and the initial improvements seem to diminish with time once the program has ended.

Given the overwhelming failure of weight loss approaches in adults over the past 50 years, the failure of these same approaches to reduce children’s weight is certainly not surprising. The reduction of weight to a relatively straightforward matter of calories in vs. calories out, rather than a complex web of genetic, environmental, social, psychological, emotional and economic factors has led to a greatly oversimplified understanding of the issue and to interventions that stand little chance of succeeding in the long term. At best, the literature suggests only a weak association between children’s dietary and exercise habits and their bodyweight. In a testimony before a USDA subcommittee, nutrition expert Maureen Storey explained that even if parents and schools could perfectly control the calories, sugar, fat and television hours children received, it would be likely to have

only a minimal impact on the naturally-occurring variations in BMI. In other words, there would still be a wide variety of weights among children – some would be naturally fat, some naturally thin.

### **Are Current Approaches Harming Our Children?**

Traditional approaches to nutrition education focus on rules, restrictions and prohibitions to control what children eat. They are taught about the Food Guide Pyramid, portion size, and the do's and don'ts of appropriate food selection. Unfortunately, the literature demonstrates that these types of approaches are not only ineffective but actually counterproductive.

Many studies over the last few decades show that when adults try to regulate or control what children eat, the children are more, not less, likely to end up with weight, body image and eating-related problems. In controlled experiments, trying to encourage, pressure, or even reward children to eat certain foods actually turns them off to those foods and makes it less likely that they will eat them. Conversely, if children are deprived of certain foods, they become more interested in those foods and are more likely to over eat them when they get the opportunity. In fact, compared to children who are not so deprived, treat-deprived children actually end up being heavier. According to child nutrition and eating expert Dr. Jennifer O'Dea: "Negative messages such as sugar and fat are "bad," and the use of the term "junk food" contribute to the underlying fear of food, dietary fat, and weight gain, which precedes body image concerns and eating problems."

In this context, perhaps the most damaging effects of childhood obesity prevention programs result from the focus on weight as opposed to health. The vast majority of overweight children and adolescents know that they are fat and have already developed poor body image, low self esteem, and a fear of food. They are also



more likely to exhibit disordered eating, extreme dieting measures, greater levels of emotional distress and lower expectations of their educational future. It is hard to imagine how sending them home with report cards saying they are too fat or singling them out for special exercise or nutrition interventions could possibly be beneficial. As child nutrition and eating expert Jennifer O'Dea concluded, "the last thing that obese children need is a reminder of their undesirable weight status."

Unfortunately, similar negative consequences of the war on obesity are also being felt by normal weight children who incorrectly perceive themselves as being too fat. Surveys show that many children and most young girls classify themselves as overweight, even though they are not. In increasing numbers they are participating in unhealthy weight control measures that are unlikely to succeed, may actually promote future weight gain, and hold the potential for serious negative health consequences.

Even with the best of intentions, many if not most adults are themselves so anxious and confused about issues related to nutrition and weight that they may do more harm than good when it comes to children. In a recent study, teachers who were most likely to be involved in a childhood obesity prevention program demonstrated a low level of knowledge related to nutrition and weight control and a very high level of body dissatisfaction and self-reported eating disorders. Furthermore, 85% of the teachers reported recommending strict, calorie-reduced diets to overweight children, many of whom who were in the middle of their adolescent growth spurt.

The focus on weight rather than health in obesity prevention programs also can promote unwanted consequences with relation to physical activity. Studies show that such additional attention on fat children can increase their sensitivity to their weight and their

perceived lack of physical prowess, making them less likely to participate in physical education and sport.

The focus on weight as a means of improving our children's health is clearly misguided. As is true for adults, children of all body shapes and sizes can improve their health and quality of life, but pressuring them to eat less and exercise more in order to lose weight does not work and can yield unwanted and unhealthy consequences.

### **Is There an Effective Alternative for Helping Our Children to be Healthier?**

If we are serious about improving the health of our children, we will need to replace the focus on getting fat children to lose weight with a focus on self-acceptance, positive body image, and enjoyable eating and physical activity for *all children*. The first step in this process is to help children to accept and value themselves and others regardless of differences in body shape and size. Obese children (particularly young girls) have significantly lower levels of self-esteem, and significantly higher levels of sadness, loneliness, and nervousness. They are also more likely to engage in high risk behaviors like smoking or drinking alcohol.

Research suggests that children with positive self images are more likely to eat well and have healthier lifestyles regardless of their weight. Approaches that promote a positive self-image and a strong sense of self-worth in children are available and have also been shown to improve body image and decrease eating disorders, obsession with attaining thinness, vulnerability to media messages, anxiety and depression in adolescents. Because approaches that attempt to restrict and control what children eat don't work and often make things worse, the focus should be on helping children to listen to their innate, internal signals (*normal* eating) to guide what and how much they eat.

Parents and other adults can best help children develop *normal* eating by themselves having a joyful, relaxed attitude about eating; and by giving children positive messages about food, helping them to explore variety and trusting them to eat what is right for their bodies. Children who eat this way are less likely to respond to external and emotional cues for eating and therefore less likely to overeat as a result of advertising, super-sizing, or other outside pressure. “Inoculating” our children in this way can help them to successfully and healthfully navigate the fast-paced, message-dense world in which we live, without resorting to such tactics as vilifying whole industries, moralizing about *good* and *bad* foods and curtailing freedom of speech. With respect to the latter tactic, it is significant to note that, in countries where marketing of certain foods has been limited or prohibited for many years, there has been no discernable effect on the weight of the children or adolescents.

Most adults and many children of every size and shape could benefit from increased involvement in physical activity. As with healthy eating, the focus should be on helping *children of all sizes* to find ways of pursuing enjoyable, sustainable levels of physical activity. Because the focus on calorie burning and weight loss is ineffective and often counterproductive, physical activity should be promoted for the purpose of moving the body, not changing the body.

## **What Is Health At Every Size**

The approach to helping people, including children to be healthier without focusing on weight described above is referred to as Health At Every Size (HAES).

The basic conceptual framework of this approach includes acceptance of:

- 1.) The natural diversity in body shape and size

- 2.) The ineffectiveness and dangers of dieting
- 3.) The importance of relaxed eating and pleasurable physical activity in response to internal body cues
- 4.) The critical contribution of social, emotional and spiritual as well as physical factors to health and happiness.

HAES promotes that an appropriate “healthy weight” for an individual cannot be determined by the numbers on a scale or by an ideal height/weight chart or by using the Body Mass Index or body fat percentages. Rather, HAES defines a “healthy weight” as the weight at which a person’s body settles as they move towards a more fulfilling and meaningful lifestyle. This includes, but is certainly not limited to eating according to internally directed signals of hunger, appetite and satiety and participating in reasonable and sustainable levels of physical activity.

HAES supports a “holistic” view of health that promotes feeling good about oneself, eating well in a natural, relaxed way, and being comfortably active. Table 2 outlines the major components of the HAES philosophy.

## **Table 2. Health At Every Size: Major Components**

Self-Acceptance.

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

Physical Activity.

Support for increasing social, pleasure-based movement for enjoyment and enhanced quality of life.

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 physiological hunger and fullness cues.

HAES offers an effective, compassionate alternative to the failures of traditional approaches. There is a significant body of literature that demonstrates clearly that most so called weight-related problems can be treated effectively without weight loss.

Even with type II diabetes, blood glucose can be normalized without weight loss even when people remain markedly obese by traditional medical standards. Furthermore, recent research shows a HAES approach to be clearly superior to state of the art, behavioral, weight loss intervention for improving the long-term health of obese participants.

### **Where Do We Go From Here?**

There is little argument about the fact that populations throughout the world have experienced significant increases in weight. This has been occurring for some time and is true for both children and for adults. However, as we continue to wage our “War on Obesity” it is essential that we take steps to insure that we are protecting our children from becoming its casualties.

“Obesity Prevention” as it is currently envisioned is an oxymoron - misguided, ineffective and doomed to failure. Although we certainly should address the risks to our children posed by unhealthful lifestyles, we must alter our present focus to make sure that our children benefit rather than suffer from our interventions.

We can best do this by following the Health At Every Size approach. Although HAES differs dramatically from traditional approaches, it is, perhaps ironically, quite consistent with the clearly worded but largely ignored conclusion of the National Institutes of Health Consensus Panel on Obesity which suggested as far back as 1992 that: “A focus on approaches that produce health benefits independently of weight loss may be the best way

to improve the physical and psychological healthy of Americans seeking to lose weight.”

Promoting healthful lifestyles for all, rather than singling out larger children for interventions that will inevitably fail and cause increased harm, holds the best promise for improving the health and well being of our children.

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