VOLUME 7, NUMBER 1

Absolute ADVANTAGE

THE WORKPLACE WELLNESS MAGAZINE

HELPING WITHOUT HARMING

Kids, Eating, Weight and Health

IN THIS ISSUE:

In this issue of *Absolute Advantage,* we're addressing the topic of childhood obesity. From a worksite wellness perspective, some may argue that this is not one of the most salient topics that could be addressed—we disagree. In fact, our country is at a crossroads of sorts. Thus, it is essential that we begin to look at the health and well-being of the next generation of workers.

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LETTER FROM THE **EXECUTIVE EDITOR** | DAVID HUNNICUTT, PHD

Helping Without Harming

Kids, Eating, Weight & Health

In this issue of *Absolute Advantage*, we're addressing the topic of childhood obesity. With the help of our guest editor, Dr. Jon Robison and contributing authors Carmen Cool, Elizabeth Jackson, and Ellyn Satter, we've dedicated the pages of this month's publication to taking on this very important issue.

From a worksite wellness perspective, some may argue that this is not one of the most salient topics that could be addressed—we disagree. In fact, our country is at a crossroads of sorts. And what has served us well in the past may not serve us as well in the future. Indeed, we believe that in order to create a healthier America we have to be much more forward-thinking. Thus, it is essential that we begin to look at the health and well-being of the next generation of workers.

That being said, I'll tell you right up front that the articles contained in this issue of *Absolute Advantage* will stimulate some significant discussion. Undeniably, there is much disagreement around what works and what doesn't when it comes to keeping children (and adults for that matter) healthy. However, the authors that we've selected are well-respected, well-read, and well-spoken in this important area.

Specifically, the purpose of this issue of *Absolute Advantage* is to 1.) critically examine the premises on which the present childhood obesity crisis is built; 2.) document the lack of efficacy and dangers of current approaches; and 3.) present alternative approaches for parents, teachers, and communities that will provide help for our children without harming them.

I hope that you enjoy this issue of *Absolute Advantage*.

Yours in good health,

Dr. David Hunnicutt
President

> "...it is essential that we begin to look at the **health** and **well-being** of the next generation of workers."

Absolute ADVANTAGE

VOLUME 7, NUMBER 1

THE WORKPLACE WELLNESS MAGAZINE

Organizational Founder, William Kizer, Sr.

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KIDS, WEI H

EATING, IGHT & HEALTH

Helping Without Harming

By Jon Robison, PhD, MS

KIDS EATING

IT WOULD BE DIFFICULT TO OVERSTATE THE URGENCY THAT U.S. GOVERNMENT AND HEALTH OFFICIALS HAVE PLACED ON THE DANGERS POSED BY OBESITY. In 2003 U.S. Surgeon General Richard Carmona warned that obesity was "a greater threat than weapons of mass destruction" from which nothing short of a "cultural transformation" could save us.[1] No sector of the population is safe from the almost obsessive focus on reducing weight. Government agencies are demanding that their workers go on diets and wear pedometers. Hospital systems all over the country are scrambling to cash in on the skyrocketing demand for organ-mutilating surgeries. Unfortunately, workplaces and ever growing numbers of individuals continue to waste valuable time, energy and resources on weight loss initiatives that show no evidence of efficacy.[2-4]

Even our children are not safe. In a recent article in the prestigious New England Journal of Medicine, a group of researchers menacingly warned that "the tsunami of childhood obesity has not yet hit shore" and that it was only a matter of time before heart attack and kidney failure became "a relatively common condition of young adulthood."[5] They went on to suggest that the millennia-long trend of increasing human life expectancy would soon be reversed by the growing world-wide increase in body mass.

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 at the same time they are subjected to an overload of media images of often seriously underweight celebrity role models. Growing efforts to promote "healthy eating" at school 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 purpose of this issue of *Absolute Advantage* is to 1) critically examine the premises on which the "childhood obesity crisis" is built, 2) document the lack of efficacy and dangers of current approaches and 3) present alternative approaches for parents, teachers and communities that will help our children without harming them.

WEIGHT HEALTH

How Is "Childhood Obesity" Measured?

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.[6] Recently, the Expert Committee on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity of the American Medical Association recommended amending this classification so that children (from 2-18 years old) at or above the 95th percentile would be labeled "obese" and those between the 85th and 95th percentile would be labeled "overweight."[7]

The use of BMI to measure weight and related health status in adults has become widespread largely due to the difficulty of accurately measuring body fat in non-clinical environments. Unfortunately there are significant problems with its use. The BMI is actually not a good predictor of total body fat in individuals.[8] Furthermore; it does not take into consideration any discrepancies in terms of gender, race, age or ethnicity. The BMI also doesn't distinguish between fat and muscle tissue, resulting in dramatically inaccurate conclusions about who is and is not "overweight" and "obese" (*table 1 below*).

The evidence against the validity of the BMI as a health indicator is perhaps most damaging with respect to cardiovascular disease, where the impact of weight on health has traditionally been considered to be the strongest. A recent, large meta-analysis of the literature in the British Medical Journal, Lancet, found the BMI to be a very poor predictor of cardiovascular disease or total mortality.[9] As one cardiovascular researcher concluded in an accompanying editorial; "BMI can definitely be left aside as a clinical and epidemiological measure of cardiovascular risk for both primary and secondary prevention."[10]

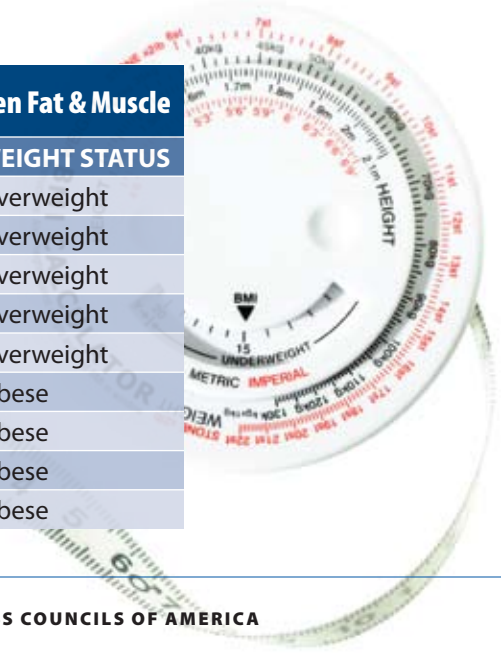
Research indicates that the relationship between body fat and BMI in children is even more tenuous than it is for adults.[11,12] In an article in the Journal Of Pediatrics that evaluated this relationship, the authors concluded that "the available data do not show that BMI adequately reflects body fat mass in children and adolescents."[13] 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.[14,15]

To make matters worse, the most commonly used growth charts published in 2000 are based on a previous, slimmer population of children.[16] 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.[17]

TABLE 1

BMI Does Not Distinguish Between Fat & Muscle

NAME	BMI	WEIGHT STATUS
George W. Bush	26.3	Overweight
Will Smith	27	Overweight
Yao Ming	27.7	Overweight
George Clooney	29	Overweight
Johnny Depp	29.8	Overweight
Matt LeBlanc	30	Obese
Tom Cruise	31	Obese
Shaquille O'Neil	31.6	Obese
Arnold Schwarzenegger	33	Obese



What Is Normal Growth And Development For Children?

Children's weights, like many human biological measurements, are distributed according to a symmetrical bell-shaped curve (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.

Therefore, the designation of the 95th percentile as a cutoff point for determining whether a child is "overweight" is a relatively arbitrary one. 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.[17] Unfortunately, with all of the attention 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."***[17]

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 consistently 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.[18]

A 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."[19] 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.[20]

In 2005, scientists from Kaiser Permanente and the Oregon Health and Science University in Portland conducted a comprehensive review of the evidence entitled Screening and Interventions for Childhood Overweight for the US Preventive Services Task Force. They concluded that "a substantial proportion of children under age 12 or 13, even with BMIs of >95th percentile will not develop adult obesity."[21] 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."[22]

Do Fat Children Grow To Be Unhealthy Adults?

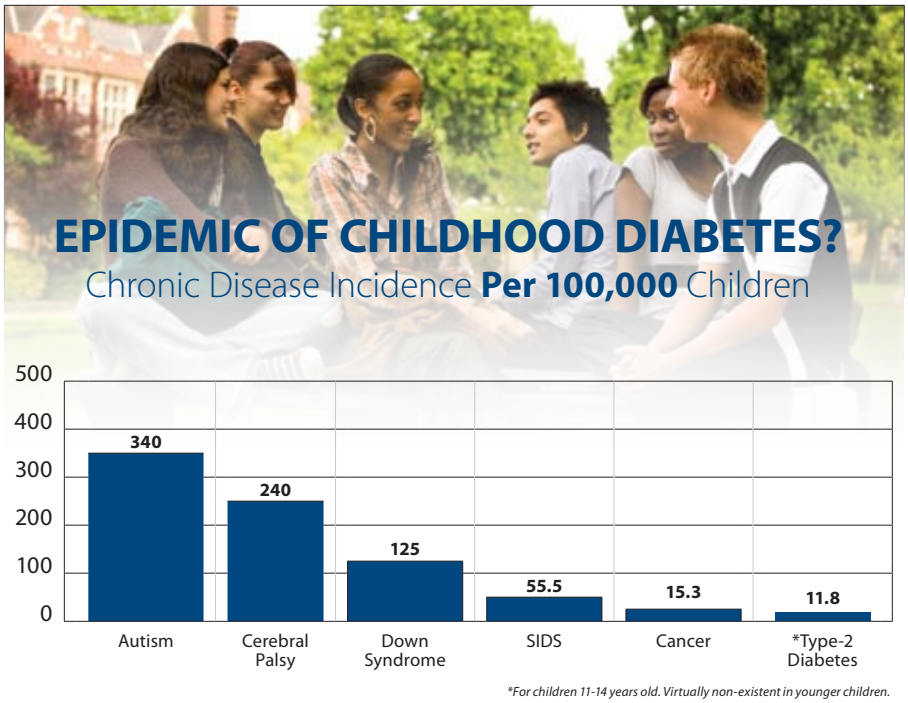
The focus on controlling children's weight is based on the premise that without intervention they will grow up fat, resulting in increased risk for premature mortality and morbidity. However, most epidemiological studies do not show a strong correlation between weight and mortality except at the extremes of the bell-shaped curve.[23] In fact, 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. Furthermore, Blair et. al, have shown that, when fitness is taken into consideration, fatness has little bearing on mortality for either men or women.[24] Finally, the most recent research shows that the impact of overweight and obesity on mortality has been greatly exaggerated, with most fat people having little or no extra risk over their thinner counterparts.[25]

In spite of recent predictions of impending doom due to the increased weight of the population it is informative that for more than a century, increasing body weight has been strongly associated with increased life expectancy.[25] Like so many of the other emotionally explosive claims surrounding obesity, the claims that our children will be the first generation not to live as long as their parents were recently exposed as scientifically inaccurate, with the authors admitting that their estimates were "just back-of-the-envelope, plausible scenarios" and that they "never meant for them to be portrayed as precise."[26]

When it comes to fat children and adult morbidity, the relationship appears to be just as tenuous. In the study of a thousand British families the authors concluded that there was "no excess adult health risk from childhood or teenage overweight."[19] 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.[18]

Though it is often taken for granted that fat children means unhealthy children, the extensive review of screening and interventions for childhood overweight in the journal Pediatrics in 2005 "did not locate adequate longitudinal data relating childhood weight status to childhood weight outcomes."[21] The much heralded national "epidemic" of childhood diabetes has also failed to materialize. Although type II diabetes may be increasing in certain ethnic groups, according to the U.S. Centers for Disease Control, the disease is "still rare in childhood"[27] with the incidence remaining much lower than other childhood afflictions that seem to garner significantly less media coverage. (*see table below—ref #28-33*)

The assumption that as children are getting fatter they are becoming unhealthier is also not supported by the latest research from England that concluded there was "no rise in the number of children suffering from longstanding illnesses, which include type II diabetes."[34]



*For children 11-14 years old. Virtually non-existent in younger children.

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 one 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 questionable cutoff points that have been described.[35] This 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.[36]

Interestingly, the accuracy of similarly fearful 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."[34]***

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."[34]***

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. Therefore our children are getting fat because they eat too much of the wrong foods and move too little. Once again, in spite of the widespread acceptance and intuitive appeal of this claim, the research does not conclusively support an increase in caloric intake among children.[37,38] 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.[39] 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."[40]***

With the resurrection of the low-carbohydrate craze 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.[41-43] 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."[44-46]

Unfortunately, the science supporting the role of sugary foods in the etiology of obesity is quite limited. Most studies do not show a positive relationship between sugar intake and obesity in children.[47-50] Research has also generally found little relationship between beverage consumption and BMI. A large 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.[51] Other research has supported the lack of relationship between BMI and beverage consumption in children and adolescents and shown that removing beverages from school vending machines has no impact on children's BMI's.[50,52] 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.[53] Contrary to popular opinion, the research suggests that sweeteners have little affect on the nutrients children and teens receive or on the quality of their diet.[54,55]

Similarly, though much has been made of the supposed contribution of "fast" and "junk" food to obesity, the actual evidence for such an effect is anything but convincing. In a study conducted in Australia and published in the International Journal of Obesity in 2005, researchers concluded that "fast food consumption was not associated with greater obesity," that "there was no relationship between availability of eating places and prevalence of obesity " and that "public health policy targeting takeaway food and eating out are likely to have little impact."[56] Interestingly, according to the World Health Organization, the countries in the world with the fattest children are Uzbekistan, Kiribati, Algeria and Egypt; all places where fast and junk foods are relatively rare. While what children eat certainly plays a role in their health, blaming child overweight and obesity on particular foods and food groups is simply not supported by the scientific evidence.[57]

> "Contrary to popular opinion, the research 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 television, 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 gaining weight. As before, though this assumption seems to make intuitive sense, the research to back it up is equivocal. Most of the studies to date have looked at the relationship between television viewing, physical activity and weight. Though there are conflicting data, in general the findings suggest little relationship between the time children spend watching television and the amount of physical activity in which they engage.[58-60]

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."[60]***

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."***[61]

In fact, even the relatively 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."***[62]

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."***[63]

Interestingly, in Australia, where similar alarms over the "obesity epidemic" have been repeatedly sounded, a recent, government-funded study of 5500 school children from all over the country found that the prevalence of moderate to vigorous physical activity had risen by 15-25% from 1985 to 2004, as had the percentage of children considered to be adequately fit. As far as the relationship between physical activity and weight, in the authors' own words; "surprisingly, the survey did not show any clear correlation between BMI and the amount of physical activity."[64]

Are Current Approaches Helping Our Children?

In spite of the lack of scientific support that the "childhood obesity epidemic" is primarily the result of poor eating and sedentary lifestyle, anti-obesity initiatives have focused on getting fat children to decrease their energy intake and increase their energy expenditure with the ultimate goal of losing weight. As has been the almost undisputed case with their parents for decades, these efforts have been decidedly unsuccessful.

One of the largest school-based prevention programs to be studied was the Child Adolescent Trial for Cardiovascular Health (CATCH) 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.[65]

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."[66] 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.[67]

This conclusion was supported by a recent study published in the International Journal of Obesity involving 1500 children of various ages and socioeconomic status in the United States. Researchers gathered information on the number of hours each student spent in physical activity classes during school hours. They then gave each student an accelerometer and had them keep track of the duration, time and intensity of their physical activity outside of school during the week. Despite a wide range of time spent in PE classes during school (1.8-9 hrs./week), the children engaged "in the same amount of daily activities regardless of their environment or exposure to school-based physical education."[68]

Given the overwhelming failure of weight loss diets in adults over the past 50 years, the failure of similar approaches to reduce children's weight is certainly not surprising. A recent systematic review of dietary interventions for weight reduction in childhood in the UK concluded that there was "little evidence to support the current recommendation of a low-fat energy-restricted diet."[69]

The reality is that at best, the literature suggests only a weak association between children's dietary and exercise habits and their bodyweight.[70] 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 fatter, some naturally thinner.[71]

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.[72-74]

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.[75] Rather than reducing schoolchildren's interest in candy, for instance, recent attempts to eliminate these foods from school vending machines have resulted in the growth of "black market" candy operations in which students buy large quantities of candy outside of school and sell them covertly for a profit to fellow students in the hallways and bathrooms.[76] Furthermore, research supports that compared to children who are not so deprived, treat-deprived children actually end up being heavier.[77] 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."[78]***

The struggles between adults and children that often result from traditional, control-oriented approaches to feeding can have consequences far beyond their nutrition and weight implications. The feeding relationship is a major source through which children learn to feel loved, nurtured, listened to and safe in the world. Research shows that the parent-child feeding relationship can have a powerful impact on how children feel about themselves and how they interact with the people around them.[79] Treating this relationship as primarily an opportunity to control food intake and thus prevent childhood obesity is not only likely to fail but may end up being "counterproductive and damaging to the child's social, emotional and physical health."[80]

Perhaps the most damaging affects 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.[81-83] They are also more likely to exhibit disordered eating, extreme dieting measures, greater levels of emotional distress and lower expectations of their educational future.[84,85] 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."[86]

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.[87] Surveys show that many children and most young girls classify themselves as overweight, even though they are not.[87,88] In increasing numbers they are participating in unhealthy weight control measures that are unlikely to succeed and hold the potential for serious negative health consequences.[82,88,89] Not surprisingly, in a prospective nutrition study of over 14,000 children published in the journal Pediatrics, the author's concluded that "dieting to control weight is not only ineffective, it may actually promote weight gain."[90]

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! [91]

The focus on weight rather than health in obesity prevention programs also can promote unwanted consequences with relation to physical activity. Research suggests 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.[92]

Clearly, the focus on weight as a means of improving our children's health is 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.

> "Research shows that the parent-child feeding relationship can have a powerful impact on how children feel about themselves and how they interact with the people around them."

Helping Without Harming: From Obesity Prevention To Health Promotion

If we are serious about helping without harming, we need to move from childhood obesity prevention to childhood health promotion. We can do this by replacing the focus on getting fat children to lose weight with a focus on self-acceptance, positive body image, healthy eating and pleasurable physical activity for all children.

The first step in this process is to help children to accept and value themselves and others regardless of their differences—including differences in body shape and size. Fat 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.[93] 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 been shown to improve body image and decrease eating disorders, obsession with attaining thinness, vulnerability to media messages, anxiety and depression in adolescents.[94,95]

In the second of the three articles in this issue, therapist Carmen Cool describes in detail the kind of school and community based intervention that we should be providing for our children as an alternative to sure-to-fail "obesity prevention" programs. The Boulder Youth Body Alliance provides a powerful, evidence-based model for teaching children to respect and honor the natural existing diversity in body shapes and sizes as a first important step towards honoring and caring for the bodies they presently have.

Because approaches that attempt to restrict and control what children eat don't work and often make things worse, the nutrition focus in all settings should be on helping children to listen to their innate, internal signals (intuitive or normal eating) to guide what and how much they eat. Parents, teachers and other adults can best help children develop truly healthy 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.[96]

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 pressures.[17] By "inoculating" our children in this way, we can help them to successfully and healthfully navigate the so called "obesigenic" environment in which we live, without squandering critically limited resources on tactics such as vilifying the food industry, 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 "junk" foods has been limited or prohibited for many years, there has been no discernable effect on the weight of children or adolescents.[97]

In her insightful contribution to this issue of *Absolute Advantage* dietitian Elizabeth Jackson, faculty member of The Ellyn Satter Institute, describes how "prevention" actually becomes a meaningful possibility when the definition of the clinical term "overweight," changes from avoiding some arbitrary cutoff point to supporting each individual child's normal growth and development. She shows us that by allowing children to reconnect with their internal cues of appetite, hunger and satiety we can help them to make peace with food and with their bodies.

Many adults and 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. Involving children in enjoyable physical activities can boost their self-esteem, social interactions and friendships.[98,99] However, singling out or pressuring larger children to engage in sport and physical activity can increase stigmatization and reduce the likelihood of participation.[99] Because the focus on exercising for 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."[100]

Health At Every Size

Approaches to helping children (and adults) to be healthier without focusing on weight are based on a philosophy/movement referred to as Health At Every Size (HAES).[101] 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 using the Body Mass Index or body fat percentages. Rather, HAES defines a "healthy weight" as the natural weight a person's body adopts given healthy eating (based on internal cues) and reasonable levels of physical activity for that individual. Table 2 outlines the major components of the HAES philosophy.[101]

HAES offers an effective, compassionate, health-centered alternative to the failures of traditional approaches to weight and health. There is a significant body of literature that demonstrates that most so called weight-related problems can be treated effectively without weight loss.[102-104] 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 the HAES approach to be clearly superior to state of the art, behavioral, weight loss intervention for improving the long-term health of fat participants.[105,106]

Into The Future

There is little argument that populations throughout the world have experienced significant increases in weight. 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 ineffective and iatrogenic. Although we must address the risks to our children posed by unhealthful lifestyles, we must also make sure that our children benefit rather than suffer from our interventions. We can do this by following the Health At Every Size approach, ensuring that all our interventions are "health-centered" rather than "weight-centered." Although this may seem a radical departure from tradition, it is consistent with the clearly worded but largely ignored conclusion of the United States National Institutes of Health Consensus Panel on Obesity which suggested as far back as 1992 that:

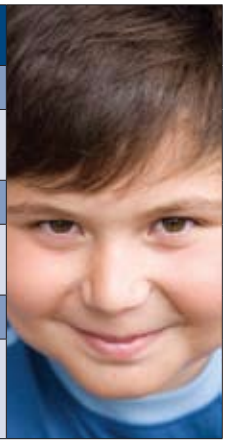
"A focus on approaches that produce health benefits independently of weight loss may be the best way to improve the physical and psychological healthy of Americans seeking to lose weight."[107]

Current approaches based on "preventing" childhood overweight and obesity are fundamentally flawed in that they deny the naturally existing, normal distribution of body weight. Rather than attempting to "prevent" childhood "overweight" based on arbitrary cutoff points and interventions with no evidence of efficacy, we can help our children to embrace diversity, feel better about their bodies and make peace with their weight and their food. This holistic approach can help all our children to lead happier and healthier lives by loving and caring for the bodies that they have—right now! ★

To view the source references for this article, please turn to the section, *Kids, Eating, Weight & Health References* on page 30-31.

Table 2

HEALTH AT EVERY SIZE: THE 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.



Jonathan Robison, PHD, MS

Dr. Jonathan Robison holds a doctorate in health education/exercise physiology and a master of science in human nutrition from Michigan State University where he is assistant professor. Dr. Robison presents frequently at national and international conferences and has authored many articles on health-related topics. His work promotes shifting health promotion away from its traditional, biomedical, control-oriented focus. Formerly co-editor of the journal *Health At Every Size*—he has been helping people with weight and eating-related concerns for more than 15 years.

Dr. Robison is available for speaking engagements on a wide variety of health-related topics. He is also available to conduct intensive training workshops for groups and organizations that are interesting in learning about and implementing *Health At Every Size* approaches. You can learn more about Dr. Robison's work by visiting his website at www.jonrobison.net and he can be contacted via email at ***robisonj@msu.edu***.

The biographical information for co-writers Carmen Cool and Elizabeth Jackson can be found on pages 23 and 28.

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anging The Conversation:

From "Preventing Obesity" To Promoting Health For ALL Children

By Carmen Cool MA, LPC

My earliest memory of hating my body came during one particular Thanksgiving at my grandmother's house. I was in the fifth grade, and after dinner I was looking out of the big picture window and thinking about the carving knife that I had somehow become enchanted with. It was the first time we had an electric one. How effortless it was—just turn it on, and watch how the buzzing blade easily sliced off pieces of the turkey. I looked down at my stomach, gathered it up into my young hands, and said to no one in particular, "I wish I could cut this off the way we cut the turkey".

Looking back, I realize what a perfect moment that might have been for an intervention. If I'd had an adult in my life who could have heard me, sat down and helped me gently unpack the feelings about myself I wasn't even aware of, it could have changed the trajectory of my life. Instead, my aunts, mother and grandmother who were sitting around me looked at each other and laughed, saying, "Yeah, me too! Wouldn't that be great?" and "I'd like to do that to my upper arms!"

> "If it's true that you can be any size and hate your body, then it's also true that you can be any size and love it."

The conversation continued, with each woman imagining how much better her life would be without certain pieces of herself, while I listened and learned. I learned three things in that moment; one, that women are supposed to hate their bodies, two, that it would indeed be better if my stomach were smaller, and three, you can always form an instant community around body hatred.

Thirty years later, I walked into an art gallery in downtown Boulder, Colorado and saw the many colorful bathroom scales hanging on the walls. Several Boulder teens from the **Boulder Youth Body Alliance** had transformed these scales into individual pieces of art, working with their body image in the process. The traditionally powerful numbers on the dial were replaced with positive adjectives or phrases—those things that each person wanted to see reflected back to themselves. One scale was decorated with pieces of blue and purple tissue paper, individually torn to represent the scales of a mermaid's tail, with words on the dial like "luscious" and "captivating". With the facilitation of art therapist Merryl Rothaus, MA, ATR-BC, the teens re-authored the scales, and each teen refused to believe that happiness was based upon a number. Rather, the language of art assisted them in celebrating their feelings about their bodies and they redefined the nature and meaning of a scale and their relationship to it. Beside each scale was a text written by the artist. One of them said,

> ***"Despite all the pressure I feel to attain physical perfection, I have realized that in the end, when I look back, the things in my life I will be proud of will have nothing to do with the size or shape of my body."***

The reinvention of these scales became a form of art as social action, where each artist's personal feelings and thoughts were able to positively affect others. Hundreds of people came through the gallery that night, creating an opportunity for teens and community members to talk together about an issue that undoubtedly affects all of us in some way and to share in a different possibility—that it might be possible to feel good about and in our own bodies. People left the gallery with a new experience. Suddenly they abandoned the idea that self-esteem equals a number. From across the room, I watched a woman in mid-life approach a converted scale placed on the floor with hesitancy; her eyes down, and her body hunched over. But with a teen's encouragement, she allowed herself to step on the scale, peek through her covered eyes to see that she was "alluring", and step off smiling and standing tall.

If it's true that you can be any size and hate your body, then it's also true that you can be any size and love it. And

if a community can join together in body disparagement, then a community can also join together in support of one another—and especially our teens—in reclaiming our bodies and allowing ourselves to fully express our joy, comfort, and ease in our bodies, exactly as they are.

The Boulder Youth Body Alliance (BYBA)

I am a therapist who works with eating and body image issues and I'm a woman who has lost people close to me (literally and figuratively) to the constant obsession with weight we face. Because of what I witness on a daily basis, I have become interested in the work of prevention and education. On a Tuesday morning in September 2004, I walked into New Vista High School in Boulder, Colorado. The school was recruiting teens for a new pilot peer-education program on body image that I would be leading. It began with a simple idea: teens talking to other teens about how they felt about weight, body image, and the messages they receive about how they're 'supposed' to look. Interested kids were asked to gather in the Community Room for an informational meeting. I was expecting around 6 to 8 kids. I walked into the room and saw 24 high school students looking expectantly at me.

From this meeting, the Boulder Youth Body Alliance was born. The BYBA is a youth-driven, peer education program that empowers teens to create social change around the ideas, beliefs and messages that lead to eating disorders and body dissatisfaction. Our program is based on The Body Positive curriculum[1], a successful intervention model that teaches children and teens to creatively transform the conditions that shape their relationships with their bodies, food, and exercise. Understanding that messages are strongest when delivered through real stories from role models and peers, the Body Positive's programs and educational materials are developed with this philosophy, and are delivered to audiences through a variety of creative and thought-provoking methods, including videos, lesson plans, books and art. The BYBA program also integrates curriculum from Healthy Body Image, a primary prevention curriculum by Kathy Kater[2], and Full of Ourselves: Advancing Girl Power, Health and Leadership, by Catherine Steiner-Adair.[3] All of these approaches promote self-acceptance, intuitive eating, pleasurable movement, and critical analysis of cultural imagery and ideals.

Embracing Our Bodies, Reclaiming Our Lives

During our first day together, we talked about our relationships with our bodies and the ways that relationship affects our ability to be present in our own lives. We talked about the messages we get, how we respond to those messages, and how we can choose something different. We explored stereotypes of thinness, fatness and eating disorders and we investigated what people really mean when they say, "I feel fat". I quickly learned that the kids want to have the chance to do something about these issues. The cultural messages they were receiving didn't make logical sense to them, but they found themselves stuck inside the pressure to conform. Once they had the chance to speak honestly about their feelings, we spent hours discussing their questions, anger and their hope in the possibility that they could do something and work together to create a different reality.

We continued to meet twice a month throughout the school year to talk about what they observed and what they could do about it. After initiating the dialogue, I simply got out of the way while their heightened awareness burst forth. Students came in reporting on things they've noticed in the world, whether it was an article they found, a reality TV show, a comment from a teacher, or the way their peers are dieting and doing drugs to lose weight before prom night. For example, one teen reported, " Our nutrition teacher said today that when she wants to lose weight, she picks up smoking for two weeks."

By doing this work together, and examining the feelings they have about their own bodies, these BYBA teens became peer educators. They applied their critical thinking skills, and analyzed the ubiquitous, often harmful societal messages about how they should look. Their willingness to explore our culture's beauty ideal, from the inside out, and to resist pressures to conform, made them credible role models for other teens and adults in their community.

These days, BYBA peer leaders conduct presentations to people of all ages, co-facilitate teen drop-in support groups with adults, and participate in community events. By sharing how a positive body image has transformed their self-esteem, they have become change-makers. They embolden teens to question society's prevailing views about body image and inspire them to accept their bodies. Their own family members have also benefited as the teens interact with them around what they are learning. In this way, the effects of a young person learning to be at peace with her body ripples out into the community. The message they are teaching us is nothing less than revolutionary. As one participant said;

"Before I joined BYBA, I thought that the only way that I could ever be happy with my body would be to change how I looked. As I began to research, read, and teach about how to love your body rather than hate it, I realized that the path towards contentment with my body didn't have anything to do with losing weight or getting makeovers, but with accepting and appreciating my body as it is."

There is a certain kind of power that role models have[4]. High school students standing and delivering a positive message to middle school students is uniquely effective. The younger students feel more deeply understood and related with when the message they hear comes from someone who faces the same pressures.[4] I have heard the conversation inside of a ten-year old change from, "I'm not supposed to like my body. I want to be skinny—I want to be perfect"—to "thank you for telling us it is okay to be ourselves. Some people needed to hear that. Especially me!"

Positively Affirming

The BYBA message is rooted in the Health at Every Size philosophy, a researched-based paradigm that focuses on health and well being, not weight. To inspire teens to reclaim their self-worth, our peer educators challenge society's narrowly defined restrictions about 'acceptable' body size.

The pressure that girls feel to be thin is clear. Boys may feel this pressure also, or they may feel the need to be strong and muscular. But both girls and boys feel the constant pressure to not be fat. They inherently know what is wrong with the focus on obesity prevention. And if you want to listen, they'll tell you how it affects them. They report experiences of feeling constantly judged, watched and monitored. As one participant said; "My mom is more afraid of me becoming fat than of any other thing that could happen to me."

Weight-focused approaches to health can often inadvertently plant the seeds for anxiety and self-scrutiny. Young people often receive teachings about health, nutrition and exercise that are heavily laced with moral underpinnings. When that happens, those who fall outside the lines are at risk for stigmatization and bullying, and those who fall inside the lines are constantly worried and hyper-vigilant. So decisions that should be

about what is best for their well being become decisions directed towards what will make them thin.

But kids know this. One young woman said to me, "If we respect and appreciate our bodies, we make choices that are good for us." They inherently understand the link between the pressure they feel to be thin and "healthy", and fat prejudice. They know that there has to be a different path, they just need our support in order to find it. One of the things that successfully engages kids is appealing to their sense of social justice. Harnessing the anger and rebellion that characterizes adolescence in the service of ending discrimination propels them to stand in front of their peers and say: "Sizism is a really big deal. It's another form of oppression. Stereotypes are hurtful to others and they also damage our self-esteem." They become more able to ask themselves and their peers, "How can we move away from assumptions and look deeper than this?"

BYBA In Action

Over the past three years, the Boulder Youth Body Alliance has developed their leadership skills in a number of innovative ways. Some of these include:

»	Presenting to over 875 high school and middle school students and offering an alternative to body dissatisfaction
»	Raising community awareness with interactive activities at events such as Eating Disorder Awareness Week, 9News Health Fair, the Boulder Creek Festival, and others
»	Media appearances in the newspaper and in a Comcast MetroBeat TV program, ***Student Voices: Dying to be Thin***, winner of a Heartland Regional Emmy Award.
»	Writing body positive messages on school windows and sidewalks
»	Building school/community partnerships to strengthen their ability to bring the message of positive body image to more members of their communities
»	Increasing inter-generational outreach & dialogue between students, faculty, and parents
»	Starting to work on changing the non-discrimination policies at the school to include body shape and size.

A Community Joining Together

The Boulder community got involved for the Great Jeans Giveaway, an event in March 2007 sponsored by the National Eating Disorder Association. The Great Jeans Giveaway encourages people to donate old jeans that no longer fit for whatever reason, rather than holding on to them for the "some day" when their bodies are different. The Twenty-Ninth Street Mall, Boulder's newly opened shopping district, hosted the event for us and provided media coverage, and local retail stores offered discounts to anyone who donated a pair of jeans. BYBA partnered with the University of Colorado's Student Wellness Program, and college volunteers from Metropolitan State College also came to help. I was stunned as people arrived—and kept arriving throughout the afternoon—bringing bags and boxes of old jeans. BYBA collected over 375 pairs of jeans in just three hours and donated them to the National Pediatric Aids Network and Treasure the Children, an organization that turns used denim into quilts for kids with HIV. This is a wonderful example of social activism in action. Like the scales in the gallery where BYBA partnered with the Naropa Community Art Studio and Art and Soul Gallery, we took common objects that often make us feel badly about ourselves, and transformed them into objects with the power to do good in the world.

There is tremendous power in support. One peer educator, at the beginning of her second year in BYBA, talked about her summer and said "I thought more negatively about my body over the summer when we weren't meeting. It was harder to contradict the messages on my own. Without discussion and critical thinking, it comes back in." This is the strongest evidence that these teens need both the peer support of one another and our support as well.

A Different Way of Thinking

The teens with whom I have worked have repeatedly described the depth of the societal pressure they feel about how they "should" look. They are barraged with messages from media influences and peers, to physicians and the war on obesity. The collective input of the teens I have spoken with is that there is an imminent need for a program that can serve as an antidote to this dominant, damaging part of their culture. They articulately and passionately describe the ways in which being a part of this peer educator group has affected them. As Rachel, one BYBA peer leader said;

"BYBA has been more meaningful to me than any other experience I have had. It has helped me in my own personal growth. I have emerged a more confident, body positive, self-accepting, knowledgeable and aware young woman. I have never felt more comfortable or beautiful in my own skin."

Doing this work with teens is to invite them into a different way of thinking that runs counter to the usual I-have-to-change-my-body-in-order-to-be-happy-and-healthy message. And slowly, change is emerging. The conversations between kids, in classrooms, and in families, are different than they once were. Some examples of these changes include;

- One's participant's brother who came home from school and told her how he noticed and spoke out about a size-prejudiced comment he heard as a result of her talking about it over the course of a year.
- Another teen's little sister spoke to her about how often she heard her friends in middle school talking about feeling fat. "I think twice about it when I hear it now." she said. "Before, it's just how it was."
- And another teen described the way her mother got on the scale every morning and always said something disparaging about herself, comparing her body with her daughter's. The teen said "I sat down and talked to my mom for the first time and told her how that makes me feel."

A Call To Action

It is clear that we can choose to be allies with our bodies, we can be allies with our children, and together we can engage our communities to weave a web of support. This work starts when we begin to pay attention, non-judgmentally, to the conversations we engage in and dare to start new ones. We must include kids in policy and decision-making, because they often know better than we do what they need and what will work. Support for organizations like the Boulder Youth Body Alliance and The Body Positive is essential, so that teens can continue working towards the kinds of social change that benefit all of us. If you are interested in sponsoring the eating disorders prevention and body image work of The Body Positive or BYBA, please let us know! Send an email to The Body Positive at ***connie.sobczak@gmail.com***, or The Boulder Youth Body Alliance at ***carmenccool@yahoo.com***. All donations are tax-deductible. We thank you in advance.

Working with adolescents is challenging, and one of the most rewarding things I've done. They teach me how to be an effective adult in their lives. I have witnessed one of the peer educators standing up in a classroom and embodying a powerful message. I have heard an eleven-year old during a BYBA presentation say that she will never see the world the same way again and will no longer commit herself to looking like the models. I have seen someone bring back a calendar they found in Alaska that has drawings of women of all sizes on it. All these things make me feel incredibly hopeful.

I wonder what would have changed if the women in that kitchen with me on that Thanksgiving Day all those years ago had stood up for my stomach and engaged me in a different conversation. I often imagine what it would have been like if the fifth-grader who wanted to slice off her belly could have heard an 11-grader talk about learning to be okay in her body.

There are groups of kids across the country right now who are sick and tired of worrying about their bodies, and want an easier and healthier way to live their lives. As one young woman said, "We think that if we can change, maybe we can start a whole movement of change."

The only question left is; will we join them? ★

To view the source references for this article, please turn to the section, *Changing The Conversation* on page 31.

About Carmen Cool, MA, LPC

Carmen Cool is a licensed psychotherapist in private practice in Boulder, Colorado, where she works primarily with adults, teens and groups around eating problems and weight concerns. She received her Masters in Transpersonal Counseling from Naropa University and is the Founder and Director of the Boulder Youth Body Alliance, helping teens change the world, rather than their bodies. Carmen has worked closely with the University of Colorado at Boulder, helping them implement a Health At Every Size approach in their training programs. She is a frequent presenter in the Denver Metro area, and she especially enjoys speaking to psychology students about the importance of eliminating size bias in their work. Carmen can be reached at ***carmenccool@yahoo.com***, or 303-440-5775.

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Changing The Conversation:

From "Getting Kids Thin" to Promoting Nurturing Eating for *ALL* Children

By Elizabeth Jackson MS, RD

As carefully argued by Dr. Robison, recent proclamations and policy directives about child obesity are, to a large extent, misinterpretations of the data about children who are naturally larger than average and oversimplifications about the etiology, prevention and treatment of childhood weight issues. There is no denying that many American children, whether genetically predisposed to be small, medium or large, have diverged from a normal growth trajectory.

The problem with sounding a call to arms about these children is that we misdiagnose (in fact, pathologize) normally growing large children, very likely leading to the problems we are trying to avoid, i.e., escalating weight gain. Likewise, we miss out on early opportunities to work in primary intervention settings with children who are, indeed, showing abnormal growth divergence. Is there an alternative to a blanket categorization of risk for all children falling above (or below) standard BMI-for-age percentiles?

Trust vs. Control

There is, according to Ellyn Satter, a leading authority on child and adult feeding and eating problems. Ms. Satter is a mental health therapist and registered dietitian with 40 years of clinical experience. She has written many scholarly articles and four books on child feeding for professionals and parents, and she leads advanced training workshops for nutrition, health and mental health professionals.

The Satter Feeding Dynamics Approach (or fdSatter) hinges on a core concept of trust: trust that children come hardwired to have certain bodies and are born with strong internal regulators of eating—hunger (drive for fuel), appetite (drive for pleasure) and satiety (satisfaction, the natural stopping point when hunger and appetite are fulfilled). If these internal regulators are preserved with the help of nurturing feeding from caregivers, children can grow up to have the bodies that are right for them. The trust model contrasts with the traditional approach of adult caregivers working to control children's eating in order to ensure their "proper" size.[1]

Satter describes a new definition of child overweight as an upward weight divergence that is abnormal for a given child and can be determined, therefore, only by comparing the child to him or herself over time.[1] This is accomplished via an accurately-kept growth chart, rather than an arbitrary BMI cutoff. Likewise, underweight is defined as an abnormal downward divergence in a child's growth pattern. If a child does begin to grow abnormally, something is undermining his or her powerful inborn ability to regulate and the disrupting factors need to be uncovered and corrected to treat the abnormally diverging growth. Satter has crystallized this concept in a position stand on child overweight which appears following this article.[2]

The prevention and treatment of child overweight are therefore both guided by the same principles: preservation or restoration of internal regulation of eating for children. Satter believes parents can optimize child growth from birth with the trust model as implemented through her Division of Responsibility (DOR) in feeding.[3] According to DOR, parents are

responsible for some tasks in child feeding, children others, and families stay out of trouble if these lines are not crossed. Specifically, parents take leadership in choosing foods, preparing (or facilitating) meals and planned snacks at structured times, and keeping eating times pleasant and companionable. This means sitting down, eating and conversing with their children, rather than just feeding them. It also means that they trust their children and give autonomy for them to enact their part of the DOR. Children are responsible for choosing from the foods provided and eating as much or as little as they want of each (sometimes varying wildly in type and amount from day to day!) without parents needing to coax, bribe, threaten or restrict certain foods. It is within this context of non-pressured structure and emotionally gratifying time with adults that children are able to heed hunger, appetite and satiety signals and become competent eaters.

What about food selection goals? More milk, vegetables and fruits? Less soda? These are all best accomplished within the context of the family meal. When children are raised with DOR, they will eat the amount they need to grow according to their genetic blueprint, learn to eat a variety of foods, acquire all the socialization implicit in communal meals (hinging on regular access to their parents), feel good about their bodies and gain food procurement and preparation skills to become independent with feeding themselves by the time they leave home.[4] Implicit in this model is that not all children will be slim. Therefore, we need to help children feel positive about the notion that bodies come in all sizes. This is how we can help children of all sizes to be healthy.[5, 6, 7]

> Satter describes a new definition of child overweight as an ***upward weight divergence*** that is abnormal for a given child and can be determined, therefore, ***only by comparing the child to him or herself over time.***

An Evidence-Based Approach

Satter's approach is evidence-based and ties together work from diverse fields, from the premise that size is largely determined genetically[8] to the efficacy of authoritative parenting styles[9] to the advocacy of family meals as a framework for everything from better nutritional intake[10, 11, 12] to better emotional health,[13] lower incidence of adolescent risky behaviors,[14, 15] including eating disorders,[16] and yes, even to weight regulation.[17, 18] Furthermore, in the context of feeding, strategies and parenting styles that contradict DOR have been shown to undermine a child's ability to regulate and can lead to childhood growth and weight problems. Researchers have found that overcontrolling or undersupportive parental feeding practices (restriction, pushy feeding, lack of structure, lack of limits) are counterproductive, whether with healthy children[19-22] or those with a chronic illness.[23, 24] Parents with their own significant eating, weight and body image struggles often engender these problems in their children and create higher risk for both abnormal weight divergence and eating problems or eating disorders.[25-29]

The phenomenon of disinhibited eating following restricted eating was first described in the famous Minnesota experiment in semi-starvation over half a century ago[30] and in deliberately restricting (dieting or restrained eating) adults over

thirty years ago.[31] In the mid-1980s, Costanzo and Woody[32] proposed a model whereby concerned parents trying to slim their children would create the very problem they were attempting to avoid by interfering with children's ability to learn to self-regulate, creating "eating-guilty" children. These children would feel shame and anxiety about eating, yet would have "brittle restraint" and would be easily induced to eat by environmental cues or emotions. Sure enough, whether at their own initiation or following advice from a health professional, parents who diet and then disinhibit[33] or who restrict their child's food because of concern over a child's weight or size often precipitate disinhibited eating in children[34] which can lead to weight acceleration.[35] In fact, a recent review linked parental feeding restriction as the key behavior facilitating development of overweight in children.[36] In this way, the iatrogenic paradox is clear: restricting children backfires and can make them heavier. In addition, parents' negativity about a child's weight can lead to significant, lasting psychological damage.[37]

> "Restricting children backfires and can make them heavier."

It is also important to remember that situations which mimic deliberate food restriction, such as food insecurity (living with hunger and the fear of starvation), lead to another paradox: some of the heaviest children (and adults) in America are the poorest. Indeed, many researchers blame the same mechanisms— cycles of food deprivation and binge-like eating when food is available.[38, 39, 40] In addition, research indicates that children with the most profound growth aberrations—extreme obesity and growth failure—often have profoundly troubled lives[41-44] and growth problems can thereby serve as an important red flags.

Clearly, these are extremely complex issues. Satter's paradigm takes abnormal weight divergence very seriously. In the behavioral realm of how we feed our kids, day in and day out, we do now have clear, evidence-based answers. Instead of obesity prevention or treatment programs that attempt to reduce weight by controlling children's eating, we need interventions that help children maintain their internal regulation signals and at the same time help adults provide positive feeding and eating experiences for children of all sizes. As Satter says, we must provide, not deprive. ★

To view the source references for this article, please turn to the section, *Redefining Childhood "Overweight," Rethinking "Healthy" Eating* on page 32.

About Elizabeth Jackson, MS, RD

Elizabeth Jackson, MS, RD has used internal regulation of eating as the cornerstone of her work in dietetics for 20 years, after having embraced Ellyn Satter's teachings as a dietetics student in Wisconsin. In 2002, she was invited by Satter to be one of the founding members of the Ellyn Satter Institute (ESI), which is currently creating a not-for-profit foundation devoted to consulting, teaching and research. Now in her 17th year of private practice in Mt. Pleasant, Michigan, Elizabeth works as an eating and nutrition consultant for most outpatient diagnoses, specializing in child feeding, eating and growth problems and clinical eating disorders. As a part-time faculty member at Central Michigan University, she also teaches a popular upper level course she created on eating disorders for dietetics and other allied health majors, currently offered online, as well, through CMU's graduate program in dietetics. Through ESI and her consulting business, she provides presentations and workshops for health professionals and educators throughout Michigan, the U.S. and Canada. Elizabeth believes that it is only through the preservation of and return to internal regulation of eating that child and adult weight dysregulation and eating disorders can be successfully prevented and treated. Elizabeth can be reached at: ***ejacksonrd@journey.com***. For more information on Ellyn Satter and her work, see www.ellynsatter.com.

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Position Statement:

Eating Management To Prevent And Treat Child Overweight

By Ellyn Satter, MS, RD, LCSW, BCD

The position of the Ellyn Satter Institute is that the clinical definition of child overweight is not high weight *per se*, but *growth acceleration*: abnormal upward weight divergence for the *individual* child. Based on this clinical definition, each child is compared to only him- or herself, not to statistical cutoff points established for the purpose of population-wide evaluation. This definition avoids labeling as overweight the child whose weight, weight-for-height or BMI are above a certain percentile but is growing consistently. It also allows identifying for early intervention the child whose measurements fall closer to the mean but is nonetheless diverging from his or her previously established growth pattern.

Defining child overweight as growth acceleration reframes prevention. Rather than *avoiding overweight*, the emphasis becomes *supporting each child's normal growth*. Thus, child overweight can be *prevented from birth* with appropriate feeding. Growth acceleration can be *treated* by examining the underpinnings and antecedents of the divergence, restoring positive feeding and letting the child's own capability with energy and growth regulation resolve the problem. Each child has a powerful and resilient ability to eat the right amount of food in order to grow in accordance with his or her genetic endowment. However, each child needs appropriate support from parents and other care providers in order to be able to eat and grow well—to manifest that genetic endowment.

Throughout the growing up years, feeding demands a division of responsibility, with parents and other care providers providing appropriate food and children being allowed to eat as much or as little as they want of what their grownups provide. Depending on the child's stage of development, the division of responsibility plays out in different ways:

- **The infant eats and grows best when he or she is fed on demand, with parents and other care providers guiding feeding based on information coming from the child with respect to timing, tempo, amount and level of skill.**
- **The older baby eats and grows best when parents and other care providers observe the child's individual sequence of oral-motor development and provide appropriately modified food to support the child's gradual transition from semi-solid food to soft table food.**
- **The toddler, preschooler and older child eat and grow best when they have both structure and support. Parents and other care providers of older children are responsible for the *what, when* and *where of feeding*; children remain responsible for the *how much* and *whether* of *eating*. This division of responsibility continues to be essential throughout the growing-up years.**

Professionals who work with children are in a powerful position to teach and support parents in effective, stage-appropriate feeding. Moreover, professionals can help parents accept each child's consistent growth pattern, even when that pattern is outside statistical cutoff points. Finally, early childhood professionals can do early intervention in response to feeding complaints or minor growth divergences. With early intervention, those minor issues can be kept from exacerbating into seriously distorted feeding and weight patterns.

For Further Information

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NOTES

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Helping Without Harming

Kids, Eating, Weight & Health

In this issue of *Absolute Advantage*, we're addressing the topic of childhood obesity. With the help of our guest editor, Dr. Jon Robison and contributing authors Carmen Cool, Elizabeth Jackson, and Ellyn Satter, we've dedicated the pages of this month's publication to taking on this very important issue.

From a worksite wellness perspective, some may argue that this is not one of the most salient topics that could be addressed—we disagree. In fact, our country is at a crossroads of sorts. And what has served us well in the past may not serve us as well in the future. Indeed, we believe that in order to create a healthier America we have to be much more forward-thinking. Thus, it is essential that we begin to look at the health and well-being of the next generation of workers.

That being said, I'll tell you right up front that the articles contained in this issue of *Absolute Advantage* will stimulate some significant discussion. Undeniably, there is much disagreement around what works and what doesn't when it comes to keeping children (and adults for that matter) healthy. However, the authors that we've selected are well-respected, well-read, and well-spoken in this important area.

Specifically, the purpose of this issue of *Absolute Advantage* is to 1.) critically examine the premises on which the present childhood obesity crisis is built; 2.) document the lack of efficacy and dangers of current approaches; and 3.) present alternative approaches for parents, teachers, and communities that will provide help for our children without harming them.

I hope that you enjoy this issue of *Absolute Advantage*.

Yours in good health,

Dr. David Hunnicutt
President