AED Guidelines for Childhood Obesity Prevention Programs (2009)

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Studies from around the world show that body weight in youth has increased over the past decades (Chinn & Rona, 2001; Kautiainen, Rimpelä, Vikat, & Virtanen, 2002; Tremblay & Willms, 2000; Troiano & Flegal, 1998), although the most recent evidence suggests that this increase may be leveling off, at least in the United States (Ogden, Carroll, & Flegal, 2008). Concern over rising weights has spurred various community and school-based interventions aimed at decreasing childhood "overweight." These include the mandatory screening of children's BMI, banning of "junk food" in school cafeterias, limiting vending machines in schools and promotional campaigns emphasizing the dangers of excess weight. Many health professionals have voiced concern about the safety and efficacy of these interventions, fearing that they have little positive effect and may inadvertently contribute to overconcern with weight and shape, unhealthy weight control practices, and weight bias (e.g. Berg, 2001; Cogan, Smith, & Maine, 2008; Ikeda, Crawford, & Woodward-Lopez, 2006; Neumark-Sztainer, Wall, Story & van den Berg, 2008).

A substantial body of evidence from the eating disorder literature demonstrates that a general emphasis on appearance and weight control can promote eating disordered behaviors. For example, when important agents in children's social environment (e.g. parents and peers) endorse a preference for thinness and place an importance on weight control, this can contribute to body dissatisfaction, dieting, low self-esteem and weight bias among children and adolescents (Davison & Birch, 2001; Davison & Birch, 2004; Dohnt & Tiggemann, 2006; Smolak, Levine, & Schermer, 1999). Additionally, weight-control practices among young people reliably predict greater weight *gain,* regardless of baseline weight, than that of adolescents who do not engage in such practices (Neumark-Sztainer et al., 2006). Thus, it is important to evaluate the unintended consequences of "obesity prevention" programs, which may lead to unhealthy behaviors and weight displacements in both directions.

Unfortunately, few studies have examined the effects of "obesity prevention" efforts on risk-factors for eating disorders, such as body dissatisfaction and weight loss dieting. Those that have suggest that focusing on health, not weight, may be key to avoiding harm to body image and eating behaviors. For example, Austin, Field, Wiecha, Peterson & Gortmaker (2005) found lowered rates of disordered eating in a school-based intervenion that focused on promoting healthy diet and activity patterns, rather than on weight per se. These findings emphasize the feasibility of simultaneously promoting body esteem and healthy lifestyle behaviors in youth, as others have suggested (Neumark-Sztainer, 2005). Expanding the vision of "obesity prevention" programs to include the prevention of eating disorders and related issues, may help to ensure that they promote overall health and safety.

Body weight cannot be evaluated in a vacuum. It is not a reliable proxy for eating behaviors and physical activity. Although statistical associations exist between body

weight and risk for morbidity and mortality, being heavy or slender is not by definition pathological. Correlation does not imply causation and the middle of the weight spectrum can cloak a panoply of unhealthy practices. Since healthy living is important for children of all sizes, interventions should focus on lifestyle rather than weight.

The Academy for Eating Disorders applauds efforts to make children's environments as healthy as possible. However, it is important that special care be taken in the construction and implementation of "obesity prevention" programs to minimize any harm that might result. To this end, the following guidelines have been developed for school-and community-based interventions addressing rising weights in youth.

- Interventions should **focus on health, not weight, so as to not contribute to the overvaluation of weight and shape and negative attitudes about fatness that are common among children and have harmful effects on their physical, social and psychological well-being**.

- The World Health Organization defines health as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*. Consistent with this definition, interventions aimed at addressing weight concerns should be constructed from a holistic perspective, where equal consideration is given to social, emotional and physical aspects of children's health.

- Interventions should focus not only on providing opportunities for appropriate levels of physical activity and healthy eating, but also promote self-esteem, body satisfaction, and respect for body size diversity. Prospective studies show that **body dissatisfaction and weight-related teasing are associated with binge eating and other eating disordered behaviors, lower levels of physical activity and increased weight gain over time.** Thus, constructing a social environment where all children are supported in feeling good about their bodies is essential to promoting health in youth.

- Interventions should focus only on modifiable **behaviors** (e.g. physical activity, intake of sugar-sweetened beverages, teasing, time spent watching television), where there is evidence that such modification will improve children's health.

- **Weight is not a behavior and therefore not an appropriate target for behavior modification**. Children across the weight spectrum benefit from limiting time spent watching television and eating a healthy diet. **Interventions should be weight-neutral, i.e. not have specific goals for weight change but aim to increase healthy living at any size.**

- **It is unrealistic to expect all children to fit into the "normal weight" category. Thus, interventions should not be marketed as "obesity prevention." Rather, interventions should be referred to as "health promotion," as the ultimate goal is the health and well-being of all children, and health encompasses many factors besides weight**.

- **School-based interventions should avoid the language of "overweight" and "obesity" since these terms may promote weight-based stigma**. Moreover, several of the most effective interventions have not focused on weight per se.

- **Interventions should focus on making children's environments healthier rather than focusing solely on personal responsibility**. In the school setting, these **include serving healthy meals, providing opportunities for fun physical activities, implementing a no-teasing policy, and providing students and school staff with educational sessions about body image, media literacy, and weight bias. In the community setting, these include making neighborhoods safer, providing access to nutritious foods, constructing sidewalks and bicycle lanes, building safe outside play areas, and encouraging parents to serve regular family meals, create a non-distracting eating environment, and provide more active alternatives to TV viewing.**

- Interventions should be careful **not to use language that has implicit or explicit anti-fat messages**, such as "fat is bad," "fat people eat too much", etc.

- Children of all sizes deserve a healthy environment and will benefit from a healthy lifestyle and positive self-image. School-based interventions should not target heavier children specifically with segregated programs aimed at lowering weights. However, this should not discourage efforts to provide physical activities tailored for larger bodies or to address the experiences that heavier children share as a group.

- Determining normal or abnormal growth in children should be dependent on the consistency of their growth over time and not just the percentile at which they are growing. Childhood overweight should be defined as an upward weight divergence that is abnormal for an individual child, which can be determined only by comparing the child to him- or herself over time. This can be accomplished by consulting an individual growth chart, rather than an arbitrary BMI cutoff.

- Interventions should aim for the maintenance of individually appropriate weights—that is, that children will continue to grow at their natural rate and follow their own growth curve—underscoring that a healthy weight is not a fixed number but varies for each individual.

- A sudden shift away from the growth curve in either direction may indicate a problem, but further information about lifestyle habits, physical markers and psychological functioning is needed before a diagnosis can be made. Changes in weight are not always a sign of abnormal development. An increase in weight often precedes a growth spurt in children and some girls begin to gain body fat as part of normal adolescence at a very young age.

- Weighing students should only be performed when there is a clear and compelling need for the information. The height and weight of a child should be measured in a sensitive, straightforward and friendly manner, in a private setting. Height and

weight should be recorded without remark. Further, BMI assessment should be considered just one part of an overall health evaluation and not as the single marker for a student's health status.

- Weight must be handled as carefully as any other individually identifiable health information

- **The ideal intervention is an integrated approach that addresses risk factors for the spectrum of weight-related problems, including screening for unhealthy weight control behaviors; and promotes protective behaviors, such as decreasing dieting, increasing balanced nutrition, encouraging mindful eating, increasing activity, promoting positive body image and decreasing weight-related teasing and harassment**.

- **Interventions should honor the role of parents in promoting children's health and help them support and model healthy behaviors at home without overemphasizing weight**.

- Interventions should provide diversity training for parents, teachers and school-staff for the purpose of recognizing and **addressing weight-related stigma and harassment and constructing a size-friendly environment in and out of school**.

- Interventions should be created and led by qualified health care providers who acknowledge the importance of a **health focus over a weight focus when targeting lifestyle and weight concerns in youth.**

- Representatives of the community to be studied should be included in the planning process to ensure that interventions are sensitive to diverse norms, cultural traditions, and practices. In this spirit, it is important that interventions be pilot tested before implementation in order to collect quantitative and qualitative feedback from the participants themselves.

- It is important that interventions be evaluated by qualified health care providers and/or researchers, who are familiar with the research on risk factors for eating disorders, as the interventions are being implemented in schools or communities. **Ideally, the assessment should not only evaluate changes in eating and activity levels but also self-esteem, social functioning, weight bias and eating disorder risk factors, such as body dissatisfaction, dieting and thin-ideal internalization.**

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