

Submission No. 17
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The
Australian
Psychological
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Submission to
The House of Representatives:
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Inquiry into Obesity in Australia

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Executive Summary

Recommendations for adequate physical activity and appropriate dietary intake to prevent and combat obesity in Australians are well-developed. However, while many individuals are aware of these recommendations for a better diet and increased physical activity, a large number fail to integrate these recommendations into their lives for any extended period, if at all. Simply put, while many people know what they 'should do' for better health, they do not do it, and simply providing Australians with more information on what they should be doing to improve their health, without the help to implement these behaviours, will not result in effective behaviour change.

Health psychology is a burgeoning discipline within mainstream psychology that offers significant evidence-based practices for the "how to" of getting individuals to change their health behaviour for the purposes of well-being, illness prevention and chronic disease management. Health Psychologists, are a necessary part of the primary health care team working in the prevention of obesity and obesity-related illness in that they provide unique expertise in understanding how to motivate individuals to undertake and maintain long term behaviour change.

Research evidence is positive for the use of psychological interventions such as Cognitive Behaviour Therapy, Motivational Interviewing and Health Coaching in facilitating weight loss through increased adherence to health behaviour change recommendations. The research evidence indicates that standard interventions for obesity are far more effective when specialised psychological and behavioural interventions are delivered in combination with more traditional educational, diet and exercise focused approaches. Using a stepped-care approach where more intensive one-on-one psychological interventions are conducted with those who fail to respond to less intensive interventions may be the most cost-effective approach to tackling obesity.

Health behaviour psychologists need to be included in the development and delivery of interventions aimed at reducing the prevalence of obesity and overweight in Australia. Failure to do so ignores the importance of psychological factors integral in the development and maintenance of obesity in Australians across the lifespan, and ignores the issue of adherence to lifestyle change that should be a primary focus in any health behaviour change strategy. Specific recommendations for the inclusion of health psychology models and health behaviour psychologists in a national strategy to combat obesity are outlined at the end of this submission.

Obesity in Australia

Obesity is generally defined as having a Body Mass Index (BMI; weight (kg)/height² (m)) of 30 or greater, and overweight as having a BMI of greater than or equal to 25 and less than 30 (World Health Organisation; WHO, 2000). Using these criteria, in 2004-05, over half (50.6%) of Australian adults (18 years and over) were either overweight or obese, with the obese adult population at 16.4% at that time (Australian Institute of Health and Welfare; AIHW, 2006). However, the obesity problem in Australia is not confined to adults. In 1995, it was estimated that 19.5% of Australian boys and 21.1% of Australian girls were overweight or obese (Margarey, Daniels & Boulton, 2001). The continuing rise of the body weight of Australians, and indeed the global population, has been attributed largely to an increase in the consumption of energy dense foods (Department of Human Services Victoria, 2006; WHO) and a decline in daily physical activity (Australian Bureau of Statistics; ABS, 2005).

The Burden of Disease: Impacts of Obesity

Economic. For the year 2005, a report for Diabetes Australia estimated that the financial cost of obesity alone (excluding overweight) in Australia was \$21 billion (Access Economics, 2006). This total includes the costs of lost productivity, costs to the health system, carer costs, loss from foregone tax revenue, welfare payments, other government payments, loss of wellbeing and indirect costs. This staggering cost will increase from the growing obesity trend in both children and adults.

Mortality. The flow-on effects of an overweight nation are ubiquitous. Overweight and obesity and associated diet and physical inactivity act as major contributing factors to an array of other chronic, preventable, non-communicable or 'lifestyle' diseases and early deaths. In 2006, 18 of the 20 leading causes of death in Australia were non-communicable diseases including cardiovascular diseases and cancers (ABS, 2006). As stated by the World Health Organisation (2004) overweight and obesity, along with high blood pressure, high cholesterol, poor fruit and vegetable intake, and physical inactivity are among the most important risk factors for non-communicable disease, and high blood pressure and high cholesterol in turn are each closely related to physical inactivity and diet (p.2).

Morbidity. In addition to the contribution of lifestyle diseases to shortened life expectancy, there is also the contribution of obesity and overweight to loss of 'healthy life' expectancy or the 'non-fatal' burden of disease (AIHW, 2003). The AIHW reported in the *Burden of Disease and Injury in Australia 2003* (Begg *et al.*, 2007) that Type 2 Diabetes, for which obesity and overweight is a primary contributing factor, was the second leading cause of non-fatal burden of disease in both Australian men (8.5%) and women (7.2%). High body mass was shown to be the third most powerful risk factor for all causes of non-fatal burden, due to its contribution to

the development of cancers, cardiovascular disease and type 2 Diabetes, the former two of which were the leading causes of non-fatal burden in Australians aged 45 to 65 years and 75 years and over.

Psychosocial: In addition to the contribution of overweight and obesity to reduced physical health, being overweight also has a number of effects on the psychological and social functioning of the individual. Psychosocial effects on children and adolescents who are obese have been demonstrated, and obese children and adolescents are subject to negative stereotyping and stigmatisation from their peers (Lobstein, Baur & Uauy, 2004). Notwithstanding the effects of chronic disease which can which dramatically effect quality of life, overweight women have been found to be 'less pleased with life' when compared to normal weight women (AIHW, 2001), and some relationships between obesity and depression and anxiety have been reported (Scott et al., 2008).

Australia is not alone in its need to improve the health behaviours of its population. In 2004 the WHO launched a *Global Strategy on diet, physical activity and health* in response to the 'growing burden of noncommunicable diseases' occurring primarily in developed nations of the world. According to the WHO, in 2001 noncommunicable diseases accounted for 60% of the 56 million deaths worldwide, and 47% of the global burden of disease. This global approach to reducing the effects of lifestyle diseases proposes the opportunity for international learnings and collaborations on what is now a global issue.

Contributors to and interventions for overweight and obesity

That weight gain is largely the result of energy imbalance, where energy intake outweighs energy expenditure over a sustained period of time, is well documented. Largely, the increasing weight of Australians and indeed populations of all developed countries results from an increasing consumption of energy-dense food coupled with a reduction in physical activity (WHO, 2004). The former results from increased exposure and access to an ever-increasing variety of processed foods, and the latter to a decreasing need for physical movement as work, education, transport and leisure activities become increasingly sedentary.

Clear guidelines on the dietary (National Health and Medical Research Council, 2003) and physical activity (Australian Government Department of Health and Ageing, 2007) needs for Australians have been developed, and while campaigns aimed at educating the population on the content of these guidelines is often successful in increasing awareness, this increased awareness most frequently does not result in sustained behaviour change. Therefore, the difficulty in designing a successful strategy for reducing obesity lies not in the communication of messages promoting behaviour change, but rather in translating this knowledge into action, and the long-term maintenance of that change. Translating knowledge and intention into

behaviour change, for many people, requires specific psychological and/or behavioural intervention. A 2003 report by the WHO concluded;

the importance of psychological and behavioural interventions has been stressed as a result of the growing recognition that knowledge alone is insufficient to produce significant changes in behaviour (p.79)

This statement underpins the notion that individuals with weight problems need not only to be educated in what they should be doing, but also need intervention aimed at reducing psychological and behavioural barriers to long term health behaviour change. Both aspects are vital for positive outcomes.

Whether health care provider advice or information is translated into action can be referred to as *adherence*. *Adherence* is defined as:

the extent to which a persons' behaviour – taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a health care provider (WHO, p.3).

Research into people with chronic disease (such as Type 2 Diabetes) shows that adherence to medical regimens for self-management in developed countries is exceedingly poor at approximately 50%. A similar lack of adherence to dietary and exercise guidelines in Australia is apparent in our increasing body mass. Research into adherence in patients with chronic conditions led one author to conclude (Haynes, 2001) and the WHO to concur (2003, p.23) that:

increasing the effectiveness of adherence interventions may have far greater impact on the health of the population than any improvement in specific medical treatments.

That is, while the medical knowledge and interventions available to prevent and treat many chronic conditions are effective, they can only be effective if carried out or adhered to. Therefore it is necessary for a paradigm shift to occur towards the issue of adherence if there is to be hope of success in producing population behaviour change. While the need for increased focus on adherence has been expounded, according to the WHO (p.11):

Adherence problems have generally been overlooked by health stakeholders, and as a result have received little direct, systematic, intervention.

Australia now has the opportunity to become world leaders through unique public health interventions based on the notion of addressing adherence.

Health Behaviour Change Interventions

The WHO (2003) outlines a five-dimensional model of factors affecting adherence to health-related recommendations. The five dimensions are:

1. Social and economic factors (e.g. socioeconomic factors, race, age)
2. Health team and system related factors (e.g. reimbursement opportunities, medication distribution systems, health care provider knowledge and training)
3. Condition-related factors (e.g. symptom severity, level of disability, effective treatment availability, rate of progression)
4. Therapy-related factors (e.g. complexity of medical regimen, duration of treatment, side-effects, immediacy of treatment benefit)
5. Patient-related factors (e.g. psychosocial stress, anxieties about adverse effects, low motivation, hopelessness and negative feelings, frustration with health-care providers).

Given the contribution of each of these factors to adherence it is crucial that interventions aimed to increase adherence are multi-factorial and interdisciplinary in nature. The fifth dimension of *patient-related factors* affecting adherence, however, sits firmly within the realm of Health Psychology and the expertise of health behaviour psychologists.

Health Psychology and Health-Behaviour Change

Health psychology and those professionals trained in it have the potential to make significant and unique contributions to the development and implementation of a national strategy for the reduction of obesity in Australia. Health psychology is the study of the effects of psychological factors on health and illness (Australian Psychological Society, 2008). Those professionals with accredited training in health psychology, particularly health behaviour psychologists, specialise in the development and delivery of health promotion activities aimed at prevention of physical disease, and/or 'clinical health psychology' which aims at developing and delivering customised interventions with individuals or groups at risk, or currently suffering from a physical (usually chronic) illness. In particular, health psychology focuses on the prevention of chronic disease, facilitating adherence to health-focused interventions through health behaviour change, and facilitating emotional adjustment to living with chronic disease.

The complex role of psychological factors in making sustained behaviour change was captured by Baban and Craciun (2007) who stated that health professionals can increase behaviour change if they ensure that patients are:

exposed to correct information about risk behaviours; develop a positive intention to perform a health behaviour: identify social and personal barriers to performing that

behaviour; perceive themselves as having enough control over engaging in behaviour change; and have a positive affect regarding the behaviour and its outcome (p.59).

The complexity of psychological factors affecting the likelihood of behaviour change highlights the need for the presence of experts able to identify and intervene with these factors in order to facilitate behaviour change. In order to address barriers to adherence in people with chronic obesity it is necessary to increase the workforce of health professionals with an accredited level of knowledge and skill aimed at recognising the personal barriers to change in individuals and at-risk groups, and to subsequently intervene in an appropriate and effective manner. Given that psychologists are the foremost professionals in behaviour change, any intervention that aims to reduce obesity in Australia through improved diet and increased physical activity needs to include health behaviour change psychologists.

Psychological and Behavioural Interventions for Health Behaviour Change

The following section outlines a number of evidence-based psychological approaches to health behaviour changes frequently carried out by health behaviour change psychologists.

Behaviour Therapy/Behaviour Modification

Behaviour therapy aims solely at changing individual behaviour through strategies based on behavioural psychology and learning theories. Behaviour therapy aimed at increasing physical activity and changing diet would include self-monitoring of food intake and physical activity, 'breaking habits' of overeating or eating inappropriate foods through stimulus control, goal-setting using specific and measurable goals, and rewards based on achievement of those goals.

A Cochrane review of the effectiveness of behaviour therapy as an intervention for weight loss (Shaw, O'Rourke, Del Mar, & Kenardy, 2005) indicated that behaviour therapy resulted in more weight loss than a placebo in studies of both less than and greater than 12 months duration. When behaviour therapy was added to dietary and exercise interventions it was more effective in producing weight loss than dietary and weight loss interventions alone, and preferable to behaviour therapy alone. More intensive behaviour therapy was also shown to produce greater weight loss. Therefore, intensive behaviour therapy combined with specific diet and exercise interventions produced the best outcomes.

Cognitive Behaviour Therapy (CBT)

In addition to the techniques used in behaviour therapy, cognitive behaviour therapy also focuses on maladaptive thought patterns, health beliefs and negative mood states of the individual that may be acting as barriers to weight loss. The cognitive component of CBT

identifies, refutes and modifies negative thinking and core beliefs that are affecting the health and wellbeing of the individual.

Shaw *et al* (2005), in their meta-analysis of psychological interventions for obesity concluded that adding cognitive behaviour therapy to dietary and exercise interventions produced greater weight loss than dietary and exercise interventions alone.

Motivational Interviewing

Motivational Interviewing (MI) aims to resolve ambivalence to change by increasing intrinsic motivation (Miller & Rollnik, 2002). It is based on the four principles of (1) expressing empathy, (2) developing discrepancy (highlighting discrepancy between current and desired behaviours), (3) rolling with resistance from the client, and (4) supporting self-efficacy (an individual's belief that they can achieve a desired outcome).

While originally developed and validated as an effective intervention in the field of drug and alcohol addiction to improve adherence to rehabilitation programs (Burke, Arkowitz & Menchola, 2003), MI has also showed promise in achieving lifestyle change. Increased weight loss outcomes using MI have been evidenced with a variety of groups including overweight women with Type 2 Diabetes (Smith West *et al.*, 2007), those at risk of developing Coronary Heart Disease (Hardcastle, Taylor, Bailey & Castle, 2008), and sedentary and obese adults (Carels *et al.*, 2007). While evidence that tests the use of MI with children and adolescents is less available, systematic trials are currently underway (Brennan *et al.*, In press). A meta-analysis of controlled clinical trials of the effectiveness of MI in facilitating behaviour change (Burke *et al.*) concluded that MI was effective in improving adherence to diet and exercise behaviour change.

Combining Approaches: The Health Coaching Australia Model

The *Health Coaching Australia (HCA) Model* is a collection of the evidence-based interventions and techniques described above combined with techniques from coaching psychology. Health coaching is designed to assist health professionals to facilitate health behaviour change with people who have not committed to change following advice alone. That is '*health coaching is particularly relevant when barriers to health behaviour change are present*' (Gale & Lindner, 2007). Designed for delivery to individuals or small groups, when trained in the techniques of health coaching, health professionals are better able to assist their patients to achieve positive health and lifestyle outcomes through attitude and behaviour change (p.2).

Training of health professionals in health coaching requires education in five major areas:

1. Medical conditions knowledge
2. Behaviour change counselling techniques
3. Psychological models of health behaviour change
4. Behaviour modification and evidence-based coaching techniques
5. Emotion management and cognitive change strategies

Health coaching interventions have demonstrated efficacy in improving lifestyle change and therefore chronic disease self management with a variety of chronic conditions and using a variety of delivery modalities including face-to-face, via telephone and via the internet (Lindner *et al.*, 2003). As a relatively new treatment approach, empirical evidence for health coaching in reducing weight is limited. However, a 2003 Australian study of clients with Diabetes tested whether telephone health coaching would improve self-management of the participants' Diabetes. The intervention was shown to produce a raft of positive effects with substantial financial savings (Lindner, Menzies & Kelly, 2003).

Recommended strategies to address the obesity problem in Australia

Any interventions aimed at reducing the prevalence of obesity in Australia need to include the input of health behaviour change psychologists. The production and delivery of information and education campaigns, or even face-to-face intervention with diet and exercise professionals is integral but not sufficient to produce adequate behaviour change. Such campaigns may produce increased knowledge of health-related guidelines, and even an intention to change, but this is unlikely to produce adherence to recommended lifestyle changes, and less likely to produce long term behaviour changes.

Health behaviour psychologists possess unique expertise and skills that would make an invaluable contribution to interdisciplinary teams working in both the prevention and treatment of obesity. In addition, health behaviour psychologists need to be utilised in the training of other health professionals in health behaviour change techniques with demonstrated efficacy such as those included in the health coaching model.

Specific Recommendations:

1. Government health policy and strategies must recognise and reflect the absolute importance of the role of psychological factors in producing behaviour change including the dietary and physical activity changes necessary to reduce obesity in Australia across the lifespan.
2. The importance of psychological factors in reducing obesity in Australia must be reflected in adequate funding for the participation of health behaviour psychologists, as

the foremost experts in this field, in all aspects of the strategies developed to tackle Australia's obesity.

3. Provisions for adequate research into psychological factors affecting health behaviour change, and interventions addressing those barriers at varying stages of the lifespan and in differing genders, ethnicities and cultures is essential.
4. Health promotion messages aimed at reducing obesity need to include the message that some people need professional help to make sustained lifestyle change, and that seeking assistance from a health behaviour psychologist as well as medical and allied health professionals is likely to produce the best outcomes.
5. The design and delivery of obesity prevention campaigns and strategies need to include health behaviour psychologists to ensure that relevant psychological factors are addressed in these campaigns in order to produce the most effective outcomes. Health psychology factors need to be included in all campaigns and need to be relevant to the target group's age, gender, socioeconomic status, ethnicity and culture.
6. Effective treatment of obesity must also include health behaviour psychologists in interdisciplinary treatment teams in General Practice, hospitals, community health settings, residential facilities, rehabilitation and corrective services. Sufficient funding must be made available in order to create these professional positions.
7. A stepped care approach may be the most cost-effective means of obesity intervention. In stepped-care patients participate in more intensive interventions when less intensive intervention has not produced the necessary outcomes. One aspect of stepped-care intervention for obesity needs to be the opportunity for referral to and participation in one-on-one sessions with a behaviour change psychologist to address the psychological factors that are acting as barriers to change, and to improve intrinsic motivation to change. A stepped-care approach provides support for those who are ready to change and those who are ambivalent to change by providing intensive one-on-one intervention for those most at risk at failing to address risk behaviours.

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Lindner, H., Menzies, D., & Kelly, J. (2003) Telephone coach training for health professionals in patient self-management strategies. *Australian Journal of Public Health*, 9 (2&3), 1-9.

Lobstein, T., Baur, L., & Uauy, R. (2004) Obesity in children and young people: a crisis in public health. *Obesity Review*, 5 (s1), 4-85.

Margarey, A.M., Daniels, L.A., & Boulton, J.C. (2001). Prevalence of overweight and obesity in Australian children and adolescents: reassessment of 1985 and 1995 data against new standard international definitions. *Medical Journal of Australia*, 174, 561-564.

Miller, W.R. & Rollnick, S. (2002) *Motivational Interviewing: Preparing people for change*. (2nd ed.) New York: Guilford Press.

National Health and Medical Research Council (2003, April). *Dietary guidelines for Australian adults*. Retrieved 21st March, 2008 <http://www.nhmrc.gov.au/publications/synopses/dietsyn.htm>.

Scott, K.M., Bruffaerts, R., Simon, G.E., Alonso, J., Angermeyer, M., de Girolamo, G., Demyttenaere, K., et al (2008). Obesity and mental disorders in the general population: results from the world mental health surveys. *International Journal of Obesity*, 32, 192–200.

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Appendix 1

A collation of evidence for an alternative view point on the 'obesity epidemic', measures and interventions

Excerpt from communication to colleagues from Professor John Evans, Loughborough University, UK

1. It is not just sociologists seeking a more reflective view on 'obesity'; for example, take a look at the debate prompted by the *International Journal of Epidemiology (IJE)* which, to its credit (like the BMJ), has welcomed discussion in this field. The following provides excellent incentive to debate:

Campos, P., Saguy, A., Ernsberger, P., Oliver, E. and Gaesser, G (2006) The epidemiology of overweight and obesity: public health crisis or moral panic? Point - Counterpoint, in *International Journal of Epidemiology*, 2006, 35 (1) 55-60.
<http://ije.oxfordjournals.org/content/vol35/issue1/index.dtl>

2. There may be those who believe the BMI to be the bearer of incontrovertible 'facts' about the body and health and some, regrettably, may have been badly advised by academics who believe that there is no alternative to their particular version of scientific 'truth'. If it is a more reasoned view of BMI that you want, then, again, both the BMJ and AMJ have discussed both its merits and potential misuse, especially where children are concerned. However, with specific reference to the latest initiatives in the UK to weigh and measure pupils at Reception and Year 6, take a look at Westwood, M., Fayter, D., Hartley, S., Rithalia, A., Butler, G., Glaszio, P., Bland, M., Nixon, J., Stirk, L., Rudolf, M (2006) Childhood obesity: should primary children be routinely screened? A systematic review and discussion of the evidence (see attached).

This 'systematic review' says,

'the value of moving from population monitoring to screening to identify and treat individual children remains, at best, questionable; it is fundamentally dependent on benefits outweighing harms. The effectiveness of treatment is currently doubtful and the potential harms of **either monitoring or screening** (our emphasis) are poorly researched. In the light of this, current models of self-referral appear the best basis for attempts to treat obesity and should continue. The use of the population monitoring programme to identify individual children and provide information to parents and carers, as recommended in the UK House of Commons Health Committee report on obesity, would represent a move towards screening that would be difficult to justify on the basis of current evidence' (Westwood, et. al, 2007).

For a quick fix you might also like to read:

<http://www.bmj.com/cgi/content/full/317/7170/1401?ijkey=NjmjjCU2eXtfs>

We might also note a comment made in the recent Department of Health (2007) *Measuring Childhood Obesity. Guidance to Primary Care Trusts*, Appendix 3, 2.7, page 22, which says, "Screening for childhood obesity could not guarantee to do more good than harm. For these reasons the Expert Advisory Group advised that a screening programme was not appropriate."

3. For literature on the relationships between 'obesity discourse' (more commonly reported under the title of 'weightism') and attendant prejudices and stereotyping around 'weight' and

'fat', the UK is rather less well resourced with this literature than the USA and Australia. However, those interested might try the following:

Brownell, K.D., Puhl, R.M, Schwartz, M.B.,, Rudd, L (2005) *Weight Bias. Nature Consequences and Remedies on Body Disaffection*, New York: The Guildford Press (contains some excellent articles on weight bias in health, employment, in the media, in a child's world, in a teen's world, weight bias and prejudice, etc.).

The Eating Disorders (ED) literature is pretty vast, and actually the AfPE 'discussion' did rather highlight that research on 'overweight and 'underweight' too rarely converge. This is a pity as researchers are often on the same terrain, particularly as they endeavour to provide 'safe spaces' (Paul's great term) for young people to learn and rebuild their lives without undue attention to their body, size and shape. For example, in the ED world it's acknowledged that often you don't address EDs (involving weight loss) by centring on 'weight issues'; it is first about rebuilding self worth, esteem and well being. Paul's work at Leeds would echo some of these sentiments I suspect. The issue, of course, is how then do you take 'weight issues' into school (if you must) and still make them 'safe places' for all pupils irrespective of size and shape? If interested in the ED literature where reference is to the relationships between excessive attention to weight and the development of EDs then try:

Piran, N., Levine, M.P, Adair C.S (1999) *Preventing Eating Disorders*, London: Brunner/Mazel, or

K.Thompson and Smolak, L (2001) *Body Image, Eating Disorders and Obesity in Youth*, Washington DC: ASA.

Lask, B and Bryant-Waugh (2000) *Anorexia Nervosa and Related Eating Disorders in Childhood and Adolescence*, Hove: Psychology Press, offer a good introduction to the field from a balanced multi disciplinary perspective.

Or for a quick fix see the BMJ

<http://www.bmj.com/cgi/content/full/330/7497/950>

4. The literature on body image, body disaffection and excessive attention to weight loss is vast and I guess many of you will already be very familiar with this body of work but for starters see:

Grogan, S. (1999) *Body Image. Understanding Body Disaffection in Men, Women and Children*, London: Routledge, is as good a read as any.

or

Frost, L (2001) *Young Women and the Body*, London: Palgrave

5. I alluded to the 'new' categories of body disorder that are now being recognised in psychology and psychiatry such as 'orthorexia' (an obsession with eating healthy foods) and 'anorexia athletica' (which involves compulsive over exercising, often alongside restrictions on food intake). Our point here is that it is not just those who might be considered in psychiatric terms to be damaged or troubled in some ways that are prone to the dangers of obesity discourse. There are vast numbers of young people who do not experience clinically defined eating disorders yet continue to experience disordered relationships with food and the body as described above. For a take on these issues see:

Beals, K.A (200) Sub clinical eating disorders in female athletes, *Journal of Physical Education and Dance*, 71, 23-29

and

Smolak, L., Murnen, S.K and Ruble., A (2000) Female Athletes and Eating problems: A meta Analysis, *International Journal of Eating Disorders*. 27, 371- 380

Although yet to be published you might also in time read:

Treseder. P (2006) *Diet as a Social problem: an investigation of children's and young people's perspective on nutrition and body image*, Milton Keynes: The Open University

Dr Treseder is a consultant psychotherapist at an ED Unit and was prompted to the research because the unit was increasingly identifying a 'new category' of anorexic young person deeply influenced by weight issues mediated in web sites, TV media and schools.

6. As for our own research with young people with ED. It is shameful for anyone to suggest that we 'disregard' the lives of some (forty) young people, effectively silencing and dismissing as unimportant what they have had to say about their experiences of school. Of course schools have not 'caused' their eating disorders and nowhere do we, or the young people themselves, claim this to be so but all repeatedly refer to the relationships (not 'causal' but 'contributory') between their 'progress' toward disordered eating, excessive exercise and some of the prevailing health initiatives and messages in schools. Just as we should listen to the perspectives of obese (indeed of all) children and young people, then, so too we should not be dismissive of the voices of those who have chosen to become excessively (dangerously) thin, even if we don't like what they say. Too often their experiences are written off as revealing nothing about the culture we live in, but everything about the psychiatry of the child.

7. Finally, you may have noted our message is rather akin to those of the many medics, physiologist, physiologists and psychologists who are now emphasising that it is possible to be 'healthy at any size'. Indeed I'll leave you with the wisdom of Prof Stephen Blair a leading international figure in the field of epidemiology/exercise physiology whose research of 20 years or more has lead him to conclude not only that fat active people have lower mortality rates than thin inactive people (to put it terribly crudely) – i.e., size doesn't matter much outside of the extremes but also,

'The amount of physical activity required for maximal or optimal health benefits is unclear. We also are uncertain about the amount of activity necessary to prevent weight gain, and there is extensive individual variation. For example, some individuals never exercise yet also do not gain any weight during their adult years, while others gain a substantial amount of weight despite daily jogging, such as a certain ageing epidemiologist at The Cooper Institute.' (Blair, 2002, comments reported 23 September via the Australian Physical Education Discussion List: <http://www.austpe-1@hms.uq.edu.au>)

We (like Stephen Blair) do not deny morbid obesity may be a problem. Nor do we suggest that there is no relationship between physical activity and health, rather we question both the evidence base which drives current 'health' policies and the social and psychological implications of their manifestations in school settings.

We hope this limited incursion into the literature will be of some use to you in your further deliberations on how policy and pedagogy should be made and practised in Physical Education. It's not 'truth' and it's not definitive, it's science with all its attendant uncertainties, limitations and contradictions. It's offered in the spirit of everyone's voice, no matter how marginal or unpalatable it may seem, having a place in this debate.

Again, thank you for your kind comments and patience during the conference. Should you be interested in exploring any of the above issues, then we warmly welcome you to the *Society for Educational Studies* (StES) Conference to be held at Loughborough on Monday September 10th (details below).

Professor John Evans, Dr Emma Rich, Rachel Allwood
