Feed & Flourish
NUTRITION THERAPY

PROVIDERS RESOURCE: CONSIDERATIONS BEFORE UTILIZING THE NEW AAP "OB*SITY" GUIDELINES

On January 9th, 2023, the American Academy of Pediatrics (AAP) released its first edition of the "Clinical Practice Guidelines for the Evaluation and Treatment of Children and Adolescents with "Ob*sity"".[1]

WE, THE REGISTERED DIETITIANS AT FEED AND FLOURISH NUTRITION THERAPY, HAVE MANY CONCERNS SURROUNDING THE AAP GUIDELINES AND ASK THAT YOU TAKE THE TIME TO REVIEW THE INFORMATION WE ARE PROVIDING BEFORE UTILIZING THE RECOMMENDED STRATEGIES.

The fundamental basis of these guidelines is pathologizing body size. There is an underlying assumption that being at a higher number on the BMI scale is itself is a disease; this is inherently flawed due to the BMI's simplistic calculation and the fact that was never intended to be used as a health marker.[2] We ask that you keep in mind that the AMA declared "ob*sity" a disease just in 2013, against its own medical counsel.[3] Additionally, the NHANES data used to create the CDC growth charts we use today was collected in the 1970's.[4] We can recognize that certain conditions are associated with living in a larger body, but to date, there is not enough evidence to conclude that a larger body size itself is the reason for these associations.

Pathologizing body size is contributing to weight stigma and fatphobia which we do know to be correlated with worsened health outcomes. People who report experiencing weight stigma from medical providers are more likely to avoid future care, reduced trust and communication with healthcare professionals, and increased disordered eating behaviors.[5] Shame is not a motivator for change.

We understand that parents want what is best for their children and do everything they can to help them live a happy and healthy life. It is understandable that parents of children in larger bodies may feel worried for their child's future due to the fearmongering of rhetoric like "the "ob*sity" epidemic" and because of the weight-based discrimination they themselves face or witness in the world today. These recommendations might feel like the control these caring parents have been searching for to help their child avoid the unfortunate realities of living in a world with weight bias.

As Ragen Chastain phrases it, this feels like "fixing" the bullied, rather than addressing the issue at hand, the people doing the bullying.[6] Are skin-lightening products the answer to racism? Is gay conversion therapy the answer to homophobia? Of course not. So why would eradicating fatness be an ethical solution to fatphobia? Not only that, but the long-term results of these recommendations are largely unknown or shown to provide the *opposite* of the intended effect (weight gain vs. weight loss). **To date, there are no means of intentional weight loss that are effective in the long term for the majority of people, regardless of what weight loss intervention they attempt.**[7]

The guidelines acknowledge the social determinants of health, health disparities, racism, and weight stigma, as impacting health and weight status but then contradict these observations by recommending practices that are stigmatizing; which is associated with poor health outcomes including all-cause mortality.[8] Most weight related studies correlate poor health outcomes to being higher-weight without controlling for weight stigma, weight cycling, or healthcare inequities, all of which are researched to be directly harmful to health.

A systematic literature review consisting of 94 studies found that "eating disorder prevalence increased over the study period from 3.5% for the 2000-2006 period to 7.8% for the 2013-2018 period".[9] We believe the numbers have continued to rise over recent years. By following these guidelines and teaching yo-yo dieting techniques, utilizing weight loss drugs, and recommending/performing weight loss surgeries will undoubtedly contribute to the rising prevalence of eating disorders.

A BRIEF LOOK AT THE RECOMMENDATIONS:

INTENSIVE HEALTH BEHAVIOR AND LIFESTYLE TREATMENT: Over a period of 3-12 months providing 26 hours of nutrition, physical activity, and behavior change lessons. Recommending that treatment should start as early as possible (as early as 2 years of age) and continue through life. "Addressing the relapsing and remitting nature of "ob*sity"." This recommendation acknowledges that this intervention **does not provide long-term results but instead encourages weight cycling**, the process of losing and gaining weight throughout one's lifetime (yo-yo dieting) which is associated with worsened cardiovascular and mortality risk. These risks caused by weight cycling are often misattributed to living in a larger body rather than the process of losing and gaining weight.

PHARMACOTHERAPY: With the rise in popularity of utilizing drugs for off-market use as a means of weight loss, it is not surprising these are now being recommended for use in children. The guidelines state that for children between the ages of 8-11 there is not enough evidence to recommend utilizing pharmacotherapy for the sole purpose of "ob*sity", but if there is an additional health condition it may be indicated. For patients 12 and older with a BMI that classifies them as ob*se, doctors are encouraged to recommend weight loss medications.

Many of these medications come with a host of side effects that could truly impact an adolescent's quality of life. For instance, Orlistat causes significant GI side effects like foul-smelling orange, oily stools, and fecal incontinence. Also, GLP-1 agonist drugs that cause GI distress like nausea and vomiting, which aid in the desired effect of weight loss. Research shows that shortly after stopping these expensive, daily injectable medications, weight increases; meaning, in order to keep the weight off, it is expected that you will stay on this medication for life.

WEIGHT LOSS SURGERY: The recommendations suggest that primary care providers offer referrals for adolescents 13 years or older with "severe "ob*sity"" (BMI ≥ 120% of the 95th percentile for age and sex) to be evaluated for bariatric surgery. There is very limited research on performing these surgeries on children and so there is extremely limited data on the long-term effects. These surgeries are essentially forcing behaviors that mimic eating disorders. They have significant risks such as death, are often irreversible, and can often require additional surgeries. They require significant lifestyle changes that can be difficult for adults

receiving these surgeries to abide by. As teenagers, the frontal cortex is still developing; they may not understand the significance of their daily (expensive) supplements that are necessary due to the forced malnutrition occurring in their body and how limited their intake of food and liquids needs to be, likely impacting many social interactions around food.

All of these recommendations will also have significant psychosocial impacts on the day-to-day lives of children and their families.

OUR STANCE:

- There is not adequate scientific evidence that any of these recommendations improve the health or well-being of children.
- These recommendations are based on using BMI as a diagnostic tool, which has racist, classist origins and was never intended to be used for the diagnosis of individuals.[2]
- Dieting and experiencing weight stigma are significant risk factors for the development of eating disorders.[10]
- All of the recommendations have significant side effects and unknown long-term consequences.
- Families holding marginalized identities are at the greatest risk of experiencing harm from these guidelines.
- The focus of pathologizing higher body weight is shown to cause negative physical and psychological health outcomes.[11]
- Weight stigma is being perpetuated so long as you are using stigmatizing language ("ob*sity", the "ob*sity" epidemic) and focusing on eradicating fatness.

OUR RECOMMENDATIONS TO PROVIDERS:

IF PARENT(S) ARE REQUESTING YOU UTILIZE THESE RECOMMENDATIONS FOR THEIR CHILDREN:

- Request having this conversation in private away from the child.
- Once you are alone with the parent(s) ask about their specific concerns for their children.
- Review their concerns utilizing a weight-neutral approach and explain the difference between focusing on health promotion via behaviors vs. focusing on weight loss.
- Consider referring the child & parent(s) to a HAES® aligned Registered Dietitian to collaborate on the case, to provide the family nutrition education and counseling, and support them in making informed healthcare decisions.

IF YOU ARE RECOMMENDING THESE STRATEGIES TO YOUR OWN PATIENTS:

- Request having this conversation with the parent(s) in private away from the child.
- Ask for the parent(s) for permission to discuss your concerns regarding the body weight of the patient. Ask for insight from the caregiver(s) before providing any suggestions.
- Discuss your concerns for the patient and provide the parent(s) with information about these recommendations as well as weight-neutral options.
- Inform parent(s) of the risks associated with weight loss dieting, pharmacotherapy, and weight loss surgery.

- Consider referring the child & parent(s) to a HAES® aligned Registered Dietitian to collaborate on the case, to provide the family nutrition education and counseling, and support them in making informed healthcare decisions.

MORE INFORMATION ABOUT A WEIGHT-INCLUSIVE APPROACH:

- Research: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4132299/
- Association For Size Diversity And Health: https://asdah.org/about-asdah/
- Resources for Health Professionals interested in learning more: https://christyharrison.com/health-at-every-size-resources

OUR INFORMATION:

Feed and Flourish Nutrition Therapy provides weight-inclusive, HAES®-aligned nutrition counseling to children, teenagers, and adults in the states of: New Hampshire, Massachusetts, and Vermont.
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