

# Federal Trade Commission/Department of Health and Human Services Public Comment on Childhood Obesity Initiatives

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To help children develop to their full potentials and grow up healthy, great care is needed before undertaking any health policies targeting children to ensure that the problem being addressed has been correctly identified, that proposed solutions are effective, and that the long-term benefits of those solutions outweigh the harm that may result. This requires rational, careful and evidence-based thinking. Our eagerness to do something cannot substitute for our responsibilities to examine the evidence objectively.

This workshop is working under these basic premises:

1. There is an epidemic of childhood obesity.
2. There is an epidemic of type 2 diabetes and heart disease in children.
3. Children are eating increasingly poor diets.
4. "Bad" foods are responsible for childhood obesity and "obesity-related" diseases.
5. Marketing can reduce childhood obesity, type 2 diabetes and heart disease.
6. Restricting or changing children's diets may prevent or eradicate childhood obesity.
7. Anti-obesity nutritional programs and "positive nutritional messages" will reduce childhood obesity.

This brief overview will demonstrate that these premises are faulty and based on exaggerated fears and poor scientific evidence, or no scientific evidence at all. And a healthier approach will be offered.

**Childhood obesity.** Children have been growing taller and larger for more than a century, but that does not in itself constitute a problem when none has been evidenced. Most children are tracking normally on those growth curves developed decades ago, just at higher levels of maturity for their age. While there are no objective, reliable or accepted clinical measures of overweight in growing children, many children are being inappropriately labeled and stigmatized as fat. Still, even by the government's own definitions, the vast majority of children do *not* have a weight "problem," lending a cautionary note to turning "childhood obesity" into a public health crisis.

The fact of the matter is, there is no evidence of a rising epidemic. According to a revised Centers for Disease Control and Prevention analysis published in a June 2004 issue of the *Journal of the American Medical Association*, there have been no significant increases in the numbers of U.S. adults or children considered "overweight" or "obese" since 1999-2000.

**Children's health.** There is no evidence linking childhood weight to increased adult health risks. (Szwarc S. Putting Facts Over Fears: Examining Childhood Anti-Obesity Initiatives. *International Quarterly of Community Health Education*, 2005, 23(2):97-116) Of all the body weight studies published in the last half century, most and the strongest studies have found weight to be irrelevant to health and mortality except at the extremes of BMI. A 1996 study by researchers at the National Center for Health Statistics (*International Journal of Obesity Related Metabolic Disorders*, 1996; 20:63-65), for instance, analyzed more than 23 long-term

prospective epidemiological studies involving more than 600,000 people and found a wide range of weights had equally low mortalities. The CDC's own actual health statistics, in *Health United States 2002*, reported American's health has changed dramatically for the better over the past 50 years, while we've been getting larger for generations, and we now enjoy the longest life expectancies in the history of our country. There is no data to support fears that larger children will suddenly begin correlating with decreased life expectancy.

**Heart disease:** A 50-year prospective study recently published in the American Heart Association's journal, *Circulation* (2005; 111:1891-1896) concluded that obesity in childhood is *not* associated with increased heart disease later in life. And a recent study in the *Journal of the American College of Cardiology* (2004; 43 (10):1823-1827) found that after just 8 weeks of regular physical activity, without changes in diet or body weight, the blood vessels of obese teens matched those of their lean counterparts.

**Type 2 diabetes:** Despite several changes in definition and increased surveillance of type 2 diabetes in children, the incidence — number of new cases diagnosed — among children and young adults, 0 to 44 years old, actually *dropped* from 1980 to 1996, according to the CDC's Diabetes Surveillance System. The highest prevalence — the sum total number of people diagnosed in past years, not excluding those cured — continues to be highest among the elderly. In 2002, among 65 to 74 year olds it was 16.85% compared to only 1.23% in ages 0 to 44.

**Poor diets.** The panic over the "unhealthy" foods being consumed by children appears greatly exaggerated. The USDA recently reported that per capita food intake since 1970 shows Americans are eating better. We've *increased* our fresh fruit consumption by 30%, fresh vegetables by 35%, dark leafy greens by 378%, broccoli by 365%, fish by 22%, beans and legumes 22%, and skim milk 150%. Even preschoolers are eating better than they did in the 1970s, according to Penn State researchers. (See: <http://www.techcentralstation.com/011805A.html>)

**Causes for childhood obesity.** Unfortunately, the "eat less and exercise more" focus of obesity initiatives universally oversimplify the etiology of an extremely complex, multifactorial condition which has physiological, genetic, socioeconomic, prenatal and birthweight, familial, environmental, stress and other components. Maureen Storey, director of the Center for Food and Nutrition Policy at Virginia Tech, testified to the U.S. Department of Agriculture Dietary Guidelines Advisory Committee that their research has shown that even if we could perfectly control the calories, sugar, fat and television hours children received, all of those factors — together with invariable factors such as age, race, family income and gender — would impact just 6% of the variations in children's BMI. In other words, if we could exactly control for all of the factors believed to go into childhood obesity, there would still be a wide range of weights among children. Some would still be naturally fat, others naturally thin.

The reason is that our body types are mostly just normal human variations. According to obesity researcher Jeffrey Friedman, head of the Laboratory of Molecular Genetics at Rockefeller University in New York, genetics primarily determines body weight and genetically obese-prone people will become obese independent of their caloric intake. (*Nature Medicine*, 2004; 10 (6):563-569) Examining the evidence in more detail demonstrates this reality.

**Food** has been shown to have little to no impact upon childhood obesity. The American Heart Association's earlier AHA Scientific Statement, "Understanding Obesity in Youth," reviewed all of the evidence to date on childhood obesity and concluded: "Studies of diet composition in children do not identify the cause of obesity in youth. Current dietary fat and saturated-fat intakes of American children are lower than in the past." The DONALD Study (Dortmund Nutritional Anthropometric Longitudinally Designed Study) clinically followed children closely for 17 years and found that no matter what children eat, they naturally grow up to be a wide range of weights. The renowned 1991 review of some 500 studies on weight loss by doctors David Garner and Susan Wooley concluded that multiple researchers, using a variety of methodologies, have failed to find any meaningful or replicable differences in the caloric intake or eating patterns of the obese compared to the non-obese to explain obesity. (*Clinical Psychology Review*, 1991; 11:729-780)

And despite fears of bad foods, numerous researchers have found that high-calorie, low-nutrient dense foods are not correlated with children's weight and that consumption is high among *all* kids. There is more than fifty years of evidence that sugars and sweeteners do not cause obesity, heart disease, diabetes, hyperactivity, nutrient deficiencies, cancer or any chronic disease. And sweeteners have actually been found to have little affect on the nutrients children and teens receive, or on the quality of their diets. (*International Quarterly of Community Health Education*, 2005, 23(2):97-116)

**Physical activity** also has little or no impact upon childhood obesity. That earlier AHA review also found no difference in the energy expenditure between obese and lean children. Eric Stice at the University of Texas at Austin recently reported in the *Journal of Consulting and Clinical Psychology* (2005; 73 (2):195-202) that the majority of studies have found that activity levels are unrelated to body weights, and lack of exercise in kids doesn't predict future weight gain or the onset of obesity.

**Childhood obesity initiatives.** Given these facts, not surprisingly no preventative or treatment programs to date have proven effective in reducing childhood obesity long-term. Even the recent American Heart Association scientific statement, "Overweight in Children and Adolescents: Pathophysiology, Consequences, Prevention, and Treatment," (*Circulation*, 2005; 111:1999-2012) noted the dismal success rates of initiatives tried to date, saying: "Most efforts to prevent obesity among school-age children and adolescents have been implemented in school settings...that include classroom curricula, physical education curricula, changes in school meals, vending machines, and cafeterias, and after-school program....Many of these interventions have not successfully changed weight and body fat, however." In reviewing all the evidence surrounding population-based prevention efforts, the AHA scientists could find no conclusive evidence for the effectiveness of any program, be it advertising or community-based measures.

The 2004 Institute of Medicine report, "Preventing Childhood Obesity: Health in the Balance," commissioned and funded by the Robert Wood Johnson Foundation, also noted the lack of evidence for their far-reaching policy recommendations. "Presently, there is limited experimental evidence regarding the best ways to prevent childhood obesity and the extent to which various potential factors contribute to weight gain."

**First do no harm.** I and many healthcare professionals are much more concerned about the growing body of evidence for the negative effects of childhood obesity initiatives, with their escalating promotion of thinness and fears of fat, and the constant talk of the need to eat "right" and of "healthy" and "bad" foods. Exposing our children to this environment, has left almost *all* children — particularly the vast majority of girls — anxious and/or dissatisfied with their bodies, feeling fat, and subsequently making unhealthy, nutritionally inadequate, counterproductive, and even dangerous lifestyle choices. Weight and food concerns have resulted in unprecedented levels of food fears and dysfunctional relationships with food. Attempting to externally control their eating also leaves them more susceptible to media messages. Because of body weight concerns, young children are engaging in unhealthy and inappropriate weight loss attempts which are the primary triggers for life-threatening and difficult to treat eating disorders. Anti-fat messages have also escalated discrimination against heavier children. Body image, eating, fitness and weight problems develop at very early ages and are extremely difficult to reverse once they are established. (*International Quarterly of Community Health Education*, 2005, 23(2):97-116)

Increasingly, childhood weight and eating experts are cautioning that nutrition rules are beyond children's understanding and they cannot grasp the complexities of dietary guidelines, which most adults don't even comprehend. According to child nutrition and eating researcher and clinician, Jennifer O'Dea, health education messages and government dietary guidelines since the 1970s, with their "control your weight" messages, have resulted in an exponential rise in disordered eating. Her research has shown that most young people mistakenly believe "healthy" eating *is* dieting. (*Health Education Research*, 2004; 24:7-14)

Not only have dieting and weight control measures proven ineffective, they triple children's risks for obesity and double risks for heart attacks, strokes, type 2 diabetes and fractures. Restrictive eating also increases nutritional shortages in growing children who need

fats, sugars and a full range of foods. Many children fall short of nutrients needed for growth that are supplied in “fattening” foods and foods believed “bad” for them. Low-fat eating has been shown to result in lower intakes of calcium, iron, minerals, fiber and most vitamins. A study of more than 14,000 children and adults by Madeleine Sigman-Grant, professor at the University of Nevada Cooperative Extension, Las Vegas (*Journal American Dietetic Association*, 2003; 103 (5):570-576) found those eating a variety of high-fat and low-fat foods had healthier diets — higher in calcium, phosphorus, magnesium, iron, zinc, fiber, most B vitamins, vitamins A and C and folate — than those eating low-fat diets. And the Bogalusa Heart Study (*Journal of the American Dietetic Association*, May, 2004) found that children with low-fat diets (<25% of calories) were short on recommended daily allowances for critical vitamins and minerals compared to kids eating high fat diets (>40% of calories).

**Recommendations.** Increasingly, clinicians working with children’s health, weight and eating issues believe health should be our main concern, not body weight. All children can be motivated into healthier lifestyles, regardless of their weight, and that focus has the best chance for lasting positive health outcomes. This newer paradigm, “Health at Every Size,” looks for long-term benefits and avoids harm. The most efficacious childhood health initiatives are those that promote size acceptance, positive body image and self-esteem, safety, fun child-focused physical activity, and enjoyment of eating nourishing foods for all children (*Healthy Weight Journal*, 2003; 17 (2):28). There’s no mention of “obesity.”

Children need protection from the heightened fears elicited by concerns over “childhood obesity” and the unrealistic media images of thinness and continual focus on eating “right” that surround them. “Childhood should be a time to enjoy and experiment with food, not fear it. All children and adolescents need to feel safe to eat a variety of different foods knowing that everything can be part of a balanced diet. They should be supported in activity and movement simply for enjoyment and enhanced quality of life, not to lose weight. And they need to be able to do so in a positive, inspiring atmosphere. We owe all our children the opportunity to be healthier by developing peaceful relationships with food and their bodies.” (*International Quarterly of Community Health Education*, 2005, 23(2):97-116)

**Bottom line.** The position that “we cannot afford to wait to take action” should be reconsidered. While the desire to help children is understandable, we cannot afford to experiment on innocent children.

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