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Executive summary

- Very many of the issues associated with body image and mental and physical health outcomes that have been discussed by the committee and in evidence have a common underlying cause: idealisation of particular bodily/appearance ideals and devaluation of individuals who do not meet these ideals.
- These messages are internalised across gender and age groups and the response is a plethora of behaviours either aiming to change to meet societal ideals (approach strategies) or withdraw from domains where judgment might occur (avoidant strategies). Both types of strategies have negative impact on mental and physical health and wellbeing.
- The aspect of this most amenable to governmental intervention is the anti-obesity agenda. I will not repeat my previous written and oral evidence. Simply, public health messaging perpetuates and promotes weight stigma and has **negative impact across the weight spectrum**.
- A weight-neutral approach is needed both in public health policy and in individual healthcare. Accordingly, changes are needed in healthcare training and delivery (see previous written evidence).
- Weight-neutral healthcare cannot be delivered concurrently with an anti-obesity agenda. However, **weight inclusive healthcare can deliver the health outcomes that the anti-obesity agenda is failing to deliver at great expense and at immense individual and societal harm**.

Major recommendations:

- Weight-loss should not be measured, used as a treatment goal, or required as a clinical outcome. Weight-loss should not be prescribed for resolution of clinical conditions. Weight loss is not a behaviour. Practitioners should use the same evidence-base they would for a thin patient when dealing with the same condition in a higher-weight patient. It should not be permitted to withhold care from a patient based on their BMI.
- Health promotion in schools should also move away from a weight to a health focus. Having said that, "health" should not be used as a euphemism for "weight." "Healthy eating" – often a euphemism for keeping calories low – should be replaced by "intuitive eating," which involves a much healthier relationship with food and our bodies than does external regulation.

- Diversity should be a required component of the national curriculum. This should include as many types of diversity awareness and appreciation as possible, including not only race and gender, but also appearance (including weight), able-bodiedness, neurotypicality and so on.
- Funding should be made available for research on weight-inclusive health interventions, including in schools.
- Weight should be included as a protected category in UK equality and anti-discrimination legislation.

Introduction

Dr Angela Meadows is a Lecturer (Teaching and Research) in Psychology at the University of Essex in Colchester, UK. Her research specialism is weight-related stigma and its impact on health and wellbeing, which she considers at both the individual level (attitudes and behaviours) and society level (sociocultural and policy environment). She has been working in the field of weight stigma for 10 years and is recognised internationally as a leader in the field. In 2013, she founded the interdisciplinary Weight Stigma Conference, now an annual 2-day event drawing international scholars and practitioners from the fields of public health, medicine, psychology, sport and exercise science, education, business, law, social sciences, and others to consider research, policy, and practice around the issue of weight stigma.

1. Body image is not an individual problem – it is structural

As I noted in my oral evidence, many of the issues being reported by apparently diverse population groups with apparently distinct body image concerns, all come back to one underlying cause – the idealisation of a particular appearance ideal and the high status in society attached to people who display those characteristics, alongside devaluation of those considered 'deviant' in any way.

The current "ideal" human in the UK and most Western societies is thin/muscular, White, young, able-bodied, traditionally pretty/handsome, straight, cis-gendered, and so on. The solution to these issues is **less about promoting individual body satisfaction, but promoting an appreciation of diversity of all types**.

This has to start early. **In the case of weight, anti-fat attitudes are apparent in children as young as 3, and eating disorders are being recorded in children as young as 5**. Children are not born with these attitudes. They learn them in messaging from parents, teachers, and the media they

consume. Anti-fat attitudes are so normalised that they are prevalent in cartoons aimed at very young children and are considered funny. We must stop normalising this type of divisiveness.

Looking at older entertainment media for both children and adults, we would be shocked at the levels of sexism, racism, and ablism being displayed. That this is no longer acceptable is proof that **it is possible to shift the mores around 'deviance.'** This is not to say that we can eliminate sexism, racism, and so on, but that as a society, we can set the standard for what is acceptable – leading from the top. **Weight (or any appearance characteristic) is not included as a protected category in UK equality and anti-discrimination law. The evidence of structural weight stigma across education, employment, healthcare and other contexts is mounting and incontrovertible, and the need for legislation change should perhaps be the topic of a subsequent inquiry.**

2. Obesity prevention initiatives and health education in schools

Despite billions of pounds spent on obesity-prevention initiatives and public health campaigns in the UK alone, it should be evident to any observer that these initiatives are not working. This is sometimes put down to lack of personal willpower, rather than to the body's natural response to restriction (see previous written evidence about the numerous biophysiological adaptations that drive weight gain following calorie restriction). Many commentators have thus suggested that we need to start earlier – by addressing weight in younger children, beginning with weight surveillance (to "identify the problem") and informing children/parents if their weights are outside "acceptable" ranges.

A growing body of scientific evidence is testament not only to the ineffectiveness of this strategy in delivering weight loss, but a strong association with weight gain and unhealthy weight control behaviours, including smoking, use of diet pills (e.g., amphetamines), starving, bingeing, purging, and dangerous levels of exercise (anorexia athletica). Indeed, **long-term data suggest that telling people they are 'overweight' results in greater weight gain over time, irrespective of baseline weight. Further, children and adults who incorrectly perceive themselves to be 'not overweight' actually show lower weight gain over time**. For a review of studies from several countries, covering effects in tens of thousands of youngsters, and encompassing a range of evidence types, including randomised controlled trials (the gold standard to show the direction of causation, i.e., the intervention causes harm), see Mensinger et al. (2021).

Thus, while it may seem self-evident that informing children, or their parents, that they are overweight is a sensible strategy to reduce childhood obesity, the reverse is true. This is not because

parents and children don't care about such information – they do. Families often engage in behaviour change, restricting calories, cutting back on some food types, and trying to increase physical activity. Decades of evidence now speaks to the ineffectiveness of such changes in delivering weight loss beyond temporary reductions (see previous written evidence). Consequently, youngsters may try more extreme behaviours and develop life-long issues with disordered eating and body image, all the while driving further weight gain and worse physical and psychological health and wellbeing.

Unfortunately, even **health promotion education in the curriculum can have serious unintended consequences**. Development of potentially life-threatening clinical eating disorders in children have been traced back to 'healthy eating,' 'healthy living,' and 'healthy weight' programmes in schools (Pinhas et al., 2013). Numerous more likely go undiagnosed or remain at subclinical levels, but with enormous costs to individuals and society. Eating disorders are more likely to be diagnosed in children who were not previously considered 'overweight.' Heavier children who engage in activities resulting in significant weight loss are generally praised, and clinical consequences ignored. Yet, these massive changes in body weight may be even more dangerous in higher-weight children. It is now recognised that atypical anorexia – signs and symptoms of anorexia in the absence of low-weight status, carries significant health and mortality risk, yet is significantly under-diagnosed (Moskowitz & Weiselberg, 2017).

Recent evidence from **nearly 3000 patients at one inpatient eating disorder treatment centre in the US found that nearly one in five attributed the onset of their ED behaviour to anti-obesity messaging** (Mensinger et al., 2021). Of these, **nearly half identified the educational curriculum in a school context as a source of these messages** (followed by the media/Internet, healthcare professionals, and family members). It should be noted that anorexia nervosa has the highest mortality rate of any psychiatric illness.

3. An alternative approach

Health promotion in schools must move away from a weight focus. However, **this must be explicit**. Given the current anti-obesity climate, "healthy eating" has become a euphemism for "not getting fat" rather than about getting as wide a range of nutrition as possible in a culturally appropriate context. **An alternative to typical "healthy eating" curricula might be to promote an "intuitive eating" approach. Intuitive eating encourages acceptance of all foods (rather than categorising them as good and bad) and focusing on internal hunger and satiety cues to guide eating.**

While it may seem that an "eat what feels right" approach would be a recipe for disaster, the opposite is true. **Intuitive eating is associated with lower BMI** (van Dyke et al., 2014), **increased weight stability** (Tylka et al., 2020), and **higher intake of fruit and vegetables** (Christoph et al., 2021). **In pregnant women**, intuitive eating is associated with **lower gestational weight gain**, with no impact on babies' birth weight (Paterson et al., 2019) and with **more rapid weight loss (without dieting) postpartum** (Leahy et al., 2017). **In individuals with type 2 diabetes mellitus**, intuitive eating is associated with an **89% reduced risk of poor glycaemic (blood sugar) control** (Soares et al., 2021).

A number of **studies have compared an intuitive eating or other non-diet intervention with a control condition in clinical populations**; some involve a more comprehensive Health At Every Size® approach that encompasses intuitive eating as one component of the intervention (for reviews see van Dyke et al., 2014; Schaefer & Magnuson, 2014). Participants in the **non-diet groups experience improved physical and mental health markers compared with control participants** (often typical diet interventions). Markers of physical health improved with intuitive eating interventions include **cholesterol levels, blood pressure, and inflammation**. Improved mental health outcomes include **self-esteem, body image, depression, anxiety, and quality of life**. Unlike diet-based interventions, **attrition rates are low and effects continue to strengthen over time**. In diet studies, dropout rates are typically high; those who remain in the studies may exhibit short-term improvements in mood and other outcomes, but these are not maintained at follow-up as weight is typically regained.

Studies in college students show that **even very brief interventions** with an anti-diet and size-acceptance focus **can reduce body dissatisfaction and increase intuitive eating** compared with control groups, with results maintained over time (Healy et al., 2015; Humphreys et al., 2015; Wilson et al., 2020). Short **intuitive eating interventions in high school students have also showed promise** (e.g., Healy et al., 2015). However, the literature in this area is limited.

Knowing the harms produced by current 'healthy eating' approaches, pursuing a weight-neutral, non-diet, inclusivity-based programme of health promotion is an avenue that is worth pursuing. A number of resources (books, online resources, and full curricula; see e.g., works by Kathy Kater and the Be Body Positive Program, both in the US) are now available for young children through adolescents that could be tested in small-scale studies; however, funding is needed for larger scale, rigorous interventions in school settings, including in younger children.

4. Eliminating the anti-obesity agenda is not about being nice to fat people!

While the focus of this inquiry was not obesity, it was a common theme running through counter-arguments to proposed recommendations relating to the negative impact of body image issues on mental and physical health. The Chair himself mentioned repeatedly the need to strike a balance between inclusivity and fighting obesity.

These two are mutually exclusive. However**,** I am in no way suggesting that we stop caring about the health our population (children and adults), or that we should avoid fighting obesity or weighing children or telling people that they are overweight because it might upset them. This is absolutely not the argument. We should avoid these things because (1) they cause immense harm; (2) they don't have the desired solutions and produce worse health outcomes rather than better (see section 4 below); (3) the desired health outcomes can be delivered by stopping these strategies and taking an alternative approach. **"Fighting obesity" is a red herring. The goal is not a thin population but a healthy one. They are not the same thing.** See previous written evidence for further details and supporting literature.

I'd just like to finish with **a personal story**. My mother is 81 – a year older than Tam Fry. She was of the generation where students were weighed annually as a matter of course. She was a chubby child – what we'd call puppy fat now. Her weight was always an issue. As she grew, she slimmed down, as is often the case, but the issues she had developed around food and her body never left her. She continued to try and maintain a slimmer body, terrified of becoming fat again. I remember as a teenager eating dinner at the table while my mother was in the kitchen eating cottage cheese out of a pot and noting down the points value (or probably calories in those days) in her Weight Watchers food diary. As is often the case with dieting, she gradually became heavier and heavier – this is not about personal failure – it is the body's natural response to restriction, a process called adaptive thermogenesis.

After my father died, a little over 20 years ago, her disordered eating became worse. She did lose weight, and no doubt muscle and bone tissue and would often get dizzy and stagger and fall, both at home and when out and about. She didn't eat enough. Then when she was out shopping, she'd go into a café and wolf down a cake – proving to herself that she has no willpower and is greedy – what she'd always been told. In fact, this is her body doing what it's supposed to do and trying to get her to eat something when she is, literally, starving and malnourished. Yet she became worryingly thin. She still has folds of flesh, a remnant of the days when she was bigger. She still thinks she's fat. If she wants food, especially sweet food (high energy-density), it is because she is "greedy."

Four years ago, she developed cancer. Surgery helped for a while but then the cancer came back. Radiotherapy gave her relief for about a month. Until recently, she has been living with us for about six months. Getting her to eat has been a constant struggle, not aided by her mild dementia. Any arguments about how she needed to eat for her health and immune system would be quickly forgotten as she reverted to what she had been taught in the past. A few months ago, she underwent chemotherapy. She more or less stopped eating altogether. Even with the nutrition drinks prescribed by the doctor, she lost two stone in under three months. She continues to lose weight although she is no longer in treatment and not being weighed. She is shrunken, haggard, and has lost so much muscle tone that she can't hold herself upright when sitting. And if you try and get her to eat more than a couple of bites of food she refuses because "it's fattening" or "it will make [her] fat." I beg of the Committee and the Government to not buy into the idea that weighing children and promoting weight loss (even if it's called "healthy eating") does not cause harm. The anti-obesity agenda does not deliver health.

Conclusion

The goal should not be to achieve a thin population, but to achieve a healthy population. The current approach is <u>not</u> fit for purpose; it is expensive, ineffective, and magnifies existing health disparities. **The issue of body image, while critical for health and wellbeing – as this call for evidence acknowledges, is a symptom of the existing public health culture**, not a wrinkle that can be overcome while maintaining our current course. While the idea of abolishing the UK's "anti-obesity" agenda may seem farfetched, **we have an opportunity to do something better, that will deliver on the goals and missions of the department and the government: to "lead the debate on protecting and improving global and domestic health."** We have the opportunity to **lead the world in public health policy** that improves physical and mental health and wellbeing at a population level, rather than just pouring more money (billions in the UK and worldwide) into more of the same – an anti-obesity agenda that has failed to work in any country at any time no matter how much has been invested.

Additional references

Christoph, M. J., et al. (2021). Intuitive eating is associated with higher fruit and vegetable intake among adults. *Journal of Nutrition Education and Behavior*, vol *53*, 240–245. https://doi.org/10.1016/j.jneb.2020.11.015

Healy, N. et al. (2015). Impact of an intuitive eating education program on high school students' eating attitudes. *Health Education*, vol 115, 214–228. https://doi.org/10.1108/HE-03-2014-0043

Humphrey, L., Clifford, D., & Neyman Morris, M. (2015). *Health at Every Size* college course reduces dieting behaviors and improves intuitive eating, body esteem, and anti-fat attitudes. *Journal of Nutrition Education and Behavior*, vol *47*, 354–360. https://doi.org/10.1016/j.jneb.2015.01.008

Leahy, K. et al. (2017). The relationship between intuitive eating and postpartum weight loss. *Maternal and Child Health Journal*, vol *21*, 1591–1597. https://doi.org/10.1007/s10995-017-2281-4

Mensinger, J. L., Cox, S. A., & Henretty, J. R. (2021). Treatment outcomes and trajectories of change in patients attributing their eating disorder onset to anti-obesity messaging. *Psychosomatic Medicine*, vol. *83*, 777–786. https://doi.org/10.1097/PSY.0000000000000962

Moskowitz, L., & Weiselberg, E. (2017). Anorexia nervosa/Atypical anorexia nervosa. *Current Problems in Pediatric and Adolescent Health Care*, vol. *47*, 70–84. https://doi.org/10.1016/j.cppeds.2017.02.003

Paterson, H. et al. (2019). Intuitive eating and gestational weight gain. *Eating Behaviors*, vol. *34*, Article no. 101311. https://doi.org/10.1016/j.eatbeh.2019.101311

Schaefer, J. T., & Magnuson, A. B. (2014). A review of interventions that promote eating by internal cues. *Journal of the Academy of Nutrition and Dietetics*, vol *114*, 734–760. https://doi.org/10.1016/j.jand.2013.12.024

Soares, F. L. P. et al. (2021). Intuitive eating is associated with glycemic control in type 2 diabetes. *Eating and Weight Disorders*, vol. *26*, 599–608. https://doi.org/10.1007/s40519-020-00894-8

Tylka, T. L., Calogero, R. M., & Daníelsdóttir, S. (2020). Intuitive eating is connected to self-reported weight stability in community women and men. *Eating Disorders*, vol *28*, 256–264. https://doi.org/10.1080/10640266.2019.1580126

Van Dyke, N., & Drinkwater, E. J. (2014). Relationships between intuitive eating and health indicators: Literature review. *Public Health Nutrition*, vol *17*, 1757–1766. https://doi.org/10.1017/S1368980013002139

Wilson, R. E. et al. (2020). Brief non-dieting intervention increases intuitive eating and reduces dieting intention, body image dissatisfaction, and anti-fat attitudes: A randomized controlled trial. *Appetite*, vol *148*, Article no. 104556. https://doi.org/10.1016/j.appet.2019.104556

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