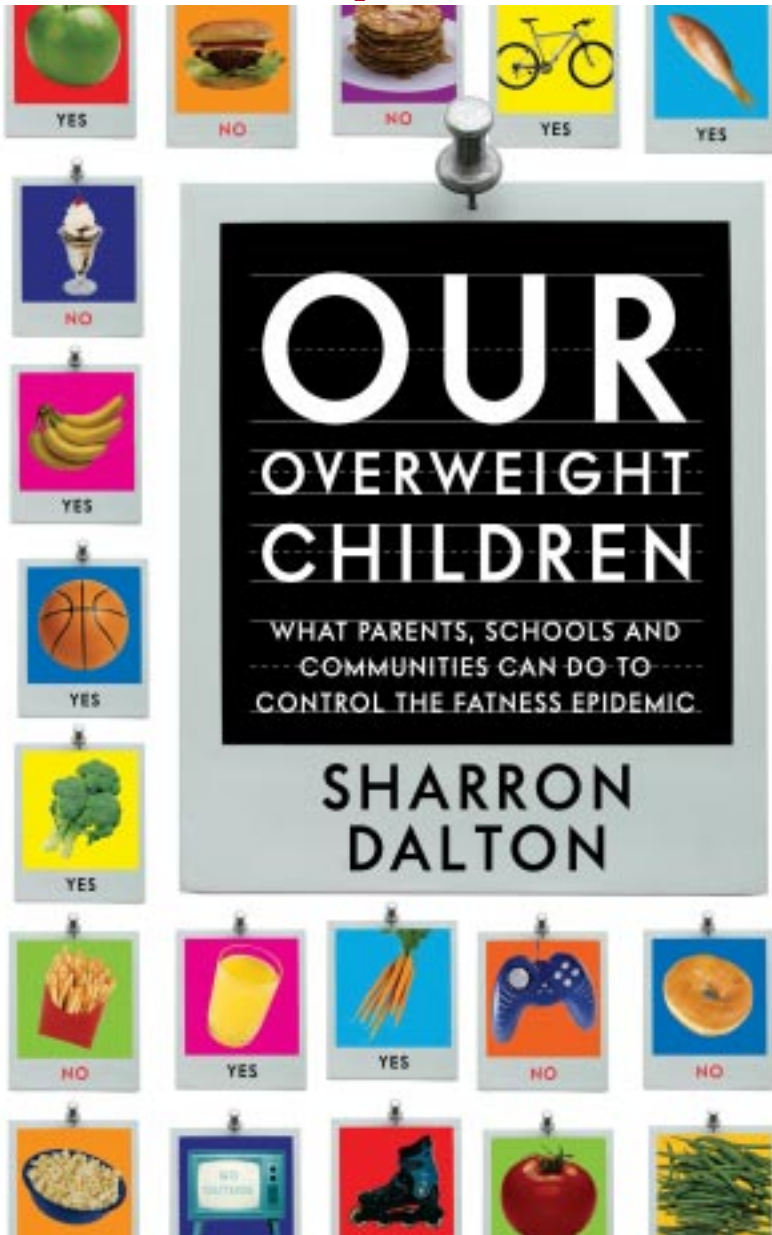


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NURTURING HEALTHY AND ACTIVE LIFESTYLES

ONE QUESTION FROM TWENTY YEARS AGO haunts my memory. I was leading a workshop with health professionals representing a variety of agencies that served parents and children. The topic was childhood obesity. Most of the participants were mothers and grandmothers; about half were African American and Hispanic; the majority worked in government and health-care programs, as administrators or directly with patients; many were in minority or low-income communities. The objectives of the workshop were ones this book shares: to understand obesity's causes and to explore and suggest appropriate, effective remedies.

I showed a video clip from a documentary dramatization of four- and five-year-old children being asked to look at drawings of children and pick one they would like to have as a friend. The drawings showed children with various physical difficulties; one was obese. Invariably the obese child came last. Most participants nodded in recognition, and some told of similar experiences among children they knew. Two or three spoke passionately about the injustice of fat discrimination.

I had just summarized prevalence data and was about to discuss the health risks of childhood obesity when an impatient voice demanded, "I want to hear something new." An articulate Hispanic director of a small center for immigrant children from the Dominican Republic worked with children she described as chronically overweight. She began by stressing the sever-

ity of the problem and said she felt frustrated and burned-out. She knew what caused the problem—“They eat big fast-food meals every day and drink lots of whole milk as they’re glued to TV”—but she had no remedies, no way to help these families stop or treat the children’s unhealthy weight gain. Then she spoke the challenge that could only come from intense experience and rings in my ears as I recall it now:

Professor, I know how to identify fat children, to talk to them so they don’t feel miserable. I know why these kids are fat and getting fatter. What I don’t know and am increasingly impatient to hear is what the experts claim is most likely to work when we try to help parents with fat kids. I’ve read the literature that says families should eat together. But after telling people that for seven years, I have no idea of how they can do it. The same is true for exercise; parents are rarely good role models for this, and even if they are themselves slim and active, that can’t compete with a peer group watching some wild video together and munching chips. Parental role modeling? Health workers like us handing out advice? Please, Professor Dalton, tell us something that actually brings results!

Shouts of “Amen!” and loud applause rang out when she finished.

The response I gave at that workshop at least began well. I agreed with the group that as health professionals we needed to find ways to help and also encourage people to help themselves. I listed the kinds of support experts propose to prevent and treat childhood obesity. I pointed out that some of the advice draws on research data but has very little evidence about what is effective, especially in the long term, and that there are many more questions about what works than there are answers. We then pooled ideas and experiences of how to treat childhood obesity.

Yet my response was surely inadequate. The problem *is* challenging and her question stands: what really works to motivate and help children who are at risk or already struggling with obesity?

This book’s final part takes up and tries to answer her question. The general approaches and practical advice I advocate on the following pages may appear relatively simple and basic. They are, because they must be. Imagine asking parents, many of whom have struggled with being overweight their entire lives, to do all of the following: decipher nutritional labels, count their children’s calories, measure their portion sizes, and keep track of their protein-carbohydrate-fat ratio at every meal—and while they do so, to avoid sugar, soda, fried foods, and certain kinds of fats but not others; to exercise daily, cook healthy meals from scratch, and fix family members’ sched-

ules so everyone can eat dinner together; *and* to banish the TV. Many parents would throw up their hands in frustration and give up trying to lead healthier lives. In fact many do give up, and thus the epidemic grows. Therefore, to help the families hardest hit by this epidemic—those on the lower end of the socioeconomic scale, who face multiple challenges in their lives that compete for their resources and attention—we must deemphasize the complexity of the issue and put forth feasible and realistic remedies everyone can adopt for the long term.

Hence we focus on understandable, general guidelines with practical strategies to implement them, and then leverage a handful of manageable and moderate steps to make a significant impact on children's health.

For example, we know that children need to become more physically active. Parents on a budget and pressed for time may think they cannot get their children to exercise more because of the cost and time needed for organized recreational classes such as gymnastics or karate. My message to everyone is that physical activity does not have to be complicated, costly, or very time consuming. Parents should try instead to turn off the television an extra hour each day and use the time to encourage their children to engage in more active pastimes, which can be as simple as playing tag or dancing to pop music. As one report noted, "Opportunities for spontaneous play may be the only requirement that young children need to increase their physical activity. Reducing the amount of time that children are allowed to watch television is one strategy that offers children opportunities for activity, and it is likely to alter requests for advertised foods as well."¹

Similarly, we know that many children eat too much and therefore need to reduce their calorie intake. Parents need to know that this does *not* have to involve embarking on a strict or trendy diet. Moderate steps to change eating behavior—such as sharing family meals, offering children a variety of healthy foods, and respecting children's choices not to eat a specified amount—will go a long way toward reducing young children's access to and consumption of foods that are fattening.²

These are not novel approaches. In fact, they were the norm a generation ago, when there were fewer alternatives. Now a return to basics seems essential. Why? Because we have few other strategies, because none of these interventions is likely to have adverse effects, and because all of these actions will improve the quality of family life. But the basics are simpler in theory than in practice, because they require that parents and children manage their many choices for eating food and spending time. It is not enough

to educate ourselves on what we should do; we need strategies for how to do it.

To that end, this chapter offers strategies to help lay a foundation for healthy eating and activity in practice, not just in theory. The focus here is on the *prevention* of excessive weight gain. We examine ways that all parents can exert the appropriate degree of control in feeding and raising children so children are more likely to self-regulate their eating and spend their time in a healthy manner. Building on that foundation, I present my top recommendations for lifelong healthy weight management and discuss ways to raise resilient children equipped to withstand the fattening forces beyond their home. Chapter 7 targets treatment, conveying specific nutritional guidance and evaluating popular weight-loss programs, as well as examining the risks, among children, associated with weight loss (namely, disordered eating and unhealthy body image). Because the line between “prevention” and “treatment” is fuzzy, strategies for prevention are also sound suggestions for children who already are too heavy and need to slow their rate of weight gain.

PREVENTION: THE FIRST—AND BEST— COURSE OF TREATMENT

Obesity is the most prevalent but also the most preventable health affliction of children today. If prevention were easy, we would not need treatment for childhood obesity. With one out of four children already overweight or at risk of becoming overweight, we clearly need both prevention and treatment strategies, now, at all levels—for individual children, families, communities, and schools, as well as in health care and other social and institutional networks.

So often, the predictable response to obesity is to put resources toward treatment with little attention to prevention. Consider, for instance, a recent addition to the already frighteningly long list of medical complications obese children often experience, a liver disease called NASH, for *non-alcoholic steatohepatitis*.³ How dreadful: obese fourteen-year-olds are getting a liver disease similar to one induced by excess alcohol in adults! One of the first questions that spring to mind is, which medication will treat the malfunctioning liver that results from obesity? The drug industry is working to develop a medication to improve liver function in obese children with NASH. Of course, we all worry about serious afflictions like this among children and hope a medical remedy can be found. But developing med-

ical treatments for obesity is a Band-Aid solution. Prevention, not medicine, represents the best hope for protecting our children from potentially life-threatening afflictions related to obesity and a lifetime of clinical treatment that may have side effects—at overwhelming cost to families and our health-care system.

Parents hold the keys to prevention; they determine what young children eat and their choice of physical activities. Choices of older children and adolescents, including what they eat and how they spend time, draw on a larger group of their parents, teachers, and peers. And to some degree, all age groups respond to the lure of products on TV, at the supermarket, and at the mall. Nonetheless, given the importance of early childhood in patterns for eating habits and the primary influence that parents exert, we must look to parents as the starting point for any strategies against childhood obesity. Recall the key risk factors for obesity, outlined in chapter 3: parental obesity; unhealthful eating patterns and eating styles; low physical activity; excessive television and computer time; low socioeconomic status. Individual parents may not be able to curb their own obesity and raise their socioeconomic status, but they can take steps to minimize the other risk factors on that list.

Obesity is not a disease that eludes prevention or recovery. Scientists know that mice, caged in an experimental laboratory, can be made fat on a typical American diet. They can be made thin if food is reduced and made thin much faster if placed on a treadmill. But we are dealing with children, not mice. We cannot force them onto a treadmill and feed them a carefully controlled diet day in and day out, because their finicky nature and their yearning for autonomy will lead them to rebel against such heavy-handed measures to control their activity and eating. Moreover, we raise them in an environment full of choices—a fully stocked refrigerator, a multichannel television set—and those choices multiply once they reach school age, gain independence, and venture out on their own. We believe in choice and want plenty of food easily available, but how can we help our children learn to choose food in moderation and gain adequate physical activity? Becoming an authoritative parent is one path toward this goal—a path any parent can and should take.

BECOME AN AUTHORITATIVE PARENT

Authoritative parenting, as outlined in chapter 4, is the middle ground between permissive and authoritarian styles. Whereas permissive parents might

have abundant high-calorie snacks always and easily available or authoritarian parents might strictly forbid eating them at all, authoritative parents have a firm but flexible structure for when and how to enjoy a variety of foods as snacks. Authoritative parents neither give their children free rein nor hold them in too tightly; rather, they set parameters for their children that help them learn how to set limits on their own and how to exercise self-control. Parents who set limits to keep their children's world a manageable size are doing the right thing, because they are showing them how to structure the many choices available for eating and spending time. Raising children to manage their lifestyle choices is one form of insurance against obesity in an environment that can be so contrary to a healthy lifestyle.

Limit setting becomes an obstacle course for some children if caregivers first encourage them to eat more than they want or need during early childhood (age one to three), and then restrict foods later (age three to five). For example, a parent might serve second helpings to a two-year-old—even though the child did not indicate she wanted more—and then tell her, “You have to make all that chicken and rice disappear from your plate before you can leave the table.” Later, when the child reaches age four, the same parent might say, “No more second helpings or dessert for you after all the snacking you did this afternoon.” In one study, overweight and normal-weight eight- to twelve-year-old children ate at significantly different paces only when the mother was in the room too. In her presence, overweight children ate faster and with larger bites than the normal-weight children and speeded up eating near the end of the meal. One interpretation is that as toddlers, they learned this response to reinforcement to “clean the plate.” Or it could be a learned coping response to stress among older overweight children.⁴ “If I hurry, no one will notice how much I ate.” Either way, the study shows that parental presence and practices affect overweight children's eating behavior more than of children with normal weight. If parents are too pushy and then too restrictive, children get mixed messages.

Key to being an authoritative parent is finding an appropriate level of control and structure in feeding a child, with the goal being to nurture the child's self-control as well as a liking for a variety of foods. Children need limits and guidance, but the evidence is quite strong that strictly prohibiting foods usually backfires when kids later on have a free choice of foods, and restricting their food likely leads to overeating.⁵ Even so, being overly permissive and serving unlimited portions of whatever older children desire leads to overeating too. Young children generally stop eating when they feel full, while older children—above age six or so—will eat beyond full-

ness when consistently exposed to large portions. Their bodies will expand by getting fatter and so will their stomach capacity as they override their satiety signals until eating too much becomes habitual.

Because parents' own eating behavior is as important as their style of parenting around food, children often get confusing messages. For example, a mother who is "always on a diet" and tells her child to "clean your plate" demonstrates food restriction while simultaneously sending the message to "eat more." Modifying parent behavior is a good place to begin in preventing a child from experiencing difficulty in noticing fullness or from overeating "forbidden foods" when they get a chance.⁶

Rather than force a child to eat specified amounts of certain foods or, at the other extreme, adopt a *laissez-faire* approach at mealtimes, parents should aim for moderation. To find that golden mean, I strongly recommend a method developed by Ellyn Satter and described in her book *Child of Mine: Feeding with Love and Good Sense*. Out of all the texts, her research and its application are outstanding and remain valid today. Satter encourages parents to observe what she calls "the division of responsibility" in child feeding:

- Parents are responsible for the *what*, *when*, and *where* of feeding.
- Children are responsible for *how much* they eat and *if* they eat some foods.

For parents, Satter stresses "the importance of providing the food and feeding environment and then letting go. This means controlling what food comes into the house, the making and presenting of meals, and regulating the timing and content of snacks. However, children are responsible for how much they eat. They also determine, based on the food provided, whether they will eat it or not. The idea is that if each party sticks to its division of responsibility, a child will grow according to his genetic blueprint—maybe fatter or thinner, shorter or taller than expected, but the right size and shape for him."⁷

Thus parents and caretakers divide up the shopping and cooking tasks among family members and are responsible for what and when foods are available. For example, parents stick to their shopping list at the grocery store, responding to children's requests consistently rather than caving in to multiple demands; preparing and deciding when food is served to younger children; and choosing what foods are eaten in restaurants (older children, who can read the menu, should have some latitude to order for themselves

when dining out, but guidelines are still in place; for example, if milk or water is usually served at home during family meals, an older child might have one soda at the restaurant, but refills will be water). Parents plan menus and shopping strategies; decide the number and type of meals together/away/brought in; designate who shops/cooks/cleans up; and setting meal and snacking guidelines—for instance, the availability of “anytime, sometimes, seldom” foods—and so determine the *what, when, and where* of feeding.

Once the food is served, children take over. Within meal and snacking guidelines, they are responsible for deciding if they eat a food and how much they eat. It’s their prerogative to be picky. At home or eating out, an uneaten meal can be wrapped up and made available later. The parents might comment on the tastiness of the food and why they like it, but in general they should try to seem unconcerned whether and how much children eat. (When kids reject a new food, however, parents should not give up but offer it at a later date; sometimes it takes ten to fifteen “exposures” for children to try and to like a new food.) Bribes or threats that aim to get children to eat their meal—“You can have ice cream for dessert if you eat all your peas,” “You cannot watch television unless you finish your milk”—should always be avoided, as should excessive praise when kids eat everything on the plate.

What about dessert? Dessert can be a part of the meal, but in a child-size portion. If the main meal was not eaten, extra dessert should not be what kids fill up on. In sum, parents choose and serve a variety of foods that they enjoy eating with their children; children eat (or do not eat) the amount they decide from the choices available.

Satter’s division of responsibility sets the authoritative approach apart not only from a highly controlling one with strict rules and forbidden foods, but also from a more permissive “self-demand” approach. One “self-demand” method, especially recommended for adults and children who already have trouble eating in a balanced manner—possibly because of previous excessive parental control—involves “legalizing” all food. The authors of *Preventing Childhood Eating Problems*, Jane Hirschmann and Carol Munter, recommend having all foods available: fresh fruits and vegetables, meats, whole grains and dairy products, as well as candy and ice cream.⁸ Nothing is forbidden. But such a permissive approach has risks. I believe children need to learn how to control their eating behavior, and learning how to respect boundaries as well as how to be in charge requires guidance and support. Dividing responsibility and exhibiting moderation from the start with children avoid the need to deal with the notion of “illegal” foods later.

With so much advice available, it's no wonder that parents, trying to do their best, either control too much or too little. The underlying principle is that it's critically important to trust kids to know if they are hungry and how much to eat. This trust applies to all kinds of foods. In order to develop a sensible relationship to high-fat and high-sugar foods, parents and caregivers should offer children foods and snacks that vary in sugar, fat, and calories. This means some ice cream and cake as well as a wide variety of fruits and vegetables—all in moderation. Children learn to like what they are offered.

A man who had struggled with his weight since childhood once told me, “If only I had learned to eat as a kid.” He recalled a moment when he was back with his family during a reunion and, trying to be healthy, came down to eat his cereal before anyone else got up: “I opened the fridge, and there were three banana cream pies. And the pie was right in front of the milk—just like when I was a kid. It was there, so I ate it. All of it. I felt awful all day.” It is difficult, if not impossible, to learn to trust and “to listen to your body,” after ignoring fullness signals for years. If we can help children learn to enjoy a variety of food, in moderation, they will find eating to be one of life's great pleasures—not a dieting landmine.

There is wide agreement on the importance of rediscovering the pleasure and ritual of family mealtimes, the theme of another Satter book, *Secrets of Feeding a Healthy Family*.⁹ The pleasure comes not from overindulgent eating, but from making room for mealtimes. It comes from slowing down and taking the time to notice and enjoy the food being served. And—I believe—it helps kids and their parents develop lifelong balanced eating patterns that will curb obesity. Learning to eat for enjoyment and taste, and noticing fullness, are the basics. Some of what we nutritionists teach—about sufficient vitamins and minerals and too much fat—are not the reasons kids (or grown-ups) eat what they eat. In fact, “new” advice that conflicts with “old” advice blurs both. Concern with news about cholesterol and trans-fats causes some parents to forbid certain foods and overuse others. The basics of moderation and balance get lost in the terminology and news-breaks. The essential take-away lesson is this: kids eat foods that taste good and are available. So parents need to make healthy foods that taste good available—and enjoy eating together.

MAKE IT WORK: MY TOP RECOMMENDATIONS TO PARENTS

How can parents carry out the fundamental approach outlined above—not just for a month, or for a year, but for life? What follow are five key

recommendations to help them—to help all of us—become authoritative parents who teach by example and exercise an appropriate level of control in feeding and raising children. These recommendations are simple to understand but may seem hard to carry out, which is why I add tips for implementing each one. They stem from my professional experience as well as from other expert guidelines. With time and a reasonable degree of effort, these recommendations become part of a family’s everyday life.¹⁰

1. Eat moderately, parents—kids will copy.
2. Plan and eat meals and snacks together, emphasizing variety.
3. Foster a preference for healthier alternatives—in particular, fruits, vegetables and whole grains—by repeated tasting and enjoying by the whole family.
4. Talk, walk, and play together indoors and outdoors as an alternative to watching television.
5. Get enough sleep (children need at least nine hours).

The method I use here—analyzing the recommendations first in theory and then in practice—is the same method I use in workshops with health advocates; I work with participants to examine the theories from reported studies on weight management, and together we try to apply them to the reality of our collective group experience. Under each “practice” discussion are tips on how to make it work.

1 *Eat moderately, parents—kids will copy.*

The theory. Children stand a greater chance of learning to eat in a healthy manner and to manage weight when using a family-based approach rather than going it on their own. Children are better copycats than listeners: they are more likely to do what their parents do, rather than what their parents say. Parents who themselves alternate between control (restrictive dieting) and loss of control (binge eating) are likely to pass on these eating habits to children.¹¹ Children do not naturally restrict food and then overeat later—unless they learn this behavior from an adult. Parents themselves should seize the opportunity to become agents of change by eating moderately and aiming for a healthy weight themselves. Several studies confirm that when an outside health professional *and* parents coach obese children,

they are more likely to change eating habits and show greater weight loss than with the conventional approach of diet advice without parental support.¹² In fact, when parents improve their own eating behaviors without actively including children, the impact of their role modeling alone positively affects children's eating behavior.

An important element of role modeling is wise social and emotional use of food, to help kids learn not to use food when they need love or other support. Comfort means a hug and attention—not M&M's. Ditto for grown-ups. Eating after stress, or erratic eating between meals, can contribute to becoming overweight.

The practice. The demands of our lifestyle and the lure of enticing food products in the marketplace make it hard for parents to be healthy and eat moderately, especially when food comes in “mega” sizes and, even at home, in restaurant-size portions (see the box “Common Portions vs. Recommended Servings”). Children try junk food at friends' houses and at school, which makes them desire it at home, too.

The practice of eating moderately means cutting down exposure to unhealthy food. How? Just as we learned to limit sun exposure because of the perils of skin cancer, so we must limit exposure to high-calorie “super-size” food or drink because of their excess calories from fat and sugar. Parents can show their children that it is okay to savor high-calorie-dense foods, but in small amounts and only occasionally. Potato chips or Oreo cookies? If they are always available, they will replace meals. If they are forbidden, they become more desirable. Better to buy them only from time to time—for the occasional snacks or dessert—rather than keep them in the house and limit children's access to them. Bottom line: offer and also eat mainly healthy foods.

How to eat moderately?

Instead of serving overly large portions to adults at meals and equally large portions for children, **try** following suggested serving sizes and eating slowly so the body can recognize fullness, then serve second helpings only if family members are still hungry. Offer children small servings and allow them to ask for more if they finish and are still hungry.

Instead of reaching for a high-calorie snack when bored or upset from stress, **try** a planned distraction. Have a list ready to go with doable suggestions: take a five-minute walk around the block, make a phone call to a friend, or do a few stretches to favorite music.

COMMON PORTIONS VS. RECOMMENDED SERVINGS

Eating moderately involves following suggested serving sizes and offering more only if hunger truly persists after the first serving is finished. Here are some sample food portions commonly served compared to the Food Guide Pyramid's recommended servings for these foods. First, consider the difference between the two terms:

- A *portion* is the amount of food you choose to eat. There is no standard portion size and no single right or wrong portion size.
- A *serving* is a standard amount and a guide on how much to eat.

Food	Typical portion size	Food Guide Pyramid's recommended serving size	Number of servings in a typical portion
Bagel	1 bagel (5" dia, 4.0 oz)	½ bagel (3" dia, 1.0 oz)	4
English muffin	1 muffin	½ muffin	2
Sweet roll	1 large bakery (6.0 oz)	1 small (1.5 oz)	4
Pasta	2 cups (cooked)	½ cup (cooked)	4
Rice	1 cup (cooked)	½ cup (cooked)	2
Popcorn	16 cups (= medium, at movie theater)	2 cups	8
Fries	1 medium order (4.0 oz)	½ cup (1.0 oz)	4
Fried chicken	3 pieces (7.0–8.0 oz)	2.0–3.0 oz	3
Broiled fish	6.0–9.0 oz	2.0–3.0 oz	3
Sirloin steak	8.0 oz (cooked, trimmed)	2.0–3.0 oz	3
Tuna salad sandwich	6.0 oz	2.0–3.0 oz	2

Instead of drinking soda and juice several times a day, **try** quenching thirst with water. Parents should try to drink water or milk at meal-times rather than soda. Let kids shop for a special water bottle; fill it with water, and pack it for school in lieu of a can of soda or fruit punch.

Instead of ordering a super-size value meal for each family member at restaurants, **try** ordering smaller portions, or ordering one super-size meal for a parent and child to share.

Instead of rewarding yourself or your child with an indulgent treat after accomplishing something challenging, **try** buying a nonedible special item—such as clothing, books, or toys—as a reward.

2 *Plan and eat meals and snacks together, emphasizing variety.*

The theory. Children ages nine to fourteen who eat with their parents frequently are likely to have healthier eating habits than those who rarely eat with parents. One study compared the diet quality of children who never or seldom ate a family dinner with the diet of children who ate with their family most or every day. Family meals were associated with healthful foods: more fruits and vegetables, less fried food and soda, and more fiber, vitamins, minerals from foods. Other studies have likewise established that eating a family sit-down meal together rather than eating while standing or while doing other activities (such as watching TV, reading, doing homework) reduces the risk of uncontrolled overeating in both parents and children.¹³

Variety also is a hallmark of better diets. The traditional wisdom, backed by scientific research, is that offering children a variety of food provides the basic nutrients for health. And indeed, variety increases the chances of their eating sufficient vitamins and minerals. Variety stimulates the taste buds, whereas eating a single, specific food may dampen them. Of course, the greater the variety of food offered, the more people eat. Hence the popularity—and overconsumption—of food served in “all you can eat” buffet-style restaurants. This means that while variety is good for getting sufficient nutrients, it is not so good for weight management. In fact, to reduce the amount of food people eat, most diets for weight loss often rely on a very few foods. Laboratory studies that measure how much people eat when offered single foods versus a variety of foods show that older children and adults eat more food when there are more choices, less when choices are few.¹⁴ Yet, given people’s set choices of the same foods at fast-food restaurants (remember that the McDonald’s lawsuit involved daily Quarter-Pounders), perhaps kids who did not have a varied diet never developed the “taste” for variety and can overindulge on monotonous diets.

Adapting this research for young children, a good approach would be to offer them *more* variety of vegetables and fruits and thus increase consumption—which would be a positive change, since most kids’ diets are deficient in fruits and vegetables, and these lower-calorie fruits and vegetables can take the place of higher-calorie, less nutritious snacks.

Yet because children are exposed to hundreds of choices in the supermarket and at the mall, and because families frequently dine at restaurants, children have opportunities to eat more, often too much. Learning to manage these choices is a major skill that helps them resist the overwhelming presence of food and drink in their environment. What and how much

people eat in restaurants really matters. A high rate of away-from-home eating relates directly to a higher rate of obesity because the variety of foods available in restaurants, combined with oversize servings, usually proves irresistible.¹⁵ Food fixed and eaten at home does provide the opportunity to reduce the portions in size and number, as well as to add vegetables to the pizza, whole-wheat buns to the burgers, and to have fruit for dessert.

The practice. Most parents think family meals are important, but long commutes from work, varying work shifts, and the children's after-school and homework commitments obviously make eating together difficult. Moreover, children often eat most of their snacks and meals at child care or school rather than at home. Family meals have become exceedingly hard to organize. One answer may be to aim for at least four out of seven dinners during the week as family meals. Dividing responsibility for preparing dinners among all family members also improves the chance of having time for family meals. Children as young as two can get involved by helping the parents wipe tabletops, tear lettuce, and bring ingredients or utensils from one place to another; kindergarten-age children can help make a shopping list, measure ingredients, set the table, and cut with a dull knife.

Breakfast is a good place to start. As emphasized earlier, breakfast improves school (and job) performance and reduces inappropriate snacking (and weight gain). As with all meals, getting kids to eat a nutritious breakfast works better if they eat at home with a parent—and whole fruit is far too messy to eat in the car on the way to school or work. But even eaten at home, breakfast is a meal with a lot of nutritional landmines, owing to the rise in popularity of sugary cereals (Oreo and S'more cereals seem to be big these days), so parents have to be more proactive to plan and serve low-sugar balanced breakfast.

Family mealtimes will be more successful and pleasant if parents stick to a routine and have a consistent policy for responding to requests to leave the table or refusals to try new food. In *Feeding Your Child for Lifelong Health*, the authors Susan Roberts and Melvin Heyman recommend: make it a rule that everyone stay at the table through the main course; leave refused foods within reach so your child can try them later in the meal; offer one plain alternative such as cereal and milk or bread, cheese, and fruit with little or no comment; let your child see you enjoy some of the food she refused.¹⁶ This is appropriate limit setting that follows the division of responsibility and curbs overly controlled parenting.

How to plan and eat meals and snacks together and incorporate variety into the family's diet?

Instead of arguing with your child over what can or cannot be purchased at the supermarket, **try** working together to make a shopping list for the week's meals and snacks; have the child write down the ingredients on the list and help find the products in the store. If he or she begs for a junk-food item not on the list, then review the list and the basic menu and snack plan. Decide if and where the coveted item fits in—maybe a trade with another “seldom” item on the list.

Instead of eating doughnuts in the car on the way to school and work because parents are too rushed getting to work to prepare breakfast, **try** getting kids involved in planning and making their own healthy breakfasts—slicing fresh fruit, toasting whole-wheat toast, serving low-sugar cereal.

Instead of piling a cupboard with bulk-size packages of salty and sweet snacks (which are often high in fat and sugar and low in nutrients), **try** labeling a shelf in the fridge and another in the cupboard as “snacks”; stock the fridge shelf with packages of fruit, sliced carrots and bell pepper strips, cheese, and yogurt, and stock the snack cupboard with low-sugar cereal, graham crackers, dried fruit, and a few salty and sweet snacks—purchased in small sizes, not bulk.

Instead of preparing the same tried-and-true meals over and over again, **try** branching out by cooking with unfamiliar ingredients and experimenting with ethnic cuisines. Once a month, have kids help plan and prepare an “international” dish from a country or region of their choice. Use this as an opportunity to learn about that part of the world.

3 *Foster a preference for healthier alternatives—in particular, fruits, vegetables and whole grains—by repeated tasting and enjoying by the whole family.*

The theory. The scientific evidence that fruits and vegetables are critically important to health is piling up so rapidly that there are many proposals to make them the foundation of the new Food Guide Pyramid, pushing grains and cereals (preferably whole) onto the second level. Besides their obvious role in weight management as low-cal/high-nutrient-dense foods, there is growing evidence that fruit and vegetables are linked to cancer prevention and blood pressure reduction. The five daily recommended serv-

ings of fruits and vegetables will soon be “five to nine a day.” The gap between recommendations and reality will widen further. Few children meet the minimal “five a day” recommendation of three vegetable servings and two fruit servings; few children get the health benefits of whole grains since they eat refined bread products. Both you and your children can grow healthier by eating more dark green vegetables (asparagus, broccoli, collards), deep yellow or orange vegetables (yellow squash, carrots), fruits (oranges, kiwis), and whole-grain products (graham crackers, oatmeal, whole-wheat bread and pasta).

The best way to foster a preference for fruits and vegetables is to offer a new item from time to time for tasting and enjoying at family mealtimes—*not* to withhold preferred foods until kids eat the new one. Not only do children learn to dislike a food, such as vegetables, that they eat only to obtain a reward (dessert), but they develop an exaggerated preference for high-fat, energy-dense foods; they limit their acceptance of a variety of foods; and they alter internal signals of hunger and satiety. A new food, especially vegetables and fruits, sometimes requires up to twenty low-key taste opportunities for a child to eat it. Some evidence suggests that early introduction of a variety of these foods acts as some sort of “buffer” against a strong dislike or “neophobia” of new foods.¹⁷ As discussed earlier, a family should divide responsibility at mealtimes: parents decide what and when; children determine if they will eat the food that is given and how much.

The practice. Parents are not always convinced that their baby has eaten enough when the baby pushes it away, so they force more food. As the child grows they worry about his or her eating right and not eating “junk food,” so they restrict the unhealthier food. Then parents tire of offering a new food when a kid refuses it a couple of times. Two strategies usually work: offer a wide variety of healthy foods during the twelve- to twenty-month “window” during toddlerhood when children explore everything with their mouth; and eat with your kids most of the time, so they see what you do. Eat and enjoy your vegetables and fruits so your kids will too.

That said, in practice it can be hard for parents to buy and prepare tasty vegetable dishes. The produce in markets in poorer neighborhoods is often not very fresh or appealing; parents accustomed to eating fried and prepackaged food often don’t know how to cook appetizing vegetable dishes for their kids.

How to foster a preference for healthier fare?

Instead of using dessert as an incentive or reward for eating vegetables at dinnertime, **try** making dessert a part of the meal, most frequently fruit or low-sugar pudding; serve high-sugar, high-fat pastries as “seldom” foods. Serve vegetables in small portions that the child can try, then serve more if child asks for more.

Instead of repeatedly buying and serving the same vegetables and fruits, **try** buying and tasting one new fruit or vegetable every week. Have a weekly fruit/vegetable ceremony to taste the new produce item—take a bite, then discuss the color, texture, and where the item comes from. Or the family can hold a fruit and vegetable tasting event where kids vote on the favorite color, texture, taste, shape, and “It looks just like . . .”

Instead of assuming a toddler doesn’t like a fruit or vegetable because he or she refused to eat it the first couple of times it was offered, **try** waiting a few months and then reintroduce it in a slightly different way. For example, a two-year-old who doesn’t like cooked and mashed peas might like to munch on a crunchy pea pod.

Instead of salty, high-fat crackers and dips to tide hungry kids over during the time it takes to cook, **try** offering them vegetables and salsa or bean dips—some kids will eat almost any new food as long as they can dip it.

4 *Talk, walk, and play together indoors and outdoors as an alternative to watching television.*

The theory. Physical activity behaviors among children and adolescents are determined by a number of factors: the children’s stage of growth and fitness; access to safe facilities for sports and play; opportunities for sedentary activities such as television watching or computer games; confidence in their own physical capability; and parental role modeling or support. As with eating, the parents’ role is key. Actively playing and enjoying a physical activity with kids is a major way parents can help children develop and continue it (see Figure 4). A parent-child walk together to school, in the park, to the store, across the field, or to piano lessons pays big dividends for the time investment in setting physical activity patterns early and in bringing about an interval together without interruptions from television and phone calls (if the cell phone is turned off!).



FIGURE 4. At each level of activity, kids can choose ways to reach and keep a healthy weight. (U.S. Department of Agriculture, Food and Nutrition Service, www.fns.usda.gov/tn/)

Reducing sedentary activity is itself likely to increase physical movement. Not only does turning off the TV encourage young people to be more active, it reduces their exposure to commercials that whet their appetite for junk food. Studies have shown that children who learned to manage their TV time (and spent more time playing creative games) decreased overall sedentary activity and ate less high-calorie snacks and had lower body fat than children who watched more TV.¹⁸

In addition, mealtimes are more relaxed if the television is off. Many kitchens and dining rooms now have TVs; a family’s mealtime focus should be on talking among themselves and on noticing food, not eating mindlessly while watching the evening news. This is a tough rule to follow. A report on “TV-dinner” kids found that 42 percent of dinners eaten at home are consumed in front of TV but that the percentage for overweight children is 50, compared to 35 percent for normal-weight kids.¹⁹

Parents who strive to make physical activity—not food or television—the focal point during parties and family gatherings will send a message to

their children that physical activity can be fun and sociable. When food is a side attraction—not the main event—at gatherings, then kids (and adults) are less likely to overeat.

The practice. If kids aren't watching television or playing video games, they have to fill the void. What can compete with TV and the computer? Kids don't like to be the only ones in the park, and if they are, parents understandably worry about their safety. Children today may know how to play freeze tag or kick the can, but who are they going to play with if their friends are still watching the tube?

One answer is to get kids into after-school programs with activities like dancing and creative games where they have fun, instead of being at home with nothing to do but sit and snack. Many parents want schools to provide these opportunities, but schools are often overburdened too. (Chapter 9 discusses how schools and communities can be a part of the solution in this epidemic.) For the safety of small children, and to make efficient use of parents' time, some neighborhoods have a rotation system to supervise four or five children, so that each parent joins in or supervises an hour of vigorous play once a week. Parents and caregivers can become proactive with imaginative ideas for promoting physical activity. For instance, some parents in Harlem took to the sidewalks, chalk in hand, and after a brief demonstration got hopscotch going in the neighborhood. Others organized a jump rope contest and held workshops for two weeks in advance to teach kids how to do it and to practice. More adults, even grandparents, who are bored with treadmills are returning to children's games like kickball; kids are watching, and some will emulate these enjoyable and vigorous activities. Research from programs to promote healthy weight among children is clear that physical activity kids choose and parents reinforce by joining in becomes increasingly enjoyable.²⁰ The point is to offer a wide range of choices and to appreciate the pleasure of participating in games, dancing, and just running around.

What exactly can parents do to limit excess television time? Americans know well how very seductive and mesmerizing television can be. Here too research evidence is clear: if you monitor the amount of watching time, make program choices, and come up with alternatives for the "freed-up" time, everyone ends up in healthier body weight.

Most parents need guidance on how to tear kids (and themselves) away from TV and computers. Parents and caregivers need not banish TV but can reduce a negative action by replacing it with a positive one. For example, make a goal of every weekend day and every weekday afternoon to re-

duce TV watching by half an hour (the length of one show), then make a parent-child play date for this time. Turning off the TV for thirty minutes a day for an activity together is a win-win. It's not enough to *tell* kids to turn off the TV; parents or caregivers must help plan and join in a casual, active alternative. Be creative; for instance, parents can make taking walks—an alternative to TV—more enticing if they make it an “adventure walk” that involves searching for fallen leaves of different colors or for tracks in the dirt or snow. This keeps interest high and allows for differences in age and ability, as do skipping, walking backward, or hopping.

How to talk, walk, and play together indoors and outdoors?

Instead of always suggesting “a walk,” **try** going on a scavenger hunt around the neighborhood, using certain landmarks, trees, or plants as “findings” (evidence could be leaves, word pictures, photos with instant cameras); or walking to a specific destination (movie, mall, or local event).

Instead of watching cartoons for two to three hours on Saturday mornings, **try** limiting Saturday-morning television to one hour and planning an hour-long family outing or game to follow it.

Instead of letting friends watch television together at each other's houses during play dates, **try** making a pact with the friend's parents that the TV will be off-limits during play dates; help them get started with alternative activities such as putting on a mock dance contest or building a fort.

Instead of holding kids' birthday parties at pizza parlors or fast-food restaurants, where food is the focus, **try** having kids' parties and family gatherings at a park. Rather than ask other adults to bring potluck dishes and desserts, ask them to be in charge of planning an activity.

5 *Get enough sleep (children need at least nine hours).*

The theory. Some may be surprised to see “sleep” on this list of recommendations. But time for sleep has a role in eating well and being active. Children ages seven to eighteen need at least nine hours of sleep a night.²¹ Younger children need more. Research has demonstrated that tired children are much more likely to eat excess foods in search of more energy to keep going. They are also much less likely to engage in the recommended

one hour of vigorous physical daily activity when they are tired. In at least two studies, a strong inverse association was observed between sleeping hours and childhood obesity: less sleep, more body fat.²²

The practice. Many children get only seven or eight hours of sleep; adolescents get even less. With homework assignments expanding in tandem with competition for college admission, and the lure of television and video games as distractions from the stress of the overscheduled kids' and parents' daily lives, cutting down on sleep is the only way to get everything done. Erratic work and household activities interfere with regular sleep schedules. The imperative is to define goals for the family's and each child's health and success. Learning time-management skills will help both children and their parents.

How to get enough sleep?

Instead of letting children stay up late watching television, working on the computer, or talking on the phone, **try** having a consistent bedtime policy—for parents as well as for children. If this means cutting corners on housework or homework in order to make time for sleep, so be it; let your children know that getting enough sleep and being healthy is a top priority.

Instead of saving child's homework for after dinner, which can push back bedtime, **try** setting a goal of finishing an hour of homework before dinner. Have children work on homework at the kitchen table during dinner preparation so parents and children can interact during both homework and meal preparation.

Instead of overscheduling and overcommitting to extracurricular activities, which spread the family thin and interfere with sleep and family mealtimes, **try** being realistic and curbing expectations of what kids—and parents—can accomplish in twenty-four hours.

RAISE RESILIENT CHILDREN

A complementary approach in authoritative parenting is to encourage resilience in both young and older children, an idea set forth by Robert Brooks and Sam Goldstein in *Raising Resilient Children*.²³ The following discussion is especially indebted to that book's inspiring conceptual analysis. The authors ask what most parents want for their children and conclude that whether it is happiness, success in school, satisfaction with their lives, or

solid friendships, “realization of these goals requires that children have the inner strength to deal competently and successfully, day after day, with the challenges and demands they encounter.” They call that capacity to cope and feel competent *resilience*.

If kids in general need to learn resilience to deal more effectively with stress and pressure, fat children need double doses of resilience to cope better with everyday challenges; to bounce back from disappointments, adversity, and trauma; to solve problems; and to treat themselves with respect. These skills, if learned early, may go a long way toward preventing the behaviors and series of events that lead to obesity.

Brooks and Goldstein speak to parents who increasingly view the world as a hostile place in which to raise children and who think that the solution is to construct taller walls around families and double-lock front doors to keep out a seemingly toxic culture. This solution, these psychologists believe and I concur, is unrealistic. But we can shield children by helping them build resilience to thrive in our culture.

To remain healthy and to achieve the expectations we place on them, children need all the help available. Parents who have an explicit or intuitive understanding of resilience can cultivate a similar mindset and behaviors in their children. If children learn self-nurturing (taking care of their needs in healthy ways, such as playing a game with a friend when bored) and limit setting (controlling urges for still more food or TV), they are more likely to avoid “emotional eating.” Children who are resilient and self-nurturing will likely find comfort and pleasure from sources other than food—friends, physical activities, games, and the like. Children who have learned limit setting feel safe and successful and have reasonable expectations of themselves.

GUIDELINES FOR RESILIENCE

One barrier to raising resilient children is the lack of know-how. Some parents are better than others at being empathic, communicative, positive rather than negative, and realistic about strengths and weaknesses—characteristics that help build resilience in their children. Even so, these abilities can be learned. And in many cases, parents have these abilities but feel too burdened with the pressures of work and worry to use them with their children.

To ask any parents to invest energy and effort in learning how to nurture resilience in their children by first learning and applying a resilient personal mindset is a tall order. To ask parents of overweight children in mi-

nority, low-income, or low-education groups to do so may seem totally unreasonable. Yet many of these parents already have resilient mindsets. With basic support from safer environments for play and better child care, increased supervised after-school activities and encouragement from health-care providers and others in the community, a family is more likely to follow guidelines that foster resilience. In looking to reverse the childhood obesity epidemic, our first step is to develop resilient children.

The guidelines Brooks and Goldstein present use violence as an example of the toxic culture. But instead we turn back to Eddie, Maria, and Dwayne and apply each guideline to the toxic forces that make children fat. Can Eddie, currently at a healthy weight, keep his resilience? Can Maria, at risk of becoming overweight, learn more resilience? And can Dwayne, already overweight, learn to become a resilient child? Let's look at ways these three may respond to parents and caretakers who follow the guidelines for raising resilient children.

1 *Be empathic; accept children for who they are and help them set realistic expectations and goals.*

Parents eager for their children's success may urge overweight or clumsy children to "try harder." Rather than assume a child must have a certain body size and shape to gain popularity with friends, or expect a child to excel in sports or school achievement, parents need to reevaluate whether these goals are realistic and reasonable and remember how they responded to similar pressure from their own parents.

Empathic parents put themselves inside the shoes of their children to appreciate their point of view. Being empathic is easy when our children are warm and responsive, but it is hard when we are upset or disappointed with our children.

Eddie at first enjoyed soccer but then began finding excuses for not going to practice. "I don't like everyone shouting at me during games," he said. His parents responded, "Just don't pay attention to them," but when he claimed he had a stomachache just before game time they got upset and accused him of faking it. When they put themselves in his shoes, they asked themselves, "Would I want my folks to believe me when I say shouting makes me upset and I have a stomachache?" Then, instead of lecturing him, "Ignore the shouting; your stomachache will go away," they helped Eddie take a leave from the soccer team. By encouraging him to work on a special project—putting together a Halloween fun house—they supported an alternative activity that validated his self-worth. Parents who are empathic toward the problem of

childhood obesity and see a fat boy as a “good helper with little Sam” or “best finder of lost items”—any label but “fat kid”—are encouraging him (and other overweight children) to identify as valuable, resilient.

Overweight kids often are better at empathy than their parents and other adults. A new parent recently emailed me for information about childhood obesity. He explained, “I was obese as a child and lost about 100 pounds when I was twenty-four. I don’t want my son to grow up obese. On the other hand, I don’t want him to grow up an entitled, spoiled punk, as he might if he is too good-looking. Kids who are constantly deferred to because they are good-looking tend to be spoiled. I think maybe I’m a nicer, better person for having grown up a fatso.” Daniel Goleman’s concept of *emotional intelligence* can be construed as another name for empathy; he describes empathy as the fundamental “people skill,” one that builds on emotional self-awareness.²⁴ Fat kids are likely to have high levels of emotional intelligence because they have developed a keen sense of “what it feels like to be different,” and they often display empathy toward other children who are different from mainstream kids in a variety of ways.

Child psychologists usually ask parents what they do to handle a difficult child, and if it worked. Oddly enough, they seldom ask parents what they believe the difficult child thought or felt. Questions parents could ask themselves might be: “How does my child feel when I tell him to eat his vegetables or to stop watching TV and do homework?” “What words would my child use to describe me as a parent?” A cornerstone of raising resilient children is conveying empathy as a way of fostering strength, hope, and optimism.

2 *Communicate effectively and listen actively.*

By validating what children are attempting to say, and by not telling them how they should feel, parents can effectively communicate and develop resilience in children. For example, Maria’s grandmother worried that Maria rarely played with other children or talked about school friends. Without asking Maria, her mother arranged a play date with Jenny, who lived on their street. Maria was so anxious that she tried to get Jenny to play with all of her games at once and gave her loads of candy she thought Jenny would like. Jenny never asked Maria to play at her house and on several occasions refused to come back to Maria’s house again. Later, Maria did not want to have a birthday party. After listening carefully, her grandmother and mother realized Maria was afraid no one would come. Her mother said she understood Maria’s concern and then searched for a recreation class

Maria could attend two days a week after school. Maria's older sister persuaded her to start swimming classes on Saturdays and took her to them. (Perhaps another time her mother will ask Maria first if she wants to play with a friend.)

3 *Change “negative scripts.”*

Parents often nag their kids the same way, using the same words for years, “Eat your vegetables or . . .” When nagging doesn't work, it's time to change the script.

Dwayne's weight became a family issue when the school nurse informed his parents that he was seriously overweight and ought to have a restricted diet. His parents then told him, no more trips to McDonald's with his siblings. When he went anyway, they said, “You always show disrespect.” One brother tattled, “Dwayne's eating another doughnut,” and his sisters teased him about his extra servings of macaroni and cheese. Each negative script fed the power struggle over his diet. Had his parents stopped all negative comments on Dwayne's eating behavior or encouraged his efforts to ride a bike or be successful at one activity, they could have showed him other ways to solve problems. Rethinking and rewording *any* issue is very hard—it takes attention and practice.

4 *Help children experience success by identifying and reinforcing their “islands of competence.”*

When some children feel hopeless about their abilities, it is hard for them to “hear” (or believe) any positive feedback. It's better to guide them to something they can do to build competence.

Dwayne's dad and older brother often told him to fight back when bullies taunted him at school. After an especially humiliating experience when five kids ganged up on him and tried to force a whole doughnut into his mouth at once—shouting, “He'll eat anything”—Dwayne's brother threatened to find the gang and beat them up. Had the family switched from “fight back” to help Dwayne learn a new skill such as karate or swimming, he could have built an “island of competence” to emphasize his strengths rather than his weakness.

5 *Help children recognize that mistakes are experiences from which to learn.*

Nobody intuitively views mistakes as opportunities for learning. More often children experience mistakes as failures. They may retreat from challenges,

feel inadequate, and blame others for their problems. If Eddie made mistake after mistake on the soccer field without encouragement to find alternative physical activities, he could dive into video games where no one notices mistakes. If Maria continues to overmanage her playmates without an opportunity to learn interpersonal skills in a group with guidance, she may more often turn to food for comfort. If Dwayne just blames others for bullying him without finding an island of competence in physical activity, he may remain a victim and learn to bully others when he grows up.

6 *Love children in ways that help them feel special and appreciated.*

A basic guideline for building resilience is the presence of at least one adult who believes in the worth of each child. Such belief helps redirect a child toward a more productive, satisfying life. Brooks and Goldstein call such adults “charismatic” because their personal appeal and engagement give them a compelling quality, and they become stakeholders in the children’s future development. Helping children feel special without indulging them requires giving love unconditionally. It does not mean an absence of discipline but rather acceptance and love, whatever their shortcomings and mistakes.

Maria’s mother tried to schedule “special times” each evening with Maria to read aloud or just talk. Maria looked forward to this time. Nonetheless, when the phone rang, her mother would interrupt their special time to answer. Maria soon chose to watch television rather than feel unimportant. Parental behavior sends a strong message about the value of family activities; for example, answering the phone during meals is often a signal to children that mealtime is worthless.

MORE IDEAS FOR ADOLESCENTS

For the purposes of this discussion, let’s fast-forward these three children’s lives and imagine they are now thirteen years old. Additional guidelines for raising resilient children are apropos as these children enter adolescence.

1 *Develop responsibility, compassion, and a social conscience by providing children with opportunities to contribute.*

Parents often teach kids to learn responsibility by giving them chores. It’s hard to stay motivated to do chores but often much easier with the chance to help others.

Maria, at thirteen, has held her own in terms of weight. She is still at risk

of becoming overweight, but she has not crossed into the overweight category. She remains an avid reader and now feels rewarded by reading to her grandmother and to several other elderly people she visits three days a week to read aloud. She even walks several blocks and up several flights of stairs to their apartments. Her growing competence provided encouragement to try out for drama club. She is now rehearsing for her first play and likes all aspects of participating in the group. She has less time alone to turn to food for comfort.

2 *Teach children to solve problems and make decisions.*

Instead of telling children what to do, parents teach problem solving best by engaging kids in brainstorming solutions. A regular family meeting time to discuss problems and solutions is a good place to do this.

Eddie has lots of friends and is quite popular. Many of his friends are now dropping out of sports and spending more time hanging around the house after school, playing video games, swallowing lots of soda and snacks. Eddie prefers to go down to a nearby stream and paddle his kayak but couldn't get any friends to go along. During the weekly family meeting, everyone joined in to make a list of ways he could solve the problem. One way was to organize a kayak club. He asked the athletic director at school for help; a twelfth-grader volunteered to provide supervision for a kayak club after school. Eddie has learned to negotiate choices and looks to a charismatic adult for help.

3 *Discipline in a way that promotes self-discipline and self-worth.*

Brooks and Goldstein point out that the word *discipline* relates to *disciple* and thus is a teaching process. Discipline can reinforce or weaken self-esteem, self-control, and resilience. Well-meaning parents often impose rules and consequences that provoke resentment, rather than learning. One alternative that worked for Maria when her mother kept after her to do a fitness workout every day was to work together in setting the rules (Mom: "I will stop nagging") as well as the consequences (Maria: "I will not get to talk on the computer chat room tonight if I skip my workout").

Whatever you do, parents be warned: pick each "self-discipline learning" project carefully, and keep the list short. A cartoon I saw illustrated the importance of choosing battles rather than expecting a child to do everything right all at once. The cartoon showed the table of contents for a book called *The Big Book of Parent-Child Fights*. The topic of chapter one, "Food Arguments," ran from page 1 to 832. "Bedtime Feuds" ran from page 833 to

1247, where “Personal-Hygiene Tiffs” picked up. “Messy-Room Run-Ins” and “Sibling Skirmishes” went on into the thousands. If you start early as a parental role model in how to eat moderately, exercise self-discipline, and lead a healthy life, you can go a long way toward reducing the volume of parent-child fights as children get older.

SUMMARY

The final part of this book focuses on ways to reverse the fatness epidemic. We started in this chapter by focusing on prevention—specifically, what parents can do, from early childhood through adolescence and to adulthood, to raise children who have a lifelong balanced, healthy approach to eating and who lead active lives. (The next chapter examines treatment options, looking first at the diet culture in America and then reviewing some popular weight-loss programs for children.) I presented my top recommendations here, with tips for implementing them, along with a complementary approach for raising resilient children. Much of this advice parents and caregivers already know. Many, however, do not follow it because it is hard—and it requires support and practice. Parents, just like their children, are lifelong learners. Even small adjustments in parenting style often yield large benefits in children’s behavior. An example of one recommendation to forestall and curb childhood obesity is to set bedtime limits so children get enough sleep as a step toward improving eating and physical activity behavior. To observe bedtime limits themselves as parents is a second step. The goal of this chapter is to encourage parents to take at least one or more similar steps toward slowing the obesity epidemic affecting all of our children. As parents, our best precept is our example. Mahatma Gandhi’s words are apt: “You must be the change you wish to see in the world.” And the poem “You Can Only Demonstrate” echoes the advice.

If you carry great expectations
For your children,
They will carry great burdens.
If you try to make them good,
You will create instead their vices.
Let your teaching be subtle.
Let your strength reside
In your flexibility.
Let your virtues be natural
And not affected.

If your children are treated
With modesty,
Grace,
Forgiveness,
And joy,
What are they likely to learn?
William C. Martin,
The Parent's Tao Te Ching

REACHING AND KEEPING A HEALTHY WEIGHT

ELEVEN-YEAR-OLD NATHANIEL ROBBINS, the protagonist in Robert Kimmel Smith's novel *Jelly Belly*, carries 109 pounds on his 4-foot-8-inch frame. "Blimpie," "Tubby," "Piggy," and "Lard-Butt" are some of the nicknames he also carries around. As the excerpt below illustrates, this boy is emotionally scarred and physically uncomfortable not only from being fat but also from trying to lose weight:

Right now there are probably three million kids reading this and laughing at me. I mean, you're probably saying, "Big deal—the kid misses one meal of spaghetti and a piece of blueberry pie and he runs upstairs and cries his head off." But it wasn't really that at all. I was lying across my bed, miserable and crying, because there wasn't any answer to it all. I was *always* going to be fat, I was *always* going to be on a stupid diet, and I was *always* going to be miserable. It just seemed like there was no hope. It was going to be the way it was, forever and ever. And that's why I was crying. I could take a diet for a week or a month. But the fact was that I had already been on a diet for four months and *I hadn't lost any weight*.¹

Rather than help, Nathaniel's diets have deepened his self-loathing and hopelessness. This chapter seeks to help the countless children who iden-

tify with his misery, the overweight young people whose pain has been compounded by misguided and ineffective weight-loss advice.

Prevention may be the best course of treatment, but how do we help children who are already seriously overweight? The advice surrounding nutrition and weight loss is often contradictory and seemingly ever-changing. It tends to leave adults as confused and hopeless as the overweight children they seek to help. I'll begin by presenting the general advice I give my clients and their parents and then review other weight-management plans and programs before addressing some of the damage our dieting culture does and potential dangers associated with campaigns to reverse the obesity epidemic.

WEIGHT MANAGEMENT AND CHILDREN

In fact and fiction, dieting to lose weight, or dreaming about the end results, is a pervasive, obsessive activity for many American children. Vanessa, age sixteen, diets and dreams, as she describes in *Fat Talk*, an ethnographic study that reports the voices of real teenage girls talking about weight, attractiveness, and dieting:

The other day my girlfriend asked me, "Can you imagine what life would be like if we both lost fifteen pounds?" and I said, "Oh, wow! Right now, I'm a little bit chubby . . . I just know that if I lost fifteen pounds, I'd be more self-confident. I'd be able to walk past the soccer team and not feel all embarrassed. I could just walk right up to those guys and say, "Hi, how are you doing?" I'd feel so much better about myself if I were thinner."²

Judi, age thirteen, a fictional character in *Fat Chance*, notes that her secret desire is "to be the thinnest girl in the entire eighth grade." Her biggest fear is "that I'll get as fat as Ms. Roth [the teacher] someday, or even fatter." Dieting is an overriding concern in her life:

I'm going to start a new diet tomorrow. I've been on diets before, but this time I'm going to be really serious about it. You see, this is my last chance to lose weight because next year I'll be in high school, and who wants to be a fat freshman?³

Vanessa and Judi match the popular profile of a teenage girl growing up in the United States today. Study after study reports that dissatisfaction with weight, as well as inappropriate dieting behaviors, are pervasive, particularly among white middle-class girls. Rather than steer them toward a

healthy weight, however, this preoccupation with weight loss and body image can promote extreme and detrimental behavior, fostering unhealthy eating habits and a negative self-image (discussed below). My goal is to put forth reasonable and moderate guidelines that will help steer these young people back toward healthy, balanced eating and enable them to break free from their obsession with dieting.

In whatever course I teach, talk I give, or workshop I lead, the recurrent questions about weight management programs are, what *really* works, and *how long* does it take? To both, the answer is that it depends. It depends on how we measure what works or what is effective; it depends on children's genetic background, age, and growth rate, as well as their home and social environment. There is no simple or easy answer, though many parents desperately wish there were.

I can say with more certainty what does *not* work for kids: restrictive diets. By restrictive diets, I mean eating plans that strictly curb the amount and type of food permitted. There is little, if any, evidence that they work. Most short-term weight loss cancels itself out, and restriction generally leads to nagging parents, anxious kids, and bad long-term results.

Drawing on a huge amount of research and experience in adult obesity, most experts agree that success in combating obesity depends on long-term *weight management*, not a "diet." Weight management is not just weight loss. Management also means rethinking individual behavior and choices to sustain a healthy weight with balanced eating and physical activity, day in and day out. This is much more difficult than "going on a diet" for a few weeks.

Traditionally the term *diet* referred to what we eat every day, which over time becomes an eating pattern. Using available, affordable, and acceptable foods, culture shapes our diet. In the past quarter century, however, the term took on a specific and sometimes pejorative sense of a short-term restrictive eating plan whose goal is weight loss. When most people consider obesity treatment, they mistakenly plan short-term penance, not lifelong weight management.

What follows are several questions and my answers related to dieting and weight management. These are typical of questions I field from parents, educators, and health providers as they seek to help seriously overweight youth reach and keep a healthier weight.

Should a five-year-old overweight child be on a diet?

No, a five-year-old overweight child should eat like a five-year-old healthy-weight child, not like an eighteen-year-old basketball player.

I do not endorse weight reduction for children—except for extremely overweight seven- to eleven-year-olds and teens with health complications—but I do support weight maintenance, which stalls excess weight gain and allows overweight children to “grow into” their weight. Children don’t need diets; they need to eat for their age and be moderately active. Guidelines endorsed by the American Academy of Pediatrics say, for overweight children ages two to seven, the goal is weight maintenance, not weight loss. If an overweight child maintains her weight as she grows, her weight and height will come back into line.⁴

If a nine-year-old child is so overweight that his blood pressure is high and he has sleep apnea (breathing difficulty), should he be on a diet to lose weight?

First, the family’s healthy eating and activity should stop the weight gain. Then, changes in eating and activity should aim toward a weight loss of about one pound per month.⁵

What are the changes in eating required to stop the weight gain or to lose a pound or two a month?

This question usually means, “I want a diet that works.” I hear it from parents, and I hear it from lots of health professionals. “You’re a dietitian; give her a diet.” Again, I give my standard answer, “A seven-year-old should eat like a seven-year-old. Choose foods from all parts of the Food Guide Pyramid in the *amounts* recommended for her age and activity.”

That sounds too easy. Why are kids still getting fatter?

After I find out what a child usually eats and we compare samples of the recommended amounts with his usual daily diet, I try to bring the family’s idea of normal amounts in line with reality. After some probing into what and how much he ate yesterday, or any day in general, I may find that this seven-year-old overweight child has been eating like a seventeen-year old. His reported daily menu, like Dwayne’s, may look something like this:

Before school: a large glass of orange juice (12 oz); Fruit Loops ($\frac{3}{4}$ cup) with whole milk (1 cup); and one jelly doughnut

Snack at school (brought from home): Snapple drink (12 oz); potato chips (6 oz bag); mozzarella cheese stick

Lunch served at school: pepperoni pizza (2 slices) and whole milk (8 oz)

After-school snack: large serving of fries with three packs of ketchup; soda (12 oz)

Supper: two pieces deep-fried chicken; rice and beans (about 1 cup); three bites (1 tablespoon) carrots; two glasses of soda (20 oz)

TV time: large bowl of chocolate ice cream (1 cup)

Snack before bed: sweetened applesauce ($\frac{3}{4}$ cup) and one chocolate graham cracker

Throughout the day: M&M candy (4 oz bag)

Total calories for day (approximately): 3,200

In one day Dwayne takes in foods from all parts of the Food Guide Pyramid in at least the minimum number of recommended servings (counting the fries, ketchup, and pizza tomato sauce as vegetables, the double-size orange juice and applesauce as three fruit servings). But he also takes in about 3,200 calories. The estimated daily calorie requirement is about 1,800 calories for a moderately active seven-year-old boy with a healthy weight-for-height. The range is 1,400 to 2,400 calories depending on activity and appropriate growth rate. Dwayne does not need “a diet.” Dwayne needs to eat like a seven-year-old and to spend at least an hour a day in moderate to vigorous physical activity—like a seven-year-old!

Dwayne’s food choices are not necessarily “bad” (though they could use improvement in the high-fat and sugar department); the main problem is they are “big.” Eating the recommended number of servings in the recommended serving sizes would give Dwayne a great start for improving his daily diet and for slimming down as he grows up. Tilting his food choices toward less calorie-packed foods would turn his diet into a healthy eating pattern with an excellent chance to have fewer chronic diseases as he grows up.

With a few modifications, Dwayne’s daily diet can be adjusted to provide approximately 1,800 calories from foods that he finds acceptable—and that meet the guidelines for a child his age. From a nutrition education perspective, these changes appear relatively easy and painless; but Dwayne and his family may think they are very restrictive, like a “diet.” The goal, then, is to include the same foods he usually eats but in smaller amounts and gradually change the type, such as moving from whole to low-fat milk, from

jelly doughnuts to toast and jelly. To help him learn choices, foods are grouped as “anytime” (carrots, rice, and beans), “sometimes” (soda, ice cream) and “seldom” (fries, doughnuts, M&Ms). Dwayne and his family will decide (with guidance) how to interpret “sometimes” and “seldom.” A sample day might look like this:

Before school: small glass of orange juice (8 oz); Wheaties topped with Fruit Loops or lightly sweetened Cheerios (1 oz), with 1 percent low-fat milk; toast and jelly

Snack: apple, banana, or kiwi, or 100 percent fruit juice (6 oz); water; mozzarella stick or peanut butter spread on 2 low-fat Triscuits

Lunch: vegetable (broccoli) pizza (2 slices) and low-fat milk (1 cup), unsweetened applesauce (4 oz)

After-school snack: Lite canned fruit (½ cup) or 100 percent fruit juice (8 oz); chocolate graham crackers (2 squares); water

Dinner: oven-fried chicken (3 oz); rice and beans (1 cup); carrots (raw or cooked, ½ cup); green and red pepper strips; ice cream (½ cup); water

TV time (or family game): popcorn and 12 oz soda

Total calories (approximately): 1,800

Will an overweight child like Dwayne actually eat this type of food, every day?

Yes, unless his family eats most meals from take-out restaurants or vending machines. This sample daily menu does require Dwayne’s family to spend a minimal amount of time shopping for groceries and preparing meals and snacks. And with very little effort his family can adopt an eating plan similar to the one outlined above that is acceptable, affordable, and available for Dwayne. It follows nutrition guidelines that represent millions of dollars in educational development and promotional materials (the USDA Food Guide Pyramid for Young Children). But most nutrition education programs stop here. They provide the information. The best programs also tailor the information to an individual’s needs and situation, and this plan does that too, for Dwayne, with modified amounts of foods he is used to and a method for choosing among the “seldom” foods that now boost his total calories into the stratosphere for a kid his age.

What is the likelihood that Dwayne will eat according to this plan and slowly grow into his weight?

A very small likelihood—if all we do is “give” his family the diet plan. What is required, experts claim and I agree, is learning to change behavior.⁶ To support healthier food choices, Dwayne and his family need to learn skills—shopping to have snacks available rather than go to McDonald’s for fries, and cooking with less grease (oven-fried chicken, home-made popcorn with minimal oil). And they need substitute activities to replace TV time and encourage them to apply their new skills. For Dwayne, this may involve learning to choose a goal and reward: “If I have only one ‘seldom’ food each day for at least five days a week, I get to go bowling with my brother” (behavioral contracting); or to check his degree of hunger, by making a fist, imagining it as his stomach, and counting how many fingers full he feels (stimulus control); or making a chart of how many “seldom” foods he eats a day or number of times a week he turns off the TV for half an hour or more, then reviewing it with a parent (self-monitoring).

For best results, parents should work with their children to make sure the goals they choose are positive, specific, and realistic, like these:

Positive goals: “I will drink more water,” *not* “I will drink less soda”

Specific goal actions: “I will play hopscotch and talk with Anna outside after school for about an hour, three out of five days a week,” *not* “I will play more outside games”

Realistic goals: “I will eat raw carrots, which I like (I hate cooked carrots)”

Should a child be in a weight-management treatment program even if the family is not part of it?

The Expert Committee on Obesity Evaluation and Treatment, a group that develops guidelines for the American Academy of Pediatrics, recommends that when a family believes obesity is inevitable or resists efforts to modify activity or meals, the treatment of an overweight child should be deferred until the family is ready to change; or the family should be referred to a therapist who can address the family’s readiness. “Lack of readiness will probably lead to failure, which will frustrate the family and perhaps prevent future weight-control efforts.” The committee further recommends that the whole family be required to participate “in creating new family be-

PARENTING SKILLS

Here are wise recommendations from the Expert Committee on Obesity Evaluation and Treatment on ways parents and caretakers can support weight management, healthy eating, and physical activity. Not coincidentally, these points echo the guidelines in chapter 6.

- Use activity and time with your children—not food—as a reward for desired behavior.
- Establish times for daily family meals and snacks.
- Determine what food and when to offer it, while children decide if and how much to eat.
- Offer only healthy options: “an apple or popcorn?”
- Remove most junk-food temptations from the home, and limit less nutritious fare by buying it only in small containers. Offer ice cream, salty high-fat snacks, soda, and candy only as part of *planned* meals and snacks.
- Be a role model; improve your own eating and activity behaviors.
- Be consistent in setting limits. “Giving in” reinforces undesirable behavior.
- Find reasons to praise your children’s behavior. Children are good; behaviors can be good or bad.

haviors consistent with the child’s new eating and activity goals.” Otherwise, regular caregivers who do not participate in these changes may undermine the treatment program.⁷

The most successful programs for kids are those that enroll both children and families.⁸ In fact, one program that targeted the parents exclusively—and not the child—found that improved parenting skills brought about the child’s weight loss (see the box “Parenting Skills”).⁹

Are there successful plans and programs—commercial or based in health clinics—that are safe for kids and that work over the long term?

It is difficult to say. An untold number of obesity treatment plans for children and adults crowd the marketplace, and some are better than others (my review of a few better-known plans and worthwhile programs follows).

A specific program’s effectiveness is hard to gauge. To most kids and par-

ents, effectiveness usually means that the program enabled participants to lose weight and keep it off. To program providers, effectiveness usually means that some participants stopped gaining weight and improved one or two eating and activity behaviors. I think effectiveness should involve maintaining weight as a child grows (not weight loss) and meeting one or two realistic behavior goals each week.

Should parents who seek to slow their overweight child's weight gain keep daily logs that detail how much the child eats and exercises?

Many weight-management programs recommend record keeping or “self-monitoring,” to keep track of and then analyze the eating and exercise behavior patterns. For overweight kids, this can be a drag and a nag point for their parents. It is better to agree on a goal and reward such as eat only one “seldom” food most days and spend time with positive activities (like Dwayne’s “go bowling with my brother”) rather than laborious writing. That said, record keeping relates to greater success for adults in weight management. There is no evidence for kids.

Self-monitoring involves recording what you eat; what’s happening (or not happening) before and during eating; and what happens after eating. The idea is to figure out the *antecedents*, *behavior*, and *consequences* of your eating patterns. These are the “ABCs” of your food and eating environment. The first tells what the triggers are to what you eat (“it’s there”; “Gramma insisted I eat it”). The second tells how much and what kind of food (“two slices of pepperoni pizza; two 12 oz colas”). The third tells how you feel and what happens after you eat it (“I felt stuffed and mad at myself”). Learning what happens helps handle the antecedents the next time in order to change unwanted behavior and consequences. A positive “ABC” could be “try to have watermelon in fridge,” “ate a big slice,” “felt full and healthy.” The theory is that reinforcing this positive pattern by repeating it will lead to new, healthier behavior (it can also apply to goals for physical activity). That’s the upside of self-monitoring. The downside is that such a close and continual analysis of self-behavior could lead to more obsessive and overcontrolling behavior. Parents can play to the positive parts (revelations and rewards) while discouraging the negative (fixation with every bite of food).

With those questions and my answers serving as the foundation, we can build on an understanding of weight-management strategies for children by examining in greater detail the advice from a handful of noteworthy books and programs.

SORTING THROUGH THE ADVICE

When we read through the details of popular plans that advocate specific nutritional and weight-loss advice, it's no wonder the public is confused about what and how much to eat. Margarine was once touted as a healthy alternative to butter, but then came the news about trans-fats. Products with fat-free labels were hailed as healthy alternatives, but then they were blamed for promoting overeating and excess sugar consumption. The public was instructed to forget about the old-fashioned "square meal" and its four basic food groups and to start eating according to the Food Guide Pyramid, but then various experts began fiddling with the pyramid—in some cases turning it upside down.

The experts continue to measure, calculate, and ceaselessly debate the recommended ratio of carbohydrates to protein to fats. They also continue to recalibrate the recommended daily amount and type of exercise needed to reap the health benefits of physical activity. Meanwhile, the public tunes out—and just gets fatter.

Sorting through this mountain of advice is not easy for parents or any consumer. An author's credentials can help. Many doctors and nutritionists have bona fide credentials, but they use them to present diets based on little or no scientific evidence and to sell products directly to their clients. Professional medical ethics require that a physician draw a distinct line between prescribing medications, supplements, and the like, *and* also selling them. This principle is meant to distinguish licensed professionals from quacks who put profit ahead of the patients' well being.

This brings us to one of the most controversial health experts, the late Dr. Robert Atkins. He was a trained and licensed cardiologist and at the same time served as executive medical director of Atkins Nutritionals, the company that sells his products. He developed a successful and lucrative weight-management practice based on the diet plan in his book, but he crossed the profession's ethical line by selling a large variety of nutritional supplements in his clinic. The Atkins plan has been dissected and debated ad nauseam, so here I add a perspective on its appropriateness for children.

LOW CARBS OR LOW FAT

Atkins's best-selling book, *Dr. Atkins' Diet Revolution*, was first published in 1972. Renamed *Dr. Atkins' New Diet Revolution* when reissued in 1992, it remained on the *New York Times* bestseller list a decade later. His high-

fat, low-carbohydrate plan includes few starchy foods, bread, or vegetables and almost no fruit—all contrary to governmental recommendations and their source the Food Guide Pyramid, which emphasizes several servings of whole grains and starchy foods and a minimum of five servings of fruits and vegetables daily.

In 1998 the kids' version of Atkins hit the market: *Taking the Atkins Program to the Next Generation, Feed Your Kids Well: How to Help Your Child Lose Weight and Get Healthy*.¹⁰

Many parents, devotees of *Dr. Atkins' Diet Revolution*, were apparently relieved to have the blessing of a famous diet doctor to restrict sugars and starchy foods in their children's diet. Several parents have told me that the whole family benefits from cutting out cookies and potato chips: "We're all on the diet and eating low-carb bars for snacks; the kids don't seem to miss fruits and vegetables." (As Atkins dieting climbed in popularity, low-carb energy bars made with nonsugar sweeteners were rushed to the market as replacements for plain energy bars to meet the "grab and go" market.) Many parents are convinced that "if Atkins is good for me, it's good for my kids."

Most health professionals raise eyebrows when kids are "doing Atkins" because those kids (and their parents) are likely to eat excessive amounts of unhealthy saturated fat while missing out on the nutrients and fiber in fruits, vegetables, and whole grains that are so essential to long-term good health. Yet a handful of pediatricians have told me, "The risk from extreme obesity in some kids far outweighs any damage from cutting carbs."

To Atkins supporters, and even to frustrated health providers who long for absolute answers from the scientific research community, one review reported in April 2003 and two studies the next month brought welcome news that the Atkins plan worked and even lowered some heart-risk factors.¹¹ Dieters, all adults, on the "low-carb" diets lost more weight than comparison groups on a conventional low-fat diet.

But wait—that's not the whole story. The trouble was that neither the Atkins approach nor the low-fat diet worked very well for the dieters; their mild success was attributed to water loss in the early phase and to eating fewer calories, regardless of the type of diet. After a year, each group had gained some of the weight back, making the difference between diets insignificant. On top of that, over 40 percent of the participants dropped out during the year. In diet studies, dropouts are likely to be those who do not lose weight or cannot follow the diet plan.

My concern, from a practical standpoint, is this: even if low-carbohydrate diets were safe over the long haul (and there's no safety evidence yet),

how long can a child—or an adult—go without a bun for the burger or without crust under the cheese and pepperoni pizza topping? One mother, in a reader review on Amazon.com, put it well when she expressed disappointment that Atkins for kids “is filled with lists of ‘off limit’ foods like fruits” and wondered what to do with the advice to feed her kids eggs every morning when her kids don’t like eggs.¹²

Still, many parents are desperate to lose weight themselves and to stall weight gain in their children, so a diet for all family members is appealing because a family that gains weight together may lose or at least manage weight together. Under careful supervision of a physician and dietitian, tailoring the low-carbohydrate approach to a child and family may be useful in helping severely overweight adolescent children learn to control and reduce weight. Even so, I would then argue against prohibiting nourishing foods that kids do like. Corn and watermelon (examples of carbohydrates that are limited under the Atkins plan) are among kids’ favorites, both good sources of vitamins, minerals, and highly touted “phyto-nutrients.” At the same time, I applaud any eating plan—including Atkins’s—that reduces soda, fries, candy, and sugar-laden snacks.

A similar diet book, *Sugar Busters for Kids*, edited by Samuel S. Andrews et al., appeals to parents who themselves pursued low-carbohydrate eating with the best-selling Sugar Busters plan.¹³ Proponents think the plan makes sense: prohibit the “terrible three” snacking staples of soda, french fries, and candy, and make kid-friendly recipes, ranging from whole-wheat pizza to tofu shakes. After all, the official surveys show that kids eat too much junk food. To its credit, it includes healthy carbohydrate foods (whole grains, fruits, and vegetables). But critics fault this plan of restrictive dieting for being too extreme—prohibiting favorite foods and imposing unusual and time-consuming preparations. These restrictions can lead to diet failure, and diet failure, in turn, relates to lowered self-esteem and depression. I discussed this plan and the criticism with a group of parents who were seeking ways to improve their children’s diets. One parent gave the predictable, and most practical, response of all: “Never eat french fries? Never drink soda? That’ll be the day! Prohibition never works with kids.” I agree; moderation is the key.

On the other end of the spectrum from Atkins are low-fat plans such as that outlined by Judith Shaw in *Raising Low-Fat Kids in a High-Fat World*. Shaw’s book is geared toward parents willing to put time and energy into a family shift away from the high-fat habit; she recommends having “your child as a primary focus while also considering you and your life.” She provides lessons in camouflaging fat, taking the fat out, restocking your

KNOW YOUR FATS

To reduce the amount of fat in our diet, it's important to know that some fats are relatively “good” and others are quite “bad.” All are fattening, but some types promote health while others decrease it by the way they affect the amount and type of cholesterol in blood.

All pure fats and oils are high in calories (9 per gram) compared to pure protein and carbohydrate (4 calories per gram). Fats contain about 120 calories per tablespoon and should make up 30 percent or less of daily calories.

Most foods contain mixtures of different types of fat—*monounsaturated* (mono), *polyunsaturated* (poly), and *saturated*—classified by the type that dominates the mix. (Saturated fats are usually solid at room temperature and are called “saturated” because their molecules have all the hydrogen they can hold.)

Hydrogenated oils and trans-fatty acids (*trans-fats*) are formed when unsaturated fats are *hydrogenated*—the process of adding hydrogen. Mono and poly fats can be hydrogenated until they are artificially saturated, making them solid at room temperature (food manufacturers hydrogenate oils to produce a more solid fat product and to extend the shelf life of products such as cookies and crackers; some margarines are produced this way.). Trans-fats are the most threatening to health because they raise the “bad” cholesterol and triglycerides in blood and lower the “good” cholesterol.

Nutritionists recommend eating foods that contain mainly mono fats, with poly fats making up the difference, and limiting saturated and trans-fats as much as possible. Look for—and try to avoid—foods with “partially hydrogenated oil” or “hydrogenated oil” on the ingredient list.

What foods contain large amounts of these fats?

MONO FATS (CHOOSE MOST OFTEN):

- Olive oil
- Canola oil
- Almond or hazelnut oil
- Soft margarines made with the above oils
- Avocados

POLY FATS (CHOOSE OFTEN):

- Corn oil
- Soybean oil
- Sesame and walnut oil
- Soft margarines made with the above oils
- Salmon and other fish
- Flax seed

SATURATED FATS (CHOOSE LEAST OFTEN):

Butter
Lard
Fat in beef and other meats
Palm and coconut oil
Hydrogenated oils (especially hard margarines)

TRANS-FATS (CHOOSE SELDOM):

Commercial french fries
Margarine
Vegetable shortening
Most crackers, cookies, pastries, breakfast bars
Most savory snacks and potato chips
Prepackaged desserts, puddings

No more than 10 percent of daily calories should come from saturated and trans-fats. This means children should eat about 15 or less grams of these combined fats daily; adults 20 grams or less daily. The average American eats about 35 grams of combined saturated and trans-fats daily. Here are some examples of foods with saturated and trans-fats.

Food	Serving size	Saturated fat	Trans-fat	Total trans- and saturated fat
Jell-O Chocolate Pudding Snack	1	1.5 g	1.5 g	3.5 g
Dunkin Donut glazed donut	1	2.5	4.0 g	6.5 g
Nabisco Wheat Thins	8	1.0 g	2.0 g	3.0
Big Mac with medium fries	1	<?>	<?>	14.0 g

kitchen, and keeping (low-fat) hamburgers on the menu. Her plan resembles the Dean Ornish low-fat diet plan but with meat and chicken, tailored for families with kids. Not a diet, this is an all-out overhaul of family eating that requires command of food ingredients, food labels, and recipes as major weapons in combating the high-fat world. Health professionals generally applaud this method because it exemplifies putting knowledge into action (see the box “Know Your Fats”). Learn the tricks, hustle up the ingredients, reorganize your kitchen, and go to work! They have confidence that, in time and with effort, the family will eat the low-fat diet. Pointing to her own success, one dedicated mother who used Shaw’s low-fat living suggestions to help her overweight twins claims, “These ideas work, given

time, energy, skills, and an ability to handle restaurant-eating-withdrawal symptoms.”¹⁴

Without skills, energy, and time, however, many parents find these laudable goals difficult to achieve. Selecting only one or two manageable suggestions to work on is more reasonable. Simply buying cinnamon graham crackers to stock the snack shelf instead of potato chips or replacing the soda shelf in the refrigerator with a big container of water gives copious returns for small changes in the kitchen.

FINDING THE RIGHT BALANCE

Because of the popularity of the Atkins (and similar) diet program, as well as doubts about its safety and effectiveness, pressure from the public prompted a governmental response to investigate what is really known about popular diets. The U.S. Department of Agriculture initiated a scientific review in 2000 of weight-loss plans and published the results in March 2001.¹⁵ The study asked: is the information in these diets scientifically sound, and are popular diets effective for weight loss and/or weight maintenance? Among its other questions it touched on these diets’ reported effects on the risk of heart disease or diabetes, and on levels of insulin and leptin, the long-term hormonal regulators of energy balance.

It measured the diet plans against scientific criteria from research studies and reviewed their diverse nutrient composition: Atkins’s and the Carbohydrate Addict’s are high fat, low carbohydrate; Weight Watchers’ is a balance of carbohydrate and fat; and the Ornish diet is low fat, low animal protein, and high vegetable. After analyzing as much relevant data as could be assembled, the study concluded with a recommendation for a diet resembling Weight Watchers’—balanced carbohydrate and fat, and flexible choice from a wide variety of foods. The study’s conclusion corresponds with the 2002 governmental recommendations for sources of calories: 25 to 35 percent fat, 45 to 60 percent carbohydrates, and 15 to 20 percent protein. The scientific report on weight management diet plans concluded, “A diet high in vegetables, fruits, complex carbohydrates (whole grains and legumes), and low-fat dairy is a moderate-fat, low-calorie diet that prevents weight gain, results in weight loss and weight maintenance. It is associated with fullness and satiety. It reduces risk of chronic disease. It is fast, convenient, and inexpensive. How can we convince people it works, and to try it?” Making a critical point that applies to children’s diets too, the report concluded: “The American public needs to be told (and believe) that diets

are not followed for 8 days, 8 weeks, or 8 months, but rather form the basis of everyday food choices throughout their life.”¹⁶

I fully agree with this report’s conclusion, and I view it as further proof that the USDA Food Guide Pyramid, with some fine-tuning, is still the best basic guide for managing weight and promoting health. To sum up, carbohydrate-rich food from the grain group are the diet’s foundation (a minimum of six daily servings recommended). Fruits and vegetables form the pyramid’s next level (three to five servings of vegetables and two to four servings of fruit); the meat group (which includes nuts and legumes) and dairy group share the third level (two to three servings each); and oils and sweets make up the pyramid’s peak (with the admonishment, “use sparingly”).¹⁷ Figure 5 presents the Children’s Food Guide Pyramid, and the box “Recommended Daily Servings” applies alike to children and adults (it complements chapter 6’s box on portions and servings).

Meanwhile, several nutritionists who are critical of the pyramid have put forth alternative versions. One proposed alternative is the Mediterranean Diet Pyramid promoted by Walter Willett at Harvard’s School of Public Health, which encourages eating more whole foods and plant-based oils and less red meat and white flour. Another pyramid guide developed by the Center for Science in the Public Interest recommends eight to ten servings of fruit and vegetables—the results of extensive research by the National Institutes of Health on dietary approaches to stop hypertension.

I agree with many critics that a pyramid overhaul could first of all emphasize serving size and recommend serving sizes by age group. And it could distinguish “healthy” carbohydrates such as those found in brown rice, whole-wheat bread, beans, vegetables, and fruits from less healthy, highly refined “white carbs” such as sugar, white bread, and pastries. It could both encourage moderate use of “healthy” fats (olive, canola, walnut oil) and discourage eating processed fat, which usually contains *trans-fats* (margarine and hydrogenated solid fats in pastries and snack foods). Finally, it could extol the importance of daily physical activity and drinking water as the main beverage instead of drinks laden with sucrose and corn syrup. But let’s not throw out the baby with the bathwater. The pyramid’s foundation, structure, and basic principles remain sound advice.

The question that echoes in the scientific study above, “How can we convince people it works, and to try it?” addresses the desire for quick fixes among adults and children for our weight problems. When medical doctors and registered dietitians recommend a diet high in vegetables, fruits, whole grains, and small amounts of low-fat animal products, the public



FIGURE 5. The children’s Food Guide Pyramid is still the best basic guide for managing weight and promoting health. (“Food Guide Pyramid for Young Children: A Daily Guide for Two- to Six-Year-Olds,” U.S. Department of Agriculture, Center for Nutrition Policy and Promotion, 1999)

questions our credentials and our advice. Why? Is it because people do not like vegetables and fruits? Is it because they have never tasted vegetables and fruits? Is it because vegetables and fruits are not available? I believe an answer lies in the strong competition from the 12,000 food products that beckon at every turn. The taste conditioning for added sugar and fat begins in childhood and gets consistent, daily taste reinforcement. Such conditioning is a very hard act to follow, no matter how strong the evidence that a balanced diet is the best bet for setting and maintaining a healthy weight. Still, I have yet to find a two-year-old—seated with adults

RECOMMENDED DAILY SERVINGS FOR CHILDREN AND ADULTS

Understanding serving sizes is essential for following the Food Guide Pyramid's recommendations. What counts as a serving?

GRAIN GROUP

(bread, cereal, rice, and pasta—preferably whole-grain)

- 1 slice of bread
- about 1 cup of ready-to-eat cereal
- ½ cup of cooked cereal, rice, or pasta

VEGETABLE GROUP

- 1 cup raw leafy vegetables
- ½ cup other vegetables (cooked or raw)
- ¾ cup vegetable juice

FRUIT GROUP

- 1 medium apple, banana, orange, or pear
- ½ cup chopped, cooked, or canned fruit
- ¾ cup fruit juice*

DAIRY GROUP

(milk, yogurt, and cheese—preferably fat-free or low-fat)

- 1 cup milk or yogurt
- 1.5 oz natural cheese (such as cheddar)
- 2 oz processed cheese (such as American)

MEAT AND BEAN GROUP

(meat, poultry, fish, dry beans, eggs, and nuts—preferably lean or low-fat)

- 2–3 oz cooked lean meat, poultry, fish
- the following foods count as ½–1 serving:
- ½ cup cooked dry beans or tofu
- 2.5 oz soyburger
- 1 egg
- 2 tablespoons peanut butter
- ½ cup nuts

How many servings from each food group do you need daily? It depends on your age, gender, and activity level:

Food group	Children ages 2–3	Children ages 4–6, women, some older adults	Older children, teen girls, women, most men	Teen boys, active men
Grain	6 (size should be two-thirds of regular serving)	6	9	11
Vegetable	2 (size should be two-thirds of regular serving)	3	4	5
Fruit	3 (size should be two-thirds of regular serving)	2	3	4
Dairy	2 (regular serving)	2–3	2–3	2–3
Meat and Bean	2 (for a total of 5 oz)	2 (for a total of 5 oz)	2 (for a total of 6 oz)	3 (for a total of 7 oz)
Total calories per day	1,000–1,400	1,600	2,200	2,800

SOURCE: USDA, 1999; American Academy of Pediatrics, 2001.

*Limit juice to one serving (4 to 6 oz) for children ages 1–6; two servings (8 to 12 oz) for children and teens ages 7–18.

who clearly enjoy watermelon and strawberries—who does not like eating them too.

What affects kids' current and future eating behavior and weight more than other factors is their parents' eating behavior and weight. Families can beat the competition from “junk foods” by exposing children to a wide variety of healthy foods and by following the pyramid's advice to eat a variety of foods in reasonable serving sizes. Healthy body weight will follow—for kids *and* adults.

GETTING FIT WHILE HAVING FUN

Fitness books, like dieting books, crowd the marketplace and target worried parents. Motivation, fun, and long-term health are the themes. Most fitness books, like most diet books, urge parents to protect their children from diseases that befall unfit children, and then they try to show that fitness is fun and not a chore. Setting a child up for success, not failure, is the goal.

Examples in this genre include *Fit-Kids: Getting Kids Hooked on Fitness Fun!* by Mandy Laderer and *Fit Kids: The Complete Shape-Up Program from Birth through High School* by Kenneth H. Cooper et al.

I endorse these books and others that encourage fitness, even if they have a highly structured exercise program. But I am never surprised that kids do not like isolated, formal workouts that quickly become boring. What most kids want, and need, is other kids to play with. Two-year-olds learn to enjoy active play from watching older siblings or other children, and children of any age generally prefer free play and active games to structured workouts. When no active siblings are around to encourage play, then television and other passive activities quickly and easily replace movement.

My views on fitness reflect contact with boys such as Alex, an only child who was born to two very successful parents in professional careers after several failed attempts to conceive a child. By age five, Alex, so treasured by his Greek parents, spent most of his time with grown-ups, or reading or watching television on his own. He was very overweight. Because he quickly tired and had trouble running, he resisted attempts to involve him in soccer or other group activities. He disliked swimming, even with a private coach. His diet was quite healthy, but he ate large amounts and snacked frequently. His parents were anxious; they worried about his weight and, at the same time, about his getting enough food. Each would independently feed him on the side, even while trying to follow a reduced food plan. So what worked to stall his weight gain was nothing the grown-ups did, but rather the arrival of his lively cousins for an extended summer vacation. These six-year-old boy twins loved running around the yard and floating boats in a brook behind the house. They and Alex built forts and kicked balls, dug big holes and played with trucks in the dirt. Alex loved it. He was so busy that food and television lost their draw. When he started school in the fall, Alex was willing to try some of the active games and to invite a classmate to play at his house. By the next year his BMI had moved down from the “overweight” to the “at risk” category.

Like most other kids, Alex benefited from free play that meets the American Academy of Pediatrics recommendation for all children ages two to eighteen: one hour of moderate to vigorous physical activity most days. To make room in their family’s life for this hour’s activities, both indoors and out, parents need to limit TV and video time—regardless of any imagined (and real) time crunch—and have fun with their kids.

GETTING PROFESSIONAL HELP

In some cases, a family and/or health provider may decide that a structured long-term program, involving outside intervention and support, is the best route to help an overweight child manage his or her weight. The degree to which the child's weight poses risks to psychological and physical health and the degree of support the family is able to provide may trigger the decision. What follows is a general review of a few different types of programs I recommend. (Note: I don't endorse commercial programs because comparisons of effectiveness with similar programs for kids are not available.)¹⁸

Committed to Kids is an integrated four-level weight management program using dietary intervention, behavior modification, and exercise. As weight management programs go, this is one of the most comprehensive, scientifically grounded, user-friendly ones available.

Targeted to a variety of age groups and families, the one-year program offers its four levels in a weekly outpatient clinical setting. A child's weight when starting the program sets the first level. "As a child loses weight, he graduates to a new level. This encourages short-term success through goal setting, feedback, and motivational techniques to improve health behaviors," states Melinda Sothern, a professor of exercise physiology and lead author of the program. The program covers all bases: medical check-ups, eating plans and snack suggestions, solving problems family style, handling emotional pitfalls, and creative ideas for physical activity. It provides workbook forms and checklists to monitor goals, activity, and food. After completing the program, children are encouraged to come to quarterly special events and evaluations free of charge and to attend classes that help prevent relapse. One report of program effectiveness cited 60 percent of participants who reduced their BMI from 32 to 28 after one year. We would only hope (dream?) to see such a program widely accessible to children and families as part of a nationwide health-care network. Sothern's Committed to Kids' program is now available in book form for individuals and families as a twelve-week plan, called *Trim Kids*.¹⁹

Other programs develop in medical centers, with training for providers, and then are offered as commercial programs to children and families by private-practice health professionals or sold for group use in health clinics. These are packaged as program kits with a leader's manual and materials for participants. Shapedown, developed in 1979, is one such family-based program that targets age groups from six to eighteen years old. The program is sensitive to psychosocial issues pertinent at each stage of develop-

ment. It emphasizes improving parenting style, such as helping children find a balance between “self-nurturing and limit setting” or learning “body pride and good health” and “balanced eating and mastery living” (mastery living means achieving a balance of all the characteristics). Workbooks include case story readings, practices, food and activity records, goals, and contracts. A related book for adult weight management that expands the concepts is *The Solution: Six Winning Ways to Permanent Weight Loss* by Laurel Mellin. The Shapedown program reported its effectiveness as a significant decrease in weight and an increase in self-esteem after fifteen months.²⁰

What “shaped” my opinion of Shapedown’s program was a riveting session of *The Oprah Winfrey Show*, aired November 14, 2002. In it Mellin, creator of Shapedown and *The Solution*, explained her approach to Oprah and illustrated it with flashback and current film clips of children and families who had used the program—many with improved weight and lifestyles. The live interview with a mother and daughter, both overweight, was heart-wrenching. First, the twelve-year-old daughter described her misery from being teased and bullied; she had no friends. Her mother then detailed her own attempts and failures to help her daughter lose weight and, in desperation, her own weight gain so her daughter would not be fat alone. Facing the family, Mellin quickly pointed out how the child had taken on the role of parent and now bullies her mother, making her miserable too. The mother and daughter were in tears, and so was I. The camera closed in on Oprah, who reminded the audience, “No child is overweight alone.” In fact, that was the theme of the show—to reveal how children are enmeshed in a society that overfeeds their bodies and underserves their emotional needs.

The point is that Mellin and her Shapedown program have it right—but her solution is complicated. She suggests dealing with “emotional trash” and learning parenting skills. To become a nurturing parent takes a lot of skill, determination, patience, and support: to know where to draw the line between indulgence and limit-setting; to be accepting and constructively critical; to be balanced and not lead a chaotic lifestyle. Yes, I say, we could all benefit from learning these skills. Shapedown is a beginning, and in the hands of well-trained and sensitive health providers, it can help overweight children and families manage the social stigma of being overweight while developing eating and activity skills.²¹

The school-based Eat Well and Keep Moving is an interdisciplinary curriculum for teaching upper elementary school nutrition and physical activity. It is “a multifaceted program that encompasses all aspects of the learning environment—from classroom, the cafeteria, and the gymnasium to

school hallways, the home, and even community centers,” according to the handbook description by its authors Lillian Cheung and Steven Gortmaker. Targeted at fourth- and fifth-grade children, the program includes actual classroom physical activities and health promotions through clubs and contests like “Freeze My TV,” a contest that teaches kids how to log and graph TV time, come up with alternative activities, and keep a journal. Other activities focus on keeping “FitScore” and “SitScore” logs and overcoming the barriers to physical activity. This 480-page program, with illustrated activities for forty-four lessons and ready-made handouts, is clearly a valuable guide. During a large field trial in ten schools, the program’s participants reduced TV time and increased fruit and vegetable consumption. The girls who participated, but not the boys, also cut their level of obesity compared with control groups. My evaluation is simple: we need look no further for sound teaching/learning materials for this important age group. Let’s move on to implementing such a program in schools nationwide.²²

There are many other programs, few with evidence of effectiveness, mainly because parents, communities, and the government do not place children’s health high on the priority list for financial and public resource support—and because any attempt to compete with the excesses of the seductively sophisticated food and entertainment marketplace offerings would demand monumental energy and audacity.

In judging the various weight management methods that are on the market, we might keep in mind the following report from a leading professional guide, *Handbook of Obesity Treatment*, published in 2002. It evaluates results from seventy-eight studies on various treatment programs for children by research design, number of participants, type of diet and exercise and concludes:

Individual child and family treatments provide short-term benefits.

Very little evidence exists for long-term treatments and weight management.

The most successful programs include diet, exercise, and behavior change methods.

The most effective diet treatments cannot be identified because comparisons are lacking.

Exercise combined with diet enhances weight loss and improves maintenance.

Less structured, flexible lifestyle exercise is more effective than high-intensity.

Reducing sedentary activity, if reinforced, leads to increased moderate physical activity.²³

Of equal note, most of the programs the *Handbook* describes required intense individual or family involvement and commitment for an extended period of time in order to be successful, even in the short term.

A lack of family support can be a major stumbling point for an otherwise well designed program. A pediatrician I know works in a clinic in a low-income urban community where 75 percent of the children are overweight or at risk of becoming overweight. He asked me to consult on a project he developed there. The program, for seven- and eight-year-olds, was held Saturday mornings and required a parent or family member to accompany the child during the sessions. The kids loved the program and clearly adored the pediatrician and other team members. But other family members were much less happy to be there, and the parents did not attend regularly. Because the multiple demands on today's families can be overwhelming—and some parents may have outside jobs on Saturday morning, while others catch up on chores, sleep, or community activities—he didn't really need an in-depth analysis to figure out why these family members were not “ready to change.” I agreed with him that working one on one with kids or even with kids and family members in a weekly group program is, at best, a good start and may work for a few overweight kids. But weight-management programs do not work for all families and cannot alone reverse the obesity epidemic.

Despite any advice and endorsements I made above, concerted weight-management efforts—or any other campaign that targets fatness—can backfire. Negative consequences are the dieting culture's nightmare and feed its obsessions, which we consider next.

THE DIETING CULTURE AND DYSFUNCTIONAL EATING

Obsessive dieting, like obesity, ranks as an epidemic; estimates are that at any given time as many as 60 percent of white girls are dieting. Dieting methods, parents are warned, escalate to higher levels of eating disorders such as anorexia nervosa and bulimia.

Countless magazine articles and books blame the drive for thinness on a

cultural misperception that the beauty ideal of slimness delivers social status or moral superiority. They claim that this ideal drives girls to control their appetites and their body size by dieting. Some feminist writers see dieting as bondage for girls who struggle to gain their own identity but end up oppressed by an unrealistic body-size ideal. Others rage against dieting as a gimmick to sell fraudulent cures and products by first promising thinness and control, then by offering other products to reward or console dieters for “being good/bad.” If following our diet exactly makes us feel great—or, conversely, blowing it upsets us—then maybe we’ll need to treat ourselves with new clothes/hair products from these nice folks!

The drive to diet varies by race and culture. African Americans, who suffer from higher obesity rates than whites do, are generally more tolerant of larger sizes, as evidenced by interviews conducted by anthropologists for the Teen Lifestyle Project in Tucson, Arizona. They followed white and black girls from middle school to high school and studied their perspectives of body image. Girls from the two groups summed up the differences with photos and quotes in *Newsweek*:

[photo caption of lean white girl] “White girls think you can never be too thin. They say, ‘I’m so fat. I’m so ugly.’ To me, the ideal is trim and strong, athletic—but not too strong.”

[photo caption of two heavy African American girls] “Black girls think size doesn’t matter—if you’ve got the right attitude. They say, ‘It’s really how you carry yourself. It’s what you wear, how your hair is done and how you put it together that gets you attention.’ The guys at my school don’t trip on skinny.”²⁴

These and other studies show that black females, as well as Latinas, are less rigid in their concepts of beauty than their white counterparts; they spoke positively of “making what you’ve got work for you.” White images of style, by contrast, encapsulate beauty ideals that can lead girls to experience dissatisfaction with their bodies and to desire weight loss as a way to be perfect and popular. One study of 4,000 fourteen- to eighteen-year-old high school girls, in equal number black and white, reported that white adolescent girls were nearly twice as likely to perceive themselves as overweight and six times more likely to engage in unhealthy weight-loss practices, such as using pills and vomiting to keep or change their weight.²⁵

In recognition of the detrimental effects of dieting, guidebooks on diet

and health for adults and children have changed their message over the past couple of decades. The pitch is now *diet-free* or *non-diet* healthy eating for kids and grown-ups. In the 1980s, books peddled weight-loss diets for children, but in the 1990s, the focus shifted to healthy lifestyle programs. Strict prescriptions for eating and exercise gave way to flexible alternatives to body beauty, inside and out. Losing weight to feel great became a quest of finding yourself through your talents and body movement. On closer view, the new labels feature the old tune—weight-loss and exercise suggestions are imbedded within these guidelines for healthy lifestyle.

To illustrate the shift, compare the titles of two books by Frances M. Berg, a family wellness specialist and the editor of *Healthy Weight Journal*. The first, *How to Be Slimmer, Trimmer and Happier: An Action Plan for Young People with a Step-by-Step Guide to Losing Weight through Positive Living*, represents the diet book genre of the 1980s: losing weight is the path to healthy body weight and happiness. The book gave sound guidance on creating good habits—eating right, counting calories, avoiding fad diets—and a reader reported that “After ten weeks on the Action Plan, I found controlling my snacking easy, and I was able to concentrate on constructive activities instead of dreaming about a cookie.”²⁶

Fourteen years later Berg wrote *Afraid to Eat: Children and Teens in Weight Crisis*. Reviewers reported, “Berg serves up a feast of facts on four major problems: dysfunctional eating, eating disorders, size prejudice, and overweight.” Berg condemns dieting as a major cause of the “crisis in eating and weight”: “Children are possessed by fear, many children don’t eat normally. They shun certain foods, they diet, and they binge. There’s a new name for these eating patterns—dysfunctional eating.”²⁷ The program Berg offers in 1997 is similar to her 1983 program; she calls for moderation in eating habits and an active lifestyle. While the pro-dieting hook in the 1980s linked dieting to happiness, the anti-dieting advice of the 1990s imparted the message that dieting leads to unhappiness and “weight crises.”

One other book, written by a credentialed health professional, illustrates this shift. In *Save Your Child from the Fat Epidemic*, the registered dietitian Gayle Alleman warns: NO DIETS. “Diets in childhood may lead to disordered eating later in life.” “Rather than a diet, just begin offering your child a different array of foods—ones that are low in fat, sugar, and calories.”²⁸ One point recurs: moderation is essential.

I applaud this movement to redefine dieting as lifetime weight management and healthy living. The problem is, parents and the media continue to pass on destructive dieting messages and unrealistic body ideals to younger

generations. In spite of the new emphasis on substituting lifetime weight management for dieting, one study showed that girls whose mothers diet or focus on weight control strategies at meals and in conversation were significantly more likely to have ideas about dieting than those whose mothers did not focus on dieting.²⁹ Clearly, a dieting culture defines this generation, passed from mothers (and fathers) to daughters—and, in some cases, to sons.

Some young people are so desperate to lose weight that they would resort to pharmaceutical and surgical procedures, even though none are approved for kids. They must get these ideas from their family and media. Consider the comments I heard from adolescent girls: “I am just going to have my fat sucked out, like my aunt did—it’s called liposuction.” “I’m gonna have my stomach closed up so I can’t eat so much. I saw on TV that Carnie Wilson, the singer, did that and she is really pretty and skinny now.” “My mom took me to this big research place where they were testing pills for kids to lose weight. I took them and this lady talked to us about eating better, but nothing worked.”

I agree with those who say we should appeal to adult role models to stop complaining about their bodies or discussing their latest diet, because such comments promote unhealthy dieting and distorted body image. In no small part because of parents’ attitudes, young kids link success and self-esteem to body image. Comments they overhear—“I’m so fat” or “So-and-so has really put on weight”—condition them to worry about their weight and make fun of others who are heavy. Children need role models who affirm their self-worth in other ways. We should focus on making balanced, moderate eating a way of life, not a diet, and make physical activity fun and desirable for children, not competitive.

A nationwide campaign to reduce obesity and to heighten awareness of obesity’s risks might inadvertently trigger young children’s lifelong obsession with body weight, be they fat or thin, and promote fat discrimination. Berg and others have brought important attention to this concern, and they argue that society’s view toward body size is what needs to change:

Our culture’s obsession with a beauty narrowly defined and the destruction left in its wake are evidenced in stories, journals, and books of girls and young women. Women and girls of all sizes, bone thin to full fleshed, tell stories of shame and abuse, struggles and sorrow, hollow victories and full-bodied failures. They speak of bingeing and purging, weight gain and weight loss, dieting and stomach pain; of feeling cold, sick, and

exhausted; of flinging themselves on the bed sobbing. They lament the wasted years and the talent and energy spent on obsessing over weight and appearance.³⁰

Those in the fat acceptance movement would argue that the answer is to embrace *all* body types and therefore accept obesity. Given the health risks and discomfort associated with being seriously overweight, however, I do not believe this is a viable option. The risks of obesity outweigh the risks of fighting it; therefore, we must proceed with efforts to reverse the fatness epidemic. The very real challenge is to ring the alarm bell on obesity's risks and to campaign against fatness in a way that does not worsen disturbed body image, perpetual dieting, eating disorders, and fat discrimination.

EATING DISORDER AWARENESS

Obesity's link to eating disorders is complex and controversial. My view on this matter has been influenced by the work of Mimi Nichter, an anthropology researcher and author of *Fat Talk: What Girls and Their Parents Say about Dieting*. She claims the media have led people to believe that eating disorders are far more common than they actually are: Though “1–3 percent of girls do suffer from eating disorders; the other 97 percent demonstrate a wide range of attitudes and behaviors toward their bodies.”³¹ Because most statistics about teenage girls and their eating habits come from surveys that report a general concern about body size, we tend to assume that dieting is prevalent too.

Nichter's in-depth studies question the assumption that there is an epidemic of dieting among teenage girls. She asks, “Do girls actually lose weight from their diets? Given the cultural imperative to be thin, are girls *overreporting* their dieting on surveys because they feel they should be dieting? If *everyone* is dieting, why do studies continually report that American youth are becoming increasingly overweight?”³² She found that for many teenage girls, activities that focus on health—including the “work” of eating—was closely aligned with beauty work. Dieting seldom meant restrictive eating; it was, rather, part of body-talk language. “I'm so fat” is a way of communicating feelings, about themselves and their body. Boys, too, worry about their bodies, especially size. Size, according to another writer, “is a kind of involuntary self-definition. Short kids were called Mouse, String Bean, Little J., Leprechaun, Shortie, Half Pint, Spaghetti.”³³

Evidence from other surveys does indicate widespread dieting among girls

but does not directly connect dieting and eating disorders. For example, a 1996 National Institutes of Health study of nine- and ten-year-old girls reported that 40 percent were trying to lose weight.³⁴ A 1997 Commonwealth Fund survey of the health of adolescent girls reported 58 percent of high school girls had dieted, one in four regularly counts calories, and nearly one in five said she had binged and purged.³⁵ A statewide study of high school students in South Carolina reported that 13 percent of white and 9 percent of black girls said they dieted to lose weight, and 2 to 3 percent in each group reported vomiting to lose weight.³⁶ Yet no study reported any cases of eating disorders, as diagnosed by meeting the full criteria. In all three studies, the researchers urged health professionals to capitalize on the concern of those who reported dieting or vomiting and to provide “proper weight control information.”

That advice is good. Because the rate of obesity is higher by several magnitudes than diagnosed eating disorders, the important lesson from Nichter’s work and the survey reports is that dieting, personally defined by individual girls, is part of our culture and is likely to continue to be a kind of lifestyle code for worrying about body size. Rather than fight it, we can join it and steer the interest and concern toward healthy eating.

I furthermore agree with health professionals and educators who say we must loosen our rigid standards of beauty and help our children accept the diversity of human appearance. And yet school-based programs to spread eating disorder awareness and promote body-size diversity may make bad matters worse. Programs to affirm acceptance of diverse body size and thus prevent disordered eating studies report little progress.³⁷ A Stanford University study of third- through sixth-graders who participated in a program to accept a diversity of body sizes found that 42 percent of girls and 35 percent of boys still wanted to look thinner; 6 percent of girls and 20 percent of boys wanted to look heavier.³⁸ Older girls with body size concerns may reduce risk of eating disorders such as bulimia.³⁹ Eating disorder prevention programs have no place in elementary schools because young girls understand very little about dieting.

These results may seem contrary to my call for increasing awareness of the health risks of obesity along with awareness of the health risks of dieting. But we do not have good methods for dealing with these contradictory societal messages: “have a perfect body” versus “eat, eat, eat.” As parents and health providers, we must know the health risks associated with these contradictory messages. Pursuit of a perfect body leads to disordered eating; eating too much leads to obesity. But we should not *overemphasize*

these risks to our children, because such awareness campaigns can heighten rather than lessen their preoccupation with their body image.

The debate about dieting as a danger to children's well-being is likely to continue between the non-diet advocates of body-size acceptance who claim dieting leads to reduced self-esteem, or worse, eating disorders, and the traditional medical view that dieting to reduce excess weight is important to improve health. Rather than push on with that debate, all of us—parents and health-care workers alike—need to support healthy living by our own moderation in eating, moderation in sedentary recreation, and moderation in high-pressure time commitments. And above all, by moderation—and one day perhaps, elimination—of discrimination against fat children.

The following chapter takes a closer look at ways to combat fat discrimination and to encourage more flexible concepts of beauty—such as those voiced by the African American teenagers above—while simultaneously encouraging overweight youth to achieve a healthier size.

SUMMARY

This chapter aimed to show why restrictive diets generally do more harm than good for overweight children. Overweight kids do not need to “go on a diet”; they need to eat for their age and be moderately active in order to grow into their weight and develop positive eating habits and active lifestyles.

Sifting through the spectrum of weight-loss and nutritional advice available to children and adults, I endorsed a diet high in vegetables, fruits, whole grains, and other complex carbohydrates, with moderate amounts of fat and protein. The government's Food Guide Pyramid is a valuable model of balanced eating for life, which can help everyone rein in the over-inflated serving sizes that have become so common in homes and restaurants. We examined some of the professional programs available to families of overweight children, as well as obesity's link to eating disorders, both of which highlighted the family's critical role in any child's success—or failure—at reaching and keeping a healthy weight. Too often parents, along with the media, pass on and reinforce unhealthy concepts of dieting and unrealistic notions of the beauty ideal. Fighting the fatness epidemic should be a matter of health and wellness, *not* personal appearance.

So far we have learned a great deal about one-on-one treatment, but the explosion of overweight kids calls for group intervention programs and populationwide prevention programs. Support and assistance at home and

school are essential. Even so, constant messages from the media and the marketplace *to eat* and *to remain seated* (at the TV, video, or in the car) are so strong that the most effective childhood obesity program would also update those messages.

In a perfect world, a utopia of universally healthy children, we know what we could do without: destructive media messages; thousands of readily available fast-food products; sugar-laden soda always within an arm's reach; the need for two or three cars in every family. In that world of Absolute Knowledge and Perfect Practice, an ideal weight management program for parents and children would exist—free of cost and with one simple rule for prevention, one rule for treatment, one rule for maintenance. We are very far indeed from this, and perhaps the only truth we can know absolutely is that putting theory into practice inevitably has costs. Once again, our search for ideal weight management calls for a spirit of moderation to balance our expectations and our limitations.

The following example of an ideal program is absurdly simple in theory and amazingly difficult in practice.

Premise: equal energy *in* (as food and drink) and *out* (as physical activity) results in a healthy weight.

Prevention: to beat a fifty-calorie energy imbalance, eat fifty calories less *or* move fifty calories more—every day, for life; OR to beat a one hundred-calorie energy imbalance, eat fifty calories less *and* move fifty calories more—every day, for life.

Treatment (slow): eat one hundred calories less *and* move one hundred calories more—every day, to a healthy weight; OR (fast): eat two hundred calories less *and* move two hundred calories more—every day, to a healthy weight.

Maintenance: after passing treatment, go back to prevention.

Program strength: lifelong healthy weight.

Program weakness: time, effort, and commitment—every day, for life.