

Changes needed to government anti-obesity strategies in order to reduce their risk of harm to people with eating disorders



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Introduction

The proliferation of government-sanctioned anti-obesity campaigns is increasing the vulnerability of those at risk of developing an eating disorder and exacerbating eating disorder symptoms in those already diagnosed with an eating disorder. This is despite paucity of evidence that the campaigns are effective in reducing obesity. Beat recognises the importance of reducing obesity and the good intention behind these campaigns, but is very concerned that their tone and content do not take into account their potential harm to people with or at risk of eating disorders. We believe that campaigns should shift away from those which increase weight stigma, view obesity as a choice and/or encourage restrictive eating patterns, to those which take a more integrated and holistic approach to obesity. Campaigns should recognise the complexity of causal and maintaining factors, and consider the potential impact of anti-obesity policies on those vulnerable to or experiencing an eating disorder.

Eating disorders have significantly raised mortality rates, with anorexia nervosa having the highest mortality rate of any mental illness (1). They predominantly affect adolescents and young adults, although the incidence in childhood is increasing (2). Despite this, it appears that the risk to people with eating disorders is not considered when anti-obesity campaigns are being planned. For instance, anorexia nervosa and bulimia nervosa are characterised by a fear of "fatness", yet obesity campaigns commonly focus on raising anxiety about the impact of obesity, thus exacerbating these anxieties in people experiencing eating disorders. They also fail to consider the fact that eating disorders and obesity are not separate issues, since many people with eating disorders also have obesity, and obesity is a risk factor for developing an eating disorder (3–5).

This paper will outline why Beat is concerned about the current approaches to reducing obesity, provide specific examples of campaigns which are potentially harmful to those with eating disorders while also having limited evidence for their effectiveness, and provide recommendations for the type of approaches which should be explored when thinking about obesity. We call for an end to campaigns that ignore the risks to people with eating disorders, thus putting lives in jeopardy, and urge that these are replaced with a more holistic approach to addressing obesity that is informed by evidence from the field of eating disorders. We urge this to be based on the principle of "first, do no harm". One death attributable to an anti-obesity campaign is one death too many.

This paper is not a literature review of the evidence-base surrounding obesity, eating disorders and the impact of anti-obesity campaigns on people experiencing an eating disorder. For a more in-depth exploration of this topic, we recommend the chapter "Going too far? How the public health anti-obesity drives could cause harm by promoting eating disorders" (6). Neither will this paper consider in detail the many other issues surrounding this topic, such as the way that the complex reasons behind a person's obesity are simplified by these campaigns (7,8), the dangers of using weight as a measure of health, and the stigmatising rhetoric that is often used for obesity. For this we recommend the British Psychological Society's report "Psychological perspectives on obesity: Addressing policy, practice and research priorities" (9), Hunger, Smith and Tomiyama's report "An evidence-based rationale for adopting weight-inclusive health policy" (10) and Flint's commentary article "The NHS long-term plan: a comparison of the narrative used for cancer and obesity" (11). We would also recommend reference to and the distribution of the Academy for Eating Disorders' "9 truths about weight and eating disorders" (12) which summarises the relationship between eating disorders, obesity and weight stigma.

Eating Disorders and Obesity

Eating disorders and obesity are not distinct issues and the relationship between them is complex. Obesity is not a mental health disorder, although many people with eating disorders are obese (13–17). There are many risk factors common to both obesity and eating disorders, for example body dissatisfaction, dieting and disordered eating (18–20).

We know that people with obesity are often encouraged to embark on strict, restrictive diets. Whilst we recognise that at times dietary restriction will be necessary to support those with obesity to lose weight, we know that the risks of this process are reduced within the context of a supportive and well-managed obesity management programme (21). Outside of these holistic weight management programmes, restrained eating is commonly associated with weight gain over time (10,22) and binge eating (23,24). Restrictive eating has also been found to trigger the onset of an eating disorder. For example, Patton et al. (25) found that recurrent dieting increased the risk of someone developing an eating disorder 18-fold. This suggests that anti-obesity public health campaigns which focus solely on encouraging restrictive eating are likely to be ineffective in reducing obesity, yet put people vulnerable to developing an eating disorder more at risk.

Mortality rates are almost twice as high for people diagnosed with eating disorders compared to people in the general population, and anorexia nervosa has the highest mortality rate of any psychiatric disorder (1). Similarly, a young person with anorexia nervosa is more likely to die compared to someone of the same age with serious diseases such as asthma or type 1 diabetes (26). Additionally, when considering the association between Body Mass Index (BMI) and all-cause mortality among non-smokers, a J-shaped association has been found (27). This suggests that mortality increases with both under- and over-weight, with the risk for someone at a BMI of 18.5 (the lower end of the 'normal range') being similar to someone at a BMI of 35 (classified as 'severe (class II) obesity'). The dangers of anorexia nervosa and low weight should therefore be considered at least as seriously as obesity and overweight.

People with obesity are often shamed and stigmatised, and made to feel to blame for the weight they are (8,10,11,28–30). Often this is exacerbated by anti-obesity campaigns, which tend to frame obesity as a choice and an individual's responsibility, rather than addressing or acknowledging societal and environmental risk factors such as deprivation (10,31).

Considering that the shame and stigma commonly associated with an eating disorder have been linked to people avoiding seeking help (32,33), this is particularly concerning. Moreover, one study found many healthcare professionals holding stigmatising views, with physicians reporting having less patience, respect and desire to help people as BMI increases (34). This is putting lives at risk as people are likely to feel less able to seek help, and eating disorders may be missed in those who also have obesity.

Many anti-obesity campaigns reinforce the notion of the "thin-ideal". Since we know that internalising the thin-ideal can contribute to body dissatisfaction and eating disorder symptoms (35–38), this is another way in which ill-considered anti-obesity campaigns can have a negative impact on people vulnerable to eating disorders.

In summary, despite the life-threatening nature of eating disorders, anti-obesity campaigns are too often putting people at an increased risk of developing eating disorders or exacerbating the distressing thoughts and behaviours that come with the illness.

Specific anti-obesity campaigns will now be explored in relation to the problems they pose to people vulnerable to and experiencing eating disorders.

Menu and food labelling

The requirement of calorie counts on restaurant and takeaway menus has been suggested in England (Department of Health, September 2018), Scotland (Food Standards Scotland, August 2019) and Wales (Welsh Government, October 2019). Beat has urged that these plans be reconsidered (39) due to concerns that they would have limited effectiveness in reducing people's weight but risk exacerbating eating disorder behaviours. For example, Haynos and Roberto (40) found that when making hypothetical food choices, people with anorexia nervosa or bulimia nervosa ordered food with significantly fewer calories when the menu included a calorie count compared to when there was no calorie count stated, whereas people with binge eating disorder ordered food with significantly more calories when the information was provided. This suggests the proposed policy would exacerbate eating disorder thoughts and behaviours, and increase distress for those with eating disorders.

"Encouragement of calorie counting and fear of obesity in public campaigns was the main source of the beginning of my eating disorder. As someone growing up with a perfectionist mindset, it truly made the fuel behind the fire worse."

- Person with lived experience of an eating disorder

“Despite having recovered from an eating disorder, the introduction of calories on more menus has at times made me question the item I’m choosing and made me feel guilty for not choosing the lower calorie option. When I was poorly, I don’t think that I would have been able to fight against the urge to choose the lowest calorie option, as the eating disorder voice would have been so strong.”

- Person with lived experience of an eating disorder

“I find calories on menus really difficult and triggering, because I try so hard in my day-to-day life to not look at calories, so it feels like a bit of a slap in the face when they are unavoidable like this. Restaurants are already a big challenge, and adding the calories on menus makes it difficult to choose what I want, and not what the eating disorder wants.”

- Person with lived experience of an eating disorder

A Cochrane review found that there is only a small body of low-quality evidence supporting the idea that calorie counts on menus lead to a reduction in calories purchased (41). Although a more recent study found that calorie labelling in US fast food restaurants was associated with a 4% reduction in calories per order, this reduction diminished over one year of follow-up (42), suggesting any small differences that may occur are not maintained.

Others have proposed that food should be labelled with the amount of activity needed to burn off the calories consumed, including in a 2019 systematic review looking into the effects of “Physical activity calorie equivalent” (PACE) labels on food (43). The authors concluded that adding PACE labels to food may reduce the number of calories selected from menus compared to other types of food labelling or no labelling.

Although the Royal Society for Public Health suggests that this type of labelling should be introduced as soon as possible, Beat urges caution. Often people with eating disorders experience difficult thoughts and urges around exercise - for example, they may feel like they have to exercise after eating to “burn the calories off” or have distressing thoughts such as that they are “lazy” or “fat” if they haven’t exercised. These types of thoughts can be all-consuming for someone with an eating disorder and can exacerbate behaviours such as compulsive exercising, restriction, bingeing, purging and self-harm. Labels such as those including PACE are likely to enhance these distressing thoughts or lead the person to feel like their distressing thoughts and the resultant behaviours are justified. Additionally, some people with an eating disorder may be advised

not to exercise due to reasons such as concerns about their low weight or the obsessional nature of their activity, therefore the encouragement to exercise from these labels could be detrimental to both their physical and mental health.

Similarly, to the idea of adding calorie counts on menus, feedback from both those with experiences of an eating disorder and professionals working in the field illustrates how detrimental this could be for those at risk of an eating disorder, those with an eating disorder, and those in recovery from an eating disorder who are vulnerable to relapse.

“For years I exercised obsessively each day as felt like I had to make up for what I had eaten. This was hard enough to break, without having food packaging encouraging me to do this and making me think that was justified.”

- Person with lived experience of an eating disorder

Furthermore, including exercise information on food labels could be scientifically flawed. It appears to be based on the assumption that we must burn off every calorie that we consume through exercise in order to maintain our weight, and fails to consider the high number of calories the body needs just to perform basic functions such as breathing, digestion and maintaining a stable temperature. It also fails to recognise that different people consume energy at different rates, depending on a wide range of factors including gender, body size, muscle mass and age. Additionally, it assumes that what one person views as ‘exercise’ is the same as another person, and does not take into account potential differences in exercise intensity, for example. Nevertheless, it is likely that someone with an eating disorder would view the proposed exercise recommendation as something that they must achieve, or would feel increased shame and guilt about what they have eaten.

Education around ‘healthy’/‘good’ and ‘unhealthy’/‘bad’ foods and calorie restrictions

Children are particularly vulnerable to developing eating disorders, especially those who are prone to anxiety or those who are worried about being overweight (6). Despite this, public health messages across the UK and nutritional information commonly targeted at children portray the message that certain foods should be avoided or are “bad”. Other campaigns (44) have promoted the idea that snacks should be restricted to a specified calorie limit, a notion that promotes food restriction and increases children’s perception of calorie consumption as something to be minimised.

Some children will internalise this portrayal of foods as either “good” or “bad”, and it is not unusual for pre-adolescents to reflect that this was a trigger for their eating disorder. For example, research by Pinhas et al. (45) presented four cases of children whose eating disorder was said to have been triggered by “healthy eating” initiatives they encountered in school. Similarly, Chen and Couturier (38) found that in a retrospective review of 50 children and young people diagnosed with anorexia nervosa, 14% of individuals report healthy eating education as an initial trigger for their eating disorder.

This is not uncommon and reflects the experiences reported regularly to Beat’s helpline, and from clinicians and professionals working in eating disorder services.

“I found that being bombarded with healthy eating campaigns that involved focus around calories as a child/teenager was incredibly unhelpful. Instead of encouraging a healthy lifestyle, it almost encouraged me to focus/obsess about every calorie I put in my mouth. All of a sudden, food became an enemy and not an enjoyable part of life.”

- Person with lived experience of an eating disorder

For those already experiencing an eating disorder, viewing foods in this black and white way is likely to exacerbate difficult thoughts and feelings, and fuel the illness. One aspect of treatment for an eating disorder commonly involves supporting the person to introduce foods that they are avoiding due to fears such as that the food will make them “fat” or lead to a binge. The person is instead encouraged to view food in a more balanced way with the idea that there are no inherently “good” or “bad” foods and that all foods are healthy if eaten in a balanced way. In particular, fats are important for brain development in children and young people. These anti-obesity campaigns are therefore directly contradicting this and instead encouraging an unhelpful and restrictive approach towards food. This is likely to increase an individual’s anxiety and guilt around eating certain foods, and could lead to an increase in eating disorder behaviours such as restricting, bingeing and purging.

School-based weight measurement programmes

The National Childhood Measurement Programme (NCMP) in England and Child Measurement Programme (CMP) in Wales were developed to help address and understand obesity, and to engage with children and families about weight issues (46,47). They involve measuring the height and weight of children

when they are in reception class (aged 4 to 5) and the NCMP also measures the child again in year six (aged 10 to 11). Parents are then sent a letter with the results of these measurements, including any recommendations based on whether they have been identified as “healthy weight”, “underweight”, “overweight” or “very overweight”. It is left up to the parents whether to share this information with the child. In Scotland, children’s weight and height are measured in Primary 1 as part of the Child Health Systems Programme School. However, there is no standard approach to the programme, so therefore there is variation across Health Boards.

Despite operational guidance in England and Wales (48,49) outlining clear procedures for how this process is undertaken, anecdotal evidence suggests that these guidelines are frequently disregarded. For example, children may be weighed in front of others rather than in a private space, results shared with the child and other children in the class rather than with just with the child’s parents, and children are being given the letter to take home themselves rather than it being posted. Additionally, contrary to the guidance that stigmatising terms such as “obese”, “fat” and “morbidly obese” should be avoided, the letter that is received by parents outlining these results is sometimes referred to by children and adults as “the fat letter”. Many clinicians have shared with Beat how receiving this information and the process of the childhood weighing programme has triggered restrictive eating patterns, which has then developed into an eating disorder.

“Every year the CAMHS eating disorder team will see a number of referrals where the young person has either misinterpreted anti-obesity messages or has been advised to seek help after the NCMP and this has been taken very literally, triggering them to develop an eating disorder.”

- Clinical dietitian

“I remember being weighed at primary school and feeling as though I would be frowned upon if I wasn’t at a healthy BMI. Everyone spoke about their weight afterwards. To me, it just doesn’t seem like a healthy thing for children to discuss.”

- Person with lived experience of an eating disorder

“I had no qualms about showing my daughter the letter as she was on 52nd percentile, which I’m sure would be the case with most parents. What I hadn’t bargained for was her response that she was obviously overweight and needed to get below the 50% line - completely out of the blue. It never occurred to me in any way that it would be a problem. I realise that if that if the

weigh-in hadn't set her off it's likely that something else would have - it's just a lot of parents say the same thing."

- Mother of a daughter with lived experience of an eating disorder

Research by Nnyanzi (50) into the impact of the NCMP found that children, especially those who are a "healthy weight" were often happy to take part in the programme, due to curiosity around their height and weight. However, prior to being measured, many children expressed feelings of anxiety and worry. Following being measured, most children were increasingly curious about their measurements, with some urging their parents to buy them scales so they could monitor their own weight. For some children this curiosity reduced over time. However, for others, anxiety over knowing their weight remained high, particularly if they perceived themselves to have weight issues. Among children told their measurements, Nnyanzi (50) found that those identified as "obese" or "overweight" reported thinking about this a lot and feeling anxious about not knowing how to change it. A study by Hunger and Tomiyama (51) found that being labelled as "too fat" results in unhealthy weight control behaviours and disordered eating cognitions regardless of the person's actual weight. This preoccupation with weight and feelings of body dissatisfaction has also been linked with depressive symptoms (52).

Similarly, a number of parents have expressed concerns over the wording of the letter they received, with concerns that scare tactics were being used (53) or that it could change their child's positive relationship with food (50). This concern from parents reinforces the notion that the programme could inadvertently be harmful to the wellbeing of children. Although some parents expressed finding the letter they received following the measurements helpful, often this did not lead to behaviour change. For example, a third of parents surveyed stated that they planned to change family behaviours following receiving the letter. However, when interviewed, very few had implemented any changes (53). Beat's conclusion is that the programme achieves little or nothing in its aim of reducing obesity, but that it does pose a significant risk to those vulnerable to eating disorders.

Recommendations

Rather than campaigns that are shaming towards people with obesity and fail to consider their potential impact on those vulnerable to developing an eating disorder or currently experiencing an eating disorder, a more holistic and integrated approach is needed. This integrated approach has been taken in Australia, with policy makers meeting with senior researchers and clinicians in the eating disorder field to seek advice on how to reduce the risks of any unintended consequences of their campaigns, such as exacerbating eating disorder symptoms and behaviours (54,55).

We call for:

1. Professionals from the eating disorder and weight management fields to work together to design evidence-based campaigns which view obesity as a complex interaction between several factors, rather than an individual's choice or something to be ashamed of.
2. Campaigns to follow the principle of "first, do no harm", and to be subject to an assessment of the potential they have to trigger eating disorders.
3. Campaigns to shift away from being weight-focused and weight-shaming, to those which focus on positive behaviour changes and improving self-esteem, as outlined in the literature. (A review of the evidence around this is outside of the remit of this paper, but see papers such as those by Puhl and Heuer (28); Puhl, Peterson & Luedicke (29); Simpson et al. (56); Lewis et al. (30).)
4. Policy makers to be mindful of the language that is used when discussing weight, shape, food or exercise, due to the potential for this to promote the thin-ideal, body dissatisfaction and calorie restriction.
5. Public Health England and Public Health Wales to acknowledge that their childhood measurement programmes are exacerbating the risk of eating disorders among children and to either abandon them or revise them into a format that avoids that risk.
6. Public Health Scotland to provide guidance to Health Boards on how to implement their childhood measurement programmes in a way that avoids exacerbating the risk of eating disorders, or to abandon them.
7. In the meantime, schools should ensure that the guidelines on implementing the childhood measurement programmes are rigorously followed.

Conclusion

Current approaches to anti-obesity campaigns appear to be largely ineffective in reducing obesity at a population level. However, they are putting those vulnerable to developing an eating disorder or those currently experiencing an eating disorder at risk. Therefore, they have potentially fatal consequences.

Immediate action is needed to review and adapt current approaches to anti-obesity campaigns which promote weight stigma and encourage restrictive behaviours. We call for public health bodies to stop developing campaigns which are putting lives at risk and instead take a more integrated approach, with professionals working in the fields of both eating disorders and obesity collaborating to consider the evidence around developing an effective campaign and any risks this could pose. Furthermore, it is unacceptable to keep ignoring the voices of people living with obesity and eating disorders who are expressing distress over these campaigns; these people's views should be sought and listened to, and campaigns co-produced with those with lived experience of eating disorders and obesity.

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