

PUBLIC COMMENTS ON DRAFT VERSION OF GUIDELINE AND PANEL’S RESPONSES TO COMMENTS

Guideline Development Panel for Obesity

American Psychological Association

September 5 – November 5, 2017

General Panel Response to Comments

The panel carefully reviewed and discussed all of the comments received during the public comment process. Several themes were noted and the panel wrote a general response to each theme and modified the document accordingly. Specific responses are noted for individual comments as well.

The panel recognizes that many commenters raised concerns about the possibility of behavioral intervention for overweight and obesity leading to feelings of shame and stigma and later development of disordered eating. Based on the available evidence, the panel is not convinced that these outcomes will occur as a result of intervention and believe that the risk of not intervening is higher in terms of the risks for a variety of health conditions that are linked to overweight and obesity. Furthermore, the implementation of high quality programs by trained interventionists is critical. Skilled providers should be attuned to issues of stigma and have greater ability to sensitively discuss size and weight with families and determine together an appropriate plan. Additionally, well considered programs do not emphasize weight loss but do emphasize health promoting behaviors such as increased consumption of fruits and vegetables, reduction in consumption of sugary drinks, and enjoyment of physical activity. Like many commenters, panel members are concerned by the frequency with which health care providers add to the stigma and shame experienced by individuals with overweight and obesity and believe all care providers should have training in when and how to have helpful conversations. Lastly, families choose whether to pursue behavioral care for overweight and obesity and regardless of their choice, it should be emphasized that providers should continue to provide health care with sensitivity. Implementation guidance for this guideline will include materials to address these matters.

Another set of comments focused on the possibility that behavioral weight management programs may induce eating disorders and other harms. Regarding benefits and potential harms, it is important to clarify that behavioral weight loss interventions for the treatment of obesity and overweight have been shown to be associated with not only improvements in weight status but also improvements in other physiological and behavioral health-related outcomes with a lack of evidence of harms. For example, these interventions have been shown to be associated with improvements in cardiometabolic outcomes (e.g., blood pressure, glucose, lipids) in children (O’Connor et al., 2017), as well as improved diet quality (Hayes et al., 2016), physical activity (Unick et al., 2011), and sleep (Martin et al., 2016) in adults. Moreover, behavioral weight loss interventions for both children and adults may have psychosocial benefits, such as improved quality of life (Fullerton et al., 2007; Rank et al., 2014; Williamson et al., 2009), reduction in depressive symptoms (Gunnarsdottir et al., 2014; Edwards et al., 2006; Fabricatore et al., 2011), and improvement in binge eating (Teder et al., 2013; Gorin et al., 2008). One common concern for behavioral interventions for the treatment of obesity and overweight in children and adolescents is that “dieting”, particularly in children, may increase risk for eating disorder

symptoms; however, in family-based multicomponent behavioral interventions that focus on healthy eating and activity behaviors, eating disorder pathology is either not affected or it is decreased (Balantekin et al., 2017; Macpherson-Sanchez, 2015). Reductions in eating disorder symptomology may be due to active treatment components, such as promotion of flexible and moderate dietary restriction, regular eating patterns, gradual weight loss, and encouragement of social network support (Goldschmidt & Wilfley, 2008). Furthermore, research has shown that among children who completed a multicomponent family-based behavioral intervention for the treatment of obesity, a social facilitation weight maintenance intervention was associated with improved weight outcomes for children with initially higher eating pathology relative to behavioral skills maintenance treatment or no maintenance treatment (Goldschmidt et al. 2014), suggesting that multicomponent family-based behavioral interventions that focus on improving overall social functioning (e.g., positive responding to teasing, encouragement to engage in more social or peer-based activities) and garnering social support for healthy lifestyle choices, are particularly well suited to children and adolescents with both obesity/overweight and eating concerns.

Overall, concerns that healthy weight loss/maintenance interventions induce eating disorders in individuals with overweight or obesity are generally not supported by empirical studies (Butryn & Wadden, 2005). Indeed, studies indicate that adolescents who have internalized a thin-ideal body shape (and thus might be considered at highest risk for development of an eating disorder) and who participate in a program focused on achieving a healthy weight have significantly reduced binge eating in comparison to girls in control conditions, suggesting that a lifestyle intervention focused on achieving a healthy weight is a beneficial treatment for those at risk of an eating disorder (Stice et al., 2006). Furthermore, while adverse events are uncommon among youth in a comprehensive behavioral weight control program (O'Connor et al., 2017), frequent monitoring of critical domains promotes early identification of potential adverse events, such as rapid weight loss and increased eating disorder pathology, which can then be addressed. Finally, it is important to clarify that family-based multicomponent behavioral interventions involve the whole family working to establish and maintain healthy eating and activity habits and that the child with overweight/obesity is never singled out. Indeed, by altering the shared home environment and modeling positive health behaviors, parents and children exhibit shared changes to the balance of ingestive behaviors (caloric intake) and physical activity that are subsequently associated with highly similar patterns of weight loss and weight maintenance (Best et al., 2016; Wilfley et al., 2017; Wrotniak, Epstein, Paluch, & Roemmich, 2005).

Citations

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Public Comments

General/Full Guideline Comments

Commenter: Catherine Bell; kate@drcatherinebell.com

Comment: As a psychologist, and a longtime provider of treatment to individuals with eating disorders, and a mother, I would like to urge the committee to consider:

1. The weakness of BMI as a screening variable (e.g., Tomiyama, Hunger, Nguyen-Cuu, and Wells, 2016);
2. The possibility that the pursuit of weight loss via dietary restriction in childhood is a cause of increased adiposity in adults, which in turn promotes weight cycling and the possible associated risks of same;
3. The paucity of evidence for the long-term (e.g., 5+ years) efficacy of any weight reduction intervention; and,
4. The extensive conflicts of interest listed among the members of the committee (e.g., Weight Watchers, weight loss centers, social and professional networks that promote the assumption that weight loss is a desirable outcome for everyone above a certain BMI).

The notions that adiposity is always undesirable, that it is the cause of illness, and that it should be addressed through lifestyle changes, are antiquated and have not led us any closer to a thin or healthy society. Consider the Health At Every Size intervention proposed by Bacon and Aphramor (2011), in which the authors promote a more interoceptive and ego-syntonic approach to health management that is not weight-focused. A paradigm shift is indeed called for.

Panel response

Please see later panel response on BMI. Please note multicomponent family interventions are typically not focused on caloric restriction and weight loss but rather on improving nutritional patterns and reducing zBMI as the child grows. A more elaborated description of treatment components has been included in the guideline and access to intervention protocols will be promoted as the guideline is implemented so that providers are aware of the breadth of the intervention.

Several commenters have raised concerns about conflicts of interest. All panel members completed an extensive conflict of interest disclosure form (available upon request) and potential conflicts were discussed at meetings. No panel member stands to gain financially by the recommendations. Panel members do endorse the link between overweight/ obesity and risk for other health conditions and the possibility of reducing risk by improving health behaviors and reducing weight.

Commenter: Aimee Schiefelbein, M.A., LMHC; inbodymentcounseling@gmail.com

Comment: I strongly recommend you rethink this position:

The basic premise of recommending an intervention if there is evidence of weight change at 12 months out is a farce. It does not answer the "key question #1" of whether the interventions "produce and maintain" change.

2. The lack of data is profound — as you admit, even the studies they have lack information about which demographic groups are included.

3. The studies that show a 12-month $-.26z$ BMI change are in children (not adolescents), which is why you urge intervention "as early as possible." But they make the recommendation for adolescents also.

4. Because BMI in children is not just height and weight but also age, there is a time component which means kids growing faster have higher BMI, and restriction of food is likely to slow their growth, which lowers their BMI whether there is a loss of fat or muscle or just a pause. No way to tell what the data are even showing.

5. The "lack of evidence" for harms is taken as evidence that there are not harms — otherwise, how can you strongly recommend intervention?

6. No one has defined residual disordered eating, anxiety about weight, frank eating disorders, avoidance of exercise after being traumatized with trying to lose weight, higher eventual weight, or weight cycling as "harms" - and they do not require data past 12 months to look for those harms. In fact they rule out studies with kids with disordered eating. No one is asking about this.

7. The report urges people providing interventions to be educated about weight stigma but fails to understand that intervening itself under these conditions is stigmatizing.

8. The Conflicts of Interest section detailing how they came up with this set of "experts" rules out people "with strong intellectual points of view" saying they would not be "objective" but rules in people who have ties to industry and pharma.

9. There is racist content about parents not knowing their kids are fat "due to cultural reasons" - being "uninformed" and needing the "objectivity" of the healthcare system.

10. There is a great line on p. 47, line 16, that the evidence pertains to kids in the 98th percentile but don't know about kids even in the 95th percentile, let alone the 85th percentile. BUT the recommendation is for kids 85th percentile and up. Also note that the change in zBMI score of $-.26$ at this level means a kid is going from (at most) the 99th to the 98th percentile and this is deemed desirable and worth doing.

11. You use "person first language" and "obesity" as a condition/disease, which is not taking into account the whole person.

12. At least it's said nothing else is really knowable. But neither is the recommendation.

You can see that $-.26$ (the supposed BMI change as a z-score) is something that is so small at the 98th percentile and up that it would not necessarily even move you out of the percentile.

This is a parallel to the bogus claim that "even 3% of weight loss can be clinically significant" which is where the "obesity experts" inevitably end up because weight loss that the average person would consider meaningful is so elusive. Clinically significant changes happen with no weight loss at all, but

that would blow the whole paradigm. I would also like to point out that with such small losses, higher weight people can produce them on demand for the weigh-in, and what we are actually seeing is mild weight-cycling.

The studies with less than 26 intervention hours were even less convincing, so the recommendation to make the most of the ones that have more hours, but there is no broad evidence justifying the recommendation.”

So, to summarize, an APA group that ruled out people with “strong feelings” about this topic, but accepted people with ties to industry and pharma, has recommended that families pay for 26 hours of therapy if their kid is a certain size regardless of the child’s actual mental health.

They have no reason to believe that this will make the children healthier or thinner. They have no idea what harm this intervention could do including to the health of growing children, those predisposed to disordered eating and eating disorders.

Panel Response

The commenter raised several points that are addressed elsewhere in this response document.

The panel did note the limited evidence for many key issues raised in the guideline and believes that much more research is warranted. However, the panel does believe there is sufficient evidence for its primary recommendation as well as a tremendous need for additional data on other possible outcomes, including harms.

Per comment #9, the panel has revised the document.

Commenter: Marci Evans; marci@marcird.com

Comment: I have no doubt that a team of extremely intelligent individuals worked on this guideline. But it is absolutely beyond me, how a team could develop a set of guidelines that have literally ZERO research to back its efficacy. Please consider the thousands of studies that prove that a weight-focused approach to health is at best, ineffective and at worst downright harmful. Drop the weight loss agenda. It's futile. We have decades of research showing it literally worsens every single issue you are trying to treat via weight loss. Please consider an inclusive, non-harmful intervention that focuses on health-promoting behaviors for ALL children. You may want to consider the work by the AAP for guidance.

<http://pediatrics.aappublications.org/content/early/2016/08/18/peds.2016-1649>

Panel Response

The panel agrees that the American Academy of Pediatrics has developed very helpful guidance for intervention. This guidance is directed at all pediatricians working in primary care settings and complements the recommendation of this guideline which addresses focused, intensive intervention. All children, adolescents and adults would likely benefit from increased emphasis on health promoting behaviors of proper nutrition, adequate activity and sleep, as well as supportive, healthy relationships and enjoyable leisure activities. Multicomponent family interventions are built on health promoting behaviors that are delivered in a more intensive, individualized format. These interventions are not focused solely on weight loss but are focused on increasing healthy

behaviors. However, in studies, typically BMI is used as the primary outcome which the panel acknowledges is insufficient.

Commenter: Kelly C. Berg, Ph.D.; berx143@umn.edu

Comment: After taking a look at the full APA report, there are some clear gaps in the literature.

1. Importantly, there is no information on the potential harms of the proposed guidelines and the only reported benefit is an average 1/4 zBMI loss.
2. There is no information provided on other physical or psychological health benefits.
3. There is very little information about what the intervention should include aside from it including the family and being multifaceted.
4. There is no information about which children would most benefit or whether there are any contraindications for this type of intervention.

Thus, it's fairly shocking to me that the APA has decided to contradict the American Academy of Pediatrics with such a dearth of clinically useful data.

To their credit, the authors of the report do acknowledge the harms associated with weight bias, weight stigma, and weight dissatisfaction; however, their proposed solution is to provide the intervention in a non-judgmental manner. What the authors failed to acknowledge is the fact that the guidelines themselves are inherently biased because the inclusion criteria are entirely based on weight and the outcomes are entirely based on weight. When you are singled out because of weight and your success or failure is based on weight changes, the system has institutionalized weight bias, weight stigma, and weight dissatisfaction.

Panel Response

Regarding points 1, 2 and 4- these are deficits of the research. The systematic review attempted to address these questions and the research data are quite limited. Reporting a greater range of possible outcomes and reporting all harms is necessary for future research. In the absence of adequate information about which children are likely to benefit from intervention, the panel opted to not place restrictions, other than to note that the interventions were not studied in children and adolescents with known eating disorders. The panel has noted this more obviously in the document. Further description of the intervention (point 3) has been added to the document. Having reviewed recent policy documents from the American Academy of Pediatrics, the panel believes its recommendations are consistent with the 2017 AAP document on weight stigma and the 2016 policy on preventing obesity and eating disorders in adolescents.

Commenter: Eleanor Mackey; emackey@childrensnational.org

Comment: As a psychologist working for a decade in weight management and the treatment of children and adolescents with obesity, I would like to commend the group for their outstanding efforts and well-written and thorough document. The process with which the review was conducted was very high quality and conclusions appropriate for the existing literature. Guidelines for new research needed to

move treatment guidelines forward were also very useful and practical and will hopefully inform funding agencies to create opportunities to answer these essential questions.

Panel Response.

Thank you.

Commenter: Lucia Gutierrez, Staff Liaison; lgutierrez@apa.org

Comment: The APA Policy and Planning Board (P&P) reviewed the draft APA Clinical Practice Guideline for the Behavioral Treatment of Obesity and Overweight in Children and Adolescents and concluded that, from a policy stand point, they meet the expected structure for APA practice guidelines with proper definitions of what a guide is, and is not. That is, per APA rules, guidelines are noted as "aspirational." And that "Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation." Further, the process of review also meets APA's policy rules. Thus, at this point in time they are appropriate for content review by the Association and governance.

P&P had no content experts in this area on our board. Thus, we defer the discussion of content to identified experts providing feedback to the review and governance process.

Commenter: Harriet Brown; harriet@harrietbrown.com

Comment: I have many objections to this recommendation, starting with the fact that it is based on assumptions rather than on strong data. They assume that dieting and pushing kids to lose weight is a benign process, one that can confer benefits and do no harm. Neither of those assumptions is borne out by data. For instance, these guidelines define success here as both a minuscule and short-term shift in children's weight. Whereas there is much evidence that a) most people do not sustain weight loss after three years, and that b) weight instability is linked to numerous important health risks. The kind of weight cycling that happens when people work to lose weight is dangerous both for physical health and mental health. We cannot assume that trying to lose weight is a benign process.

We also cannot assume that losing weight improves health. It may be true that people with lower BMIs have fewer health problems, though the jury is still out on that. Even if it is true, though, there is no evidence suggesting that for higher-weight people, losing weight shifts their health risks. In fact on the contrary, for higher-weight people with chronic diseases (type 2 diabetes, heart disease, etc) intentional weight loss seems to increase health risks and mortality.

Panel Response:

These issues have been broadly debated. The panel points to several studies, albeit primarily with adults, that support the premise that intentional weight loss, via healthy behaviors, is associated with positive health markers and that it is unintentional weight loss, typically associated with disease, that is associated with increased mortality risk and weight loss via unhealthy behaviors (e.g. skipping meals, diet pills) that is connected to later higher BMI. The panel notes that the recommended interventions promote healthy behaviors to lead to healthy weight and do not promote unhealthy behavior.

See:

MacLaughlin, H. L., Hall, W. L., Condry, J., Sanders, T. A., & Macdougall, I. C. (2015). Original Research: Participation in a Structured Weight Loss Program and All-Cause Mortality and Cardiovascular Morbidity in Obese Patients With Chronic Kidney Disease. *Journal Of Renal Nutrition*, 25472-479.

Neumark-Sztainer, D., Wall, M., Story, M., Standish, A. (2011). Dieting and Unhealthy Weight Control Behaviors During Adolescence: Associations With 10-Year Changes in Body Mass Index. *Journal of Adolescent Health* 50 (2012) 80–86.

Simone A., F., Aaron R., F., Robert W., J., & David F., W. (1999). Prospective Study of Intentionality of Weight Loss and Mortality in Older Women: The Iowa Women's Health Study. *American Journal of Epidemiology*, (6), 504.

Commenter: Stephanie Fitzpatrick; div38healthpolicycouncil@googlegroups.com

Comment: The Society for Health Psychology (APA Division 38) is pleased to see this draft of the APA Pediatric Obesity Treatment Guidelines. Obesity is a major public health epidemic and requires a multidisciplinary approach, including psychologists, to design and deliver effective treatments. Childhood obesity is of particular concern because of the increased risk for cardiovascular disease and diabetes later in adulthood. The Society for Health Psychology is overall in support of the recommendation that children and adolescents with overweight or obesity be offered family-based multicomponent behavioral interventions to combat childhood obesity. We are also in support of the call for more childhood obesity intervention research and the use of SMART and MOST designs to refine interventions. However, we have some concerns regarding the methods of the systematic review as well as limited details to support author conclusions. Below is a summary of these concerns and recommendations to strengthen the report.

1. Overall, we were surprised by the limited recommendations that were delivered in this manuscript. It is understandable if there is not data to support more. However, we are struck by the tone of the introduction when discussing limitations of past research. In the introduction, the authors place a strong emphasis on how previous meta-analyses and reviews have not adequately reported on a variety of potential moderators, mediators, etc. (child/family moderators, intervention strategies, and patient engagement), but then determine there was not enough evidence to report (draw conclusions) on any of these. Thus, we suggest reframing the introduction to highlight what is missing in the literature in a more objective manner.

Similarly, the introduction talks about how previous studies have included too much anecdotal comments from the authors, and the purpose of the current study is to make recommendations solely based on evidence. However, at the end, the authors also use anecdotal information when not enough evidence was found. We see nothing wrong with experts in the field reporting anecdotal findings; however, authors may want to remove the criticism of it in the introduction section.

Panel Response:

The panel appreciates the feedback and carefully reviewed the sections title ‘Scope of the Guideline’ and ‘Introduction to Topic’ and notes that prior systematic reviews and guidelines did not address moderators, mediators, etc in the Key Questions or recommendations. While the current systematic review that formed the basis for this guideline specifically did have Key Questions on mediators and moderators, the results again were not sufficient to inform recommendations. The panel then provides more discussion of this in the Future Research Needs section.

The panel does not believe its description of these guidelines conveys any sort of judgment; rather it is an effort to describe the state of the science and practice over the previous decades. Only recently have accepted best practices for guideline development emerged (see Institute of Medicine, 2011) and as such most previous guidelines have not been based on systematic reviews.

2. What about necessity of child involvement in treatment contacts?

- On page 31, the authors provided a recommendation under the section on potential burdens... “treatment requires two family members (parent and child).” Authors do not present data to support this conclusion. While there may not be enough evidence/support to conclude that parent-only behavioral lifestyle interventionists are as efficacious as parent+child interventions, there are no data to support a conclusion that they are less effective. If such data exist, the authors should present this data to support conclusions drawn.

Panel Response:

The panel returned to their systematic review to respond to this comment. Table 21 of the Kaiser review is the Evidence Profile for Key Question 2a. The authors note that parent modeling was “more likely included in interventions targeting preschool and elementary-aged children... No clear association between child’s age category and use of parent skills training or offering parent only sessions.” Table 23 of the Kaiser review is the Evidence Profile for Key Question 3. The authors note “Evidence suggested no association between effect size and use of... parent-only, child-only or family sessions.” Of the 36 discrete RCTs included in the review, 5 were only parent focused and no interventions were child only.

While the preference in practice appears to be interventions involving both parent/carer and child, in light of the data, the panel is modifying the statement noted above to reflect more accurately the evidence base.

3. Prevalence obesity (page 5) - It would be helpful if the authors cited some numbers/percentages for extreme obesity, especially since they talk about implications of “more severe obesity” on page 6.

Panel Response:

The panel added some data on severe obesity to the ‘Overview of Problem, Healthcare Burden’ section.

4. What is the financial viability of these programs (cost-effectiveness research)?

- In the report, the authors talk about lobbying to increase coverage for behavioral family lifestyle interventions for childhood obesity. We agree that we should encourage advocacy; however, there is no related discussion of more studies looking at cost-effectiveness of behavioral family lifestyle interventions. To successfully advocate, it will help to have data demonstrating the cost-effectiveness of lifestyle interventions to help convince policy makers and payers. A call for additional cost effectiveness studies should be highlighted in this report as this is critical information that will be needed for lobbying.

Panel Response

Excellent point. Additional suggestions for research have been added to the document just prior to the conclusion.

5. There is a lack of information on generalizability of treatment and translation of behavioral family lifestyle interventions. We realize there is not much to evaluate, but the issue is mostly ignored. Who is delivering interventions? Training protocol for interventionists? What is feasible for organizations providing services? Financial feasibility? We realize there is limited quality data on translation, and the goal was not to include such studies or evaluate, but this is a critical issue that is often ignored.

Panel Response

The panel was quite interested in these questions but as noted the data is limited. The review did not find differences regarding qualifications of the interventionist. Materials supporting the guideline will address some of these intervention questions such as providing access to protocols, more detailed information regarding training and other matters necessary for successful implementation of a multicomponent behavioral intervention.

6. There is a lack of guidance for pediatric psychologists and pediatricians as to how to create a 26-hour program. How many sessions are needed (i.e., can a 2-3 day workshop be sufficient)?

Panel Response

Most studies offered multiple sessions over weeks although at least one reviewed study consisted of 2 8-hour workshops with additional physical activity sessions. However, this model of treatment delivery was not compared with the multiple sessions offered over weeks, thus it is not yet possible to determine whether these are comparable or whether one model is preferred.

7. Given the many barriers noted, especially for those from lower SES background, it would help to note the needed research on alternative treatment delivery formats. For barriers to low SES, the authors only suggested that providers be more flexible when scheduling in-person sessions (e.g., weekend appointments). However, more detail and recommendations are needed. For instance, technology/mHealth based interventions or providing maintenance counseling over the phone are additional options that should be mentioned.

Panel Response

The panel encourages development of creative solutions to potential barriers to care, especially when those solutions are documented and assessed to determine whether or not they indeed have a positive benefit.

8. We suggest reconsideration of use of the word “flexibility” when the authors outline that there is “insufficient evidence” about which strategies are responsible for improvement in behavioral family lifestyle interventions (e.g., “thus interventionists have ‘flexibility’ in strategies they use”). Definition of flexibility is “the ability to easily modify”.....seems too loose. We suggest the authors consider language such as “use their best judgment in matching different strategies with characteristics of the family and their situation...”

Panel Response

The panel agrees that ‘flexibility’ could be misconstrued and have since conveyed the suggestion that practitioners have flexibility in selecting specific intervention packages or, as noted, using their best judgment to match intervention components with characteristics of the family or situation.

9. Table 2 - A number of confidence intervals are pretty close to not including zero, especially those related to structure of meetings (group, individual, group + individual). It seems curious that these are not discussed as possible directions given the emphasis of trying to determine under which conditions behavioral family lifestyle interventions are most efficacious.

Panel Response

The panel notes that the data suggested either no bearing on efficacy or inconclusive evidence (see Table 23 of the systematic review) regarding whether to offer care in group sessions, family sessions or individual (single family) sessions and added a sentence to the implementation section indicating that this provides some opportunity to tailor delivery of care to local needs.

10. Methods questions:

- Pg. 22 says “no requests were made to the librarian to locate full text of missing articles.” Why is this?
- Seems contradictory to note that experts were chosen who are not “treatment developers,” yet there appears to be some authors who are... it certainly makes sense to include experts, but may want to be careful when describing criteria for who could be included in the working group drafting these guidelines. Same with community members who have had obesity and are active in their community to enhance public awareness/access to services. Might there be bias?

Panel Response

In reviewing content on harms and burdens, panels must cast a wide net to find any documentation of information in the literature. While the systematic review team provided some notation of harms and burdens in the review, it was limited. APA staff then located numerous articles and reviewed those for additional content. Due to resource constraints, the panel did not request the librarian to locate missing articles.

It is always possible that panel members carry biases to the process. For that reason, every panel member completed an extensive conflict of interest disclosure that assessed both financial and intellectual conflicts of interest. While some panel members have been involved with treatment

development, they are not uniquely identified with a particular treatment and allegiance to any particular method was assessed through the disclosure process.

11. Main outcome is that there is “strong support for family-based interventions with at least 26 contact hours initiated at the earliest possible age.” The age needs to be more clearly defined. The authors state that there is evidence supporting pre-school age behavior change but “earliest possible age” could mean infancy. There was no evidence reported to support this statement.

Panel Response

As noted in the scope of the guideline, the review and recommendations are relevant to children and adolescents between the ages of 2 and 18 years. This is now noted in the statement itself.

Signed by:

The Society for Health Psychology (SfHP), APA Division 38 and the SfHP Health Policy Council

Justin Nash, PhD, President

Dawn K. Wilson, PhD, Past-President

Nancy B. Ruddy, PhD, ABPP, President-Elect

Jennifer Warnick, M.S., Health Policy Council Student Liaison

David Janicke, PhD, ABPP, SfHP Member

Panel Response

The panel appreciates the detailed and thoughtful comments from the Society for Health Psychology. The guideline document has been reviewed with each of these points in mind and has been modified accordingly and the panel believes the document has been improved.

Commenter: Bethany Teachman *on behalf of* the APA Clinical Treatment Guidelines Advisory Steering Committee; CTGASC@LISTS.APA.ORG

Comment: A big thank you to the panel and APA staff for their continued great work on this document. I think this version of the guideline document is much stronger, and the writing is clear and its contribution clarified. The inclusion of tables like Table 3 that lay out the considered intervention components are especially helpful. It is exciting to see the full draft out for public comment and I truly appreciate the panel’s care in this process. A couple final comments/suggestions follow (please let me know if my feedback isn’t clear and happy to discuss any of these comments):

I think it’s important to make sure the language is really clear about the flexibility providers have in choosing which of the tested treatment packages they select, given that there was not evidence for one subset of specific components over another. At times, the language may be confusing to readers and inadvertently imply more flexibility than intended. For instance, on p. ES-4, it says “Within this framework which includes all components, providers have flexibility in the specific strategies used to accomplish change.” I understand what is meant, but I think it will be clearer to say “Within this set of

intervention packages that include all components, providers have flexibility in the specific package used to accomplish change.” As a second example, on p. 32, I think readers could be confused by the comment “practitioners have a fair amount of flexibility when choosing specific elements or mode of delivery within the areas of physical activity, nutrition, and behavioral change when implementing or developing new programs.” I was surprised by the reference to practitioners developing new programs. Perhaps simply reduce some of the text and link the above sentence to part of the following one: e.g., “practitioners have a fair amount of flexibility when choosing from one of the studied, efficacious intervention programs when offering care.”

On p. 25, I found it difficult to follow why the # of efficacy trials changed from 12 to 20 in the statements:

- Out of 12 efficacy trials for children or adolescents with overweight or obesity, family-based multicomponent behavioral interventions with 26 or more contact hours showed an average reduction of $-.27$ zBMI (95% confidence interval -0.38 - $-.16$) relative to non-active controls.
- Out of 24 efficacy and comparative effectiveness trials for children or adolescents with overweight or obesity, family-based multicomponent behavioral interventions with 26 or more contact hours achieved a zBMI reduction greater than or equal to -0.25 in 58.3% of the trials. These 20 efficacy trials provided moderate quality and these 4 comparative effectiveness trials provided low quality evidence of a medium effect.

Can the panel clarify how the statements are referencing different pools of studies?

Panel Response

The panel has modified its language related to flexibility to be clearer regarding provider decision making.

The panel reviewed these statements (now beginning on page 27) and attempted to provide more clarity. The panel encourages interested readers to also review the supporting evidence document or the decision grid (found here:

<http://apacustomout.apa.org/commentPracGuidelines/Practice/Grid%20for%20Obesity%20GDP%20Recommendations%20for%20posting.pdf>.)

Minor stylistic comments:

On p. ES-4, I found it difficult to follow the sentence “Further, the panel decided to focus on body mass index (BMI) and standardized BMI (zBMI), and not weight loss as some children may need to stop

gaining weight while continuing to grow to return to a healthy weight range, and serious adverse events as the critical outcomes.” Might break into 2 sentences.

Throughout, some acronyms are used before they have been written out (e.g., USPSTF), and/or an acronym will be written out multiple times so that the document shifts between writing USPSTF or United States Preventive Services Task Force (USPSTF) or United States Preventive Services Task Force. Other examples of acronyms not written out are in Footnote 3 on p. 12. Obviously this is minor but good to make sure all acronyms are written out first time, and then the acronyms are used consistently.

Thank you again to the panel!

Panel Response

The panel will attend to these stylistic issues in a final review.

Commenter: Monica L. Wang *on behalf of* the Society of Behavioral Medicine; mlwang@bu.edu

Comment: The Society of Behavioral Medicine is overall in support of the recommendation of offering family-based multicomponent behavioral interventions to address overweight and obesity among children and adolescents. Below is a summary of questions and recommendations to consider for the final report.

Clarification on terminology

- Please provide additional information on the recommended level and type of engagement from parents/caregivers and children in order for an intervention to be considered “family-based”, and how this might vary by age range. For example, among preschool-age children, parents/caregivers may be the primary target group involved in the intervention, whereas among adolescents, a higher degree of child involvement may be more relevant and necessary. The evidence for including parents in *adolescent* obesity treatment is a bit unclear; it may also be worth noting this point somewhere in the document.
- The recommendation of supporting “family-based interventions with at least 26 contact hours initiated at the earliest possible age” is vague with respect to child age. Depending on the developmental age of the child and the requirements of family-based (see comment above), further specification of the child age range and supporting evidence is needed.

Intervention tailoring

- Please include discussion on the need for tailoring of intervention materials and messages by gender, given gender differences in meeting dietary and physical activity guidelines, particularly in early adolescence and adolescence.

Intervention dose

- In general, we suggest softening the recommendation of supporting interventions of at least 26 hours. This type of quantitative guideline tends to be based on the available evidence and how this evidence has been summarized, which may be a product of the quality (or lack thereof) of

the studies that are available. We suggest building in a little more flexibility into the hourly recommendation.

- As a corollary to the point above, please provide an indication of a recommended range and frequency with how contact hours should be best spaced out? For example, is it realistic to expect 3-4 day workshops with families to yield the same effect size and sustained behavior and weight loss as a weekly or monthly program?

Modality of intervention delivery

- Please comment on the possibility of using non-traditional intervention delivery modalities (e.g., technology-based, social media). This may be particularly salient in considering the time and cost burden for families to participate in family-based behavioral obesity interventions, particularly among socioeconomically disadvantaged and rural populations.

Potential for obesity interventions to yield multiple beneficial outcomes

- Though only intervention studies targeting youth populations with overweight and obesity were included in this draft report, it may be helpful to note that studies of childhood obesity prevention programs demonstrate potential in preventing obesity *and* disordered weight control behaviors among youth, particularly early adolescent females (Austin et al., 2012; Austin et al., 2007; Austin et al. 2005; Wang et al. 2011).
- To address concerns that weight management programs may lead to eating disorders among children and adolescents, it may be worth noting that eating disorder prevention trials have found that weight control programs for adolescent girls actually yield *reductions* in eating disorder symptomatology (Stice, Shaw, Burton, Wade, 2006; Stice, Trost, Chase, 2003).

Panel Response

The panel appreciates the support of the Society of Behavioral Medicine. The comments are very helpful, particularly in regards to implementation of the recommendation. To the extent that the systematic review addresses these issues, the panel has made an effort to comment in the guideline document. However, many of these issues do not have strong evidence to guide practice in a particular direction but are incredibly important factors to consider in implementation. To that end, the panel is requesting that APA develop implementation resources that address issues such as tailoring treatment by gender or age, consideration of dose and modality of delivery, etc. These will be valuable tools for implementation purposes.

Commenter: Megan Foley-Nicpon; megan-foley-nicpon@uiowa.edu

Comment: Thank you for all your work. The statement is very well-done and as a solid research basis. I would also consider noting this is a “medical model” approach to intervention. For example, the treatments seems to be missing the contextual and cultural factors that impact obesity. For example, it states, Adverse childhood experiences, such as abuse or exposure to violence, can also contribute to weight gain and should be considered. How? How specifically does a clinician do this?

For child and adolescent patients with overweight or obesity, the panel strongly recommends the provision of family-based multicomponent behavioral interventions, with a minimum of 26 contact hours, initiated at the earliest age possible.

I wonder how this overall recommendation can be made so strongly when evidence lacks regarding students of color. Also there are numerous instances where there is “insufficient evidence”, which I believe precludes making such a definitive statement. There also are social class issues inherent in recommending such an intervention, which would be incredibly challenging for lower income families to access because of multiple barriers.

These limitations to the data are all addressed quite well in the limitations / barriers section, but I just wonder how they also impact the strength of the statement made. I wonder if it is important to add a line about how obesity varies via disability status as well.

What should clinicians do if families encounter too many burdens? Is there a second choice? Can the treatment be altered? it seems like there is not enough evidence to recommend how modifications can be made given the lack of empirical evidence regarding effective components.

Panel Response:

The commenter raises several important issues that were beyond the evidence contained in the systematic review. The panel agrees that providers should have greater knowledge of the factors leading to overweight and obesity, including adverse childhood experiences and intervene regarding these factors as able. The panel was very interested in whether interventions were differentially effective for different groups of children/ adolescents and whether any documented modifications to interventions to adapt to different groups of children/ adolescents made a difference in outcomes but based on the limited evidence, the panel did not find differences in efficacy for these groups, nor did they find that cultural tailoring impacted treatment outcomes. Given that, the panel determined that making the general recommendation was important but in implementation expects that characteristics such as child gender, age, ability status and family culture will be considered. The panel hopes that when multicomponent family based interventions are delivered to diverse populations, a wide range of outcomes will be collected as well as appropriate documentation and reporting of any adaptations to the intervention so that future providers can learn from these experiences.

Commenter: Sandra Wartski, Psy.D.; sandra@wartski.org

Comment: As a psychologist who specializes in the treatment of Eating Disorders (EDs), I am very concerned about the current version of the Guidelines and feel they need considerable revision. There are numerous points to make, but a few highlights include:

- The current public health campaign of “The War on Obesity” ends up adding more detrimental layers to the already distorted crusade of attempting control of the body – not only for our clients but also for the general public. The “War on Obesity” may sound like the “War on Drugs” and the “Just Say No to Drugs” advertising campaign which was prevalent during the 1980s and 1990s; however, addressing eating and weight is a drastically different issue.
- ED clinicians have insider knowledge on how some of the conventional tactics for approaching with eating and bodies are not only ineffectual but downright damaging. They know that there are more effective, empowering, evidence-based strategies that can help individuals develop ?long-lasting ?habits of true healthful eating and positive body appreciation. ED Clinicians are uniquely positioned to provide valuable input and they need to be included on the panel!

- Intervention programs can end up providing a platform from which various adults might end up being encouraged to provide a form weight stigmatization in a very harmful way.
- Weight and BMI as indicators of health are inaccurate and misleading. Rather than focus on weight or BMI, which is a complex, multi-determined marker, can we not focus on other, more true markers of physical and emotional health?
- Children need to be compared to their own rates of growth rather than a statistical cut-off point, as this is what will allow a more accurate picture of whether there are concerns about significant weight changes for a child or not. Some people have larger bodies, are supposed to have larger bodies and are not unhealthy.
- There seem to be some inherent biases or assumptions that children who are not underweight are less likely to have EDs, and we know this to absolutely not be the case. Just as we can't assume that someone of larger body has an ED, we also can't assume that they don't.
- Children need not to be given more good/bad food labels (as our society does enough of this) or right/wrong exercise ideas; instead, they can be offered choices in a wide variety of foods, be urged to develop more of the intuitive eating abilities that are innate, and find activities they enjoy.
- There was reference tucked within the draft of the importance of treating larger sized children in a non-judgmental, non-stigmatizing manner. This needs further focus and elaboration.
- The panel has an opportunity to potentially -develop ground-breaking focus on very different ways to approach this situation, rather than do more of the same that hasn't worked.

I was actually inspired to write my monthly blog article for iaedp (International Association for Eating Disorder Professionals) on this draft and encouraged my ED clinician colleagues to also add their input into the comments. There is already some good feedback provided on the APA site, and I hope other ED clinicians will choose to provide some input as well. We have a responsibility to help educate the public and other clinicians about how weight loss interventions can and often do trigger ED behaviors and thinking. I am hoping we can help APA not support fat phobia and socially acceptable prejudice. Our country has made some progress in being more inclusive in diversity in other domains; we are overdue in the need to increase body diversity acceptance as well. To read the full article about these and additional thoughts on the draft guidelines, here is the link: <http://membershare.iaedp.com/op-ed-blog-by-sandra-wartski/>

Panel Response

Please see full response from panel at the beginning of this document on this topic (several commenters have raised this issue.)

Commenter: Carlyle Chan MD; cchan@mcw.edu

Comment: This is an excellent and very comprehensive literature review identifying and ranking the best evidenced based findings for the behavioral treatment of obesity and overweight children and

adolescents. Unfortunately, there were very few recommendations that could be made due to insufficient evidence, a reflection of current research in the field.

The panel is to be commended for delineating several points of methodological rigor and specificity that should be incorporated into future research in the field. They also identified specific variables that should be examined.

On page 24, it states that of 65 included trials, 36 were “efficacy trials” and 34 were classified as “comparative effectiveness” with “6 of the latter group also classified as efficacy trials due to including a control group”. Two of the 65 included trials were maintenance only interventions. The numbers here do not total correctly to the “65 included trials”. That is, if 2 trials are maintenance only, that leave 63 included trials. If 6 of the 34 comparative effectiveness trials were also classified as efficacy trials, that would seem to leave 28 comparative effectiveness trials to add to the 36 efficacy trials for a total of 64 trial.

On page 25, the statement of evidence rationale is also somewhat confusing. 40 efficacy and comparative effectiveness studies are cited as justification of the recommendation whereas on the previous page, only 34 trials were listed as efficacy and comparative effectiveness studies. More clarity in the wording of the rationales would be appreciated.

Panel Response

The panel appreciates the careful attention to the description of included trials (now beginning on page 26). One efficacy trial also had a maintenance arm and that data was reported and analyzed separately and accounts for the 65th study. On page 27, the 40 trials represent a total of some efficacy trials and some comparative effectiveness trials that met inclusion criteria for the particular analysis. More details can be found here:

<http://apacustomout.apa.org/commentPracGuidelines/Practice/Grid%20for%20Obesity%20GDP%20Recommendations%20for%20posting.pdf>. *The panel refers readers to the systematic review for more detail.*

Commenter: Elaine Hart; ehart@apa.org

Comment: COLI identified several concerns for the GDP to consider:

1. Given the insufficiency of evidence on numerous topics, and even within the one main recommendation (i.e., the inability to specify treatments by age, gender, race/ethnicity, and socioeconomic status), we wondered if the Guidelines were premature, and if they would be best offered after sufficient evidence has been gathered. We do appreciate the GDP’s inclusion of other agencies/associations guidelines on this topic and how their recommendations are and are not similar.
2. The term “systematic review” may be misleading and potentially inaccurate. For some, the term systematic review refers to something very specific, e.g., a meta-analysis.
3. The use of the word ‘recommend(ation)’ was unclear at times. There is one clear recommendation to emerge from the Panel’s work. On page 2 of the main document (after the Executive Summary), it is stated, “The Panel is unable to make recommendations on the following:”. This and the table that follows is clear. However, then beginning on page 24, there is a section entitled ‘Recommendations and Statement of Evidence.’ The first recommendation is fine; the ones that follow on pp. 27-29 that have

the heading Recommendation but are really not recommendations. Perhaps these headings should be changed to 'No Recommendation' for clarity.

4. The definitions of childhood overweight (> 85% BMI) and obesity (> 95% BMI) provided are helpful. However, the Executive Summary begins with the point that rates of childhood obesity have increased four-fold over five decades. Given that obesity is defined as relative to the population, a four-fold increase is confusing. The rate would always be 5% of the population. There are similar problems in the main document (p. 5). For example, how can 31.8% of children and adolescents (p. 5, lines 18-19) be overweight/obese given these definitions?

Panel Response

The panel was disappointed regarding the limited evidence; however, given that the United States Preventive Services Task Force is recommending that children and adolescents be screened for overweight and obesity and offered intensive behavioral interventions, the panel believes it is important to provide this guideline at this time to ensure that truly intensive interventions are offered (presently “intensive behavioral interventions” are often 6-10 15 minute sessions delivered by primary care providers but the USPSTF explicitly described appropriate interventions consistent with this guideline- 26+ contact hours involving family, nutrition, physical activity).

In the domain of clinical practice guideline development, systematic review does have very specific meaning. This is described in detail in the section “Comprehensive Search of the Professional Literature.”

The panel recognizes that only one recommendation actually provides specific direction and the other statements labeled as “recommendation” actually are statements indicating that the evidence base is insufficient to provide specific direction. This is an oddity in guideline language and the panel appreciates that this is not a natural use. However, in clinical practice guidelines, recommendations are those statements that are based on a systematic review of evidence and result in either strong or conditional statements in favor of or against an intervention or a statement that the evidence is insufficient to draw a conclusion.

A Body Mass Index (BMI) is a measure of body fat adjusted for height and is calculated by weight in kilograms divided by the square of the height in meters (kg/m^2). A BMI is considered an indirect measure of body fat that is meant to screen for overweight or obesity. What is considered a healthy BMI does not fluctuate with population weight; rather the proportion of individuals who exceed healthy BMI ranges does change. The panel has provided additional description of BMI in the document to clarify.

Commenter: Nabil El-Ghoroury; nel-ghoroury@apa.org

Comment: The APAGS Committee would like to recognize the extensive efforts spent in creating the draft, “APA Clinical Practice Guideline for the Behavioral Treatment of Obesity and Overweight in Children and Adolescents.” The practice guideline crafted by the APA guideline development panel appears to be comprehensive and rigorous. APAGS shares the following specific comments regarding reactions to this guideline and implications for further research efforts. Once these comments are incorporated, APAGS recommends full support of the guideline becoming APA policy.

APAGS views this guideline as an important step in the treatment of obesity. We recommend the inclusion of 1-3 sentences in the “Future Research Needs” section stating the fact that the impact of obesity treatment on psychological outcomes is largely unknown, given the paucity of research in this area. In addition, much of the current research suggests interventions with a minimum of 26 contact hours are beneficial in the short-term (e.g., weight improvements at 12 months). However, it is largely unknown whether these effects are durable over longer periods of time (e.g., weight improvements at 2 years, 5 years, 10 years). Therefore, future research should employ longitudinal study designs to address this question more directly. In particular, the longitudinal impact may differ between individuals on the basis of race, culture, ethnicity and socioeconomic class. For this reason, questions regarding the long-term efficacy must be considered within subpopulations.

Panel Response

The panel was very disappointed that psychosocial outcomes were not routinely reported in research studies and that little longitudinal outcomes are available. The panel agrees this is a pressing need, particularly in order to better serve a range of diverse subpopulations.

Commenter: Erlanger Turner, PhD; [Division 53 Diversity Committee](#)

Comment: The Diversity Committee of Division 53 (Society of Clinical Child and Adolescent Psychology) appreciates the work of the Guideline Development Panel for Obesity Treatment of the American Psychological Association in drafting the Clinical Practice Guideline for the Behavioral Treatment of Obesity and Overweight in Children and Adolescents. These guidelines have important implications for improving the health of youth and addressing health disparities. The following comments have been reviewed and approved by the Diversity Committee and Division 53 Board of Directors.

The guidelines sought to address several key questions, including how ethnicity/race impacts morbidity and treatment. However, the guidelines fall short with providing adequate recommendations to address the needs of youth from diverse backgrounds.

On page 37 (line 8), there is a reference to treatment barriers. With advances in technology and telehealth, it is recommended that language be added to encourage virtual visits or tele-health treatment when appropriate. In an article published in the Journal of Clinical Child & Adolescent Psychology (Altman & Wilfley, 2015), the authors note research that behavioral treatment delivered online is efficacious for addressing obesity in adolescents (particularly African Americans).

On page 28 and in the conclusions (p. ES-5), we agree with health care providers facilitating awareness and providing information in a non-judgmental way to parents. However, the guidelines should take into consideration the values of different families. It is recommended that psychoeducation on healthy eating and physical activity be communicated by encouraging a healthy lifestyle and not focused on weight loss.

Another concern is the lack of reference to obesity and sleep. Research has documented the influence of poor sleep on childhood obesity (e.g., Jarrin, McGrath, & Drake, 2013). Therefore, recommendations should be provided to address the role of sleep hygiene. This is particularly important for youth from diverse backgrounds that may be living in environments that directly or indirectly disrupt sleep.

Generally, the guidelines note insufficient evidence to make specific recommendations for subgroups of children or adolescents based on gender, race/ ethnicity, or socioeconomic status. We appreciate the guidelines highlighting the lack of research with respect to race/ethnicity and “cultural tailoring”. However, we believe that it is insufficient to not provide health providers with appropriate recommendations when working with youth from disadvantaged or ethnic groups. At minimum, the guidelines should reference current APA policy with respect to working with diverse groups. Specifically, it is recommended that the guidelines defer to the broader APA Ethical Guidelines, as well as, the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. The guidelines on Behavioral Treatment of Obesity and Overweight in Children and Adolescents, may include a statement to the effect of: Consistent with the broader APA guidelines, psychologists should consider not only differential diagnostic issues but also cultural beliefs and values of the clients and his/her community in providing intervention, and as such, are encouraged to do so in the behavioral treatment of obesity and overweight in youth.

References noted above:

Altman, M., & Wilfley, D. E. (2015). Evidence update on the treatment of overweight and obesity in children and adolescents. *Journal of Clinical Child & Adolescent Psychology*, 44(4), 521-537.

Jarrin, D. C., McGrath, J. J., & Drake, C. L. (2013). Beyond sleep duration: distinct sleep dimensions are associated with obesity in children and adolescents. *International Journal of Obesity*, 37(4), 552-558.

Panel Response

The panel shares the concerns regarding lack of data for diverse populations and agrees much more is needed. However, given that the systematic review which served as the evidence base for this guideline did not provide such information, the panel is not able to make specific recommendations. However, it is expected that psychologists are familiar with and utilize other APA guidelines and standards when delivering care. These issues are particularly important in the implementation of the guideline and can be referenced in materials intended to support implementation.

Sleep has been shown to be linked to overweight and obesity and for overall health, providers are encouraged to address matters such as sleep hygiene with all clients, including those with overweight and obesity. The panel did not evaluate whether or not family based multicomponent interventions included guidance on sleep but agree this could be important to address in treatment.

The panel has added a statement about the possible use of technology to facilitate access to care.

Once again, the panel notes that these interventions are principally focused on healthy behaviors (such as healthy food selection and increased physical activity) and not focused on weight loss, which can actually be inappropriate in growing children.

The guideline already references the fact that numerous patient characteristics should be considered when implementing the intervention. This will be further elaborated in resource materials developed to support use of this guideline.

Commenter: Board for the Advancement of Psychology in the Public Interest (BAPPI)

Comment: BAPPI has reviewed the Guidelines for Behavioral Treatment of Obesity and commends the authors for a thorough review of the literature on the treatment of overweight/obesity in children. The overall tone is positive. For example, the way the authors referred to “children with obesity” rather than “obese children.” BAPPI suggests that using the designation “children with a BMI >30” as a possible alternative to “obesity” would go even further in eliminating stigmatization. The Board did, however, note a number of significant omissions in this Report. The authors indicate that there is insufficient evidence to address disparities due to race/ethnicity or SES. However, the physiological effects of discrimination based on both race/ethnicity and SES. Psychoneuroimmunology research has clearly shown that perceived discrimination raises insulin, insulin resistance, abdominal obesity, and BMI. It’s in the.

In addition, there is no reference to the impact of historic traumas. There is evidence that past intergenerational trauma varies based on race and ethnicity at epidemic levels.

There is a preponderance of evidence showing a strong relationship between ethnicity/SES status and sleep, the lack of which correlates with insulin resistance and weight gain. Addressing only BMI is insufficient unless the impact of discrimination on the underlying inflammatory processes are also eliminated.

Diet is not the only factor that causes susceptibility to weight gain. While a healthy diet does make a difference, there is much more to understanding the true nature that unique cultural mores can have on efforts to eradicate obesity. The authors have failed to mention the impact of childhood trauma and adversity, about which there is extensive literature. Children with a history of physical or sexual abuse are more prone to insulin resistance, sleep problems, and substantial weight gain. This is not just a behavioral issue. There is an underlying physiology that needs to be addressed (including treating depression and PTSD). Often, children with the most threatening weight levels (the ones who may get invasive weight loss surgery) have a history of substantial trauma. It is of concern that APA has failed to adequately address this issue, particularly since a BAPPI member was part of the expert working group on BMI and childhood adversity for the Office of Women’s Health last year.

Bullying was included from the perspective of children are bullied more often when they are overweight or obese, however, there was no mention of how those who experience weight bias are more prone to inflammatory conditions, insulin resistance. and additional health concerns. A number of studies done with adults have shown that shaming, threatening social interactions, including those with health care providers, can be a cause of weight gain.

The report does little to illuminate how changing environments can be just as critical as changing the behavior of the children.

It seems that the authors chose to exclude studies that used waist circumference as a measure of obesity rather than BMI. There are many who argue that the former is a more accurate predictor of health outcomes. While the Board did not feel that this should be included in the report in conjunction with the BMI analyses it is often a key measure in studies race/ethnicity.

BAPPI members expressed concern regarding what they determined to be the narrow scope of the report. The primary focus on behavioral interventions (diet and exercise), with little understanding of the physiological processes that may make certain groups more prone to weight gain is a major omission. BAPPI commends the group on addressing issues of patient preference and values. However, the important consideration of community support for interventions seems to be missing. Often, researchers and practitioners enter communities with the preconceived notion that the “problem” lies with the target group. Successful engagement is much more likely when communities are involved and have input prior to the implementation of a program.

Panel Response

The determinants of obesity are important but were beyond the scope of the panel’s work. It is expected that providers have some knowledge of these issues and utilize that information when providing care.

The panel agrees that modifying environments that contribute to obesity is essential for overall population health. However, the scope of this particular document is in regards to behavioral management for obesity and overweight so any focus on changing environments will be part of focused behavioral treatment regarding identifying and utilizing safe places for physical activity and healthy sources of nutritious food, rather than on efforts to enact broader scale environmental change (such as advocacy for creation of sidewalks and parks.)

The panel appreciates the suggestion to eliminate use of the term obesity altogether but determined to not use BMI > 30 as an alternative. Additionally, waist circumference is an important measure but infrequently reported in the research literature.

The panel agrees that successful implementation of any intervention is more likely when communities are involved. It is expected that providers/ systems seeking to offer new programs for weight management will assess the local needs and plan implementation accordingly.

“Healthy At Every Size,” Body Acceptance, and Health-Oriented Approaches

Panel Response

Numerous commenters provided feedback indicating that offering any intervention for weight management is problematic and asserts that doing is inherently stigmatizing. The panel agrees that poorly implemented interventions have the potential to be harmful and that efforts that contribute to shaming and stigma should cease. However, the panel also asserts that properly trained providers have the potential to offer services to those who want assistance in behavioral weight management and those trained providers can do so in a way that is supportive and encouraging, not shaming and stigmatizing. Behavioral interventions emphasize healthy habits, not body size, and incorporate opportunities to teach parents and other caregivers healthy body messages and other positive communication all of which is consistent with a health oriented approach as described by some commenters. The panel stands by its recommendations.

Commenter: Sarah Hoffert; Sehoffert@mail.widener.edu

Comment: This is in regards to the draft APA guidelines on obesity treatment. The suggestions if you were to be ineffective, harmful, and stigmatizing for children (and the general public). Please consider looking at the Health at Every Size movement HAEScommunity.org. I believe what you were trying to do is positive but it's being implemented in a really shaming way. Please consider the intent versus the impact.

Sarah Hoffert

PhD Student, Human Sexuality & Member of the nonprofit community

Commenter: Alexandra Vriend; Lexievriend@gmail.com

Comment: We can do better than this. Recommending interventions for children who are labeled "overweight" and "obese" is inherently stigmatizing. We need to do much more research into the long-term detrimental effects that pushing for weight loss causes in children such as weight-cycling, interference in physical growth, disordered eating, the emotional damage of shame regarded with weight stigma, and so much more. Please reconsider Health At Every Size (HAES) models before deepening the grip of fatphobia in our society. The implications of recommending weight interventions in young children are disastrous.

Commenter: Eetexpert; secretariaat@eetexpert.be

Comment: Key question nr. 1 of the guideline is "do family –multicomponent behavioral interventions reduce and maintain change in standardized BMI testifies to a weight-focused approach on obesity treatment". We would like to suggest a health-oriented approach, as delineated in the Northern Health Position Paper (2012), where treatment is focused on healthy lifestyle to improve health (on several levels: medical, mechanical, psychological), and where weight reduction is a possible outcome but not a treatment goal in itself. In this regard, literature on the Edmonton Obesity Staging System (EOSS) and the EOSS-P (for Pediatrics) is useful. A health-oriented approach also takes into account possible "side-effects" of obesity treatment regarding eating disorder risk.

References are:

Hadjiyannakis, S., Buchholz, A., Chanoine, J.-P., Jetha, M. M., Gaboury, L., Hamilton, J., . . . Ball, G. (2016). The Edmonton Obesity Staging System for Pediatrics: A proposed clinical staging system for paediatric obesity. *Paediatrics and Child Health*, 21, 21-26.

Kuk, J. L., Ardern, C. I., Church, T. S., Sharma, A. M., Padwal, R., Sui, X., & Blair, S. N. (2011). Edmonton Obesity Staging System: association with weight history and mortality risk. *Applied Physiology, Nutrition, and Metabolism*, 36, 570–576.

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Panel Response

Please note the recommended family based multicomponent interventions also focus on a healthy lifestyle with the goal of improved health, however BMI is the frequently reported proxy in research studies.

Commenter: Lauren Canonico; laurencclsw@gmail.com

Comment: I am extremely concerned at the massive leaps taken in this draft. This is essentially promoting poorly researched interventions that equate to little more than fat shaming children.

Please review the following research which directly contradicts the recommendations made in this draft, along with suggestions on practices which you will find to be quite strongly correlated with more positive health outcomes. Actual health, not just size. Size is not the only, nor the most reliable, measure of health, particularly in 2017 when we have blood work and biometric markers to rely upon. Children especially, should be treated more cautiously, particularly given the flagrant disregard of the effects of pushing weight loss (mind you, weight loss that only bumps children from the 99th to the 98th percentile etc) on growth and future health.

<https://nutritionj.biomedcentral.com/articles/10.1186/1475-2891-9-30>

<https://www.ncbi.nlm.nih.gov/pubmed/15942543>

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<http://jabfm.org/content/25/1/9.abstract?etoc>

Commenter: Janet Carey; janet@counseling-pdx.com

Comment: This approach is SO wrong it is unethical. It amounts to large scale fat shaming of CHILDREN which inevitably leads to at least disordered eating in adulthood if not a full-fledged eating disorder.

Children's weights shift constantly because THEY ARE STILL GROWING.

Weight loss diets for children (or adults for that matter) have never been proven to work longterm.

Intuitive Eating and Health at Every Size are the ONLY sustainable protocols that have been proven to work.

This is a travesty and as an LPC in private practice, I will FIGHT it.

Panel Response

As previously noted, the interventions reviewed by the panel are not diets and promote healthy lifestyles. The panel respectfully disagrees with the assertion that Health At Every Size is the “only... protocol... proven to work.”

Outcomes and Measures

Panel Response

As previously stated, the panel is not recommending rapid weight loss or even dieting but instead interventions that develop healthy behaviors, including healthy family communication about bodies and size. The panel’s scope was not to address prevention of either obesity or eating disorders although preventing obesity and eating disorders would be preferred to individuals developing these conditions and then requiring care.

Commenter: Eetexpert; secretariaat@eetexpert.be

Comment: We appreciate the effort and concern of the authors on trying to include research on psychological and other outcomes of obesity treatment next to weight evolution. Unfortunately, their experience is that little studies include these variables. This is troubling indeed. Many of the other key questions would have become more clear if information was available on a differentiated set of health outcomes: the treatment strategies and population characteristics on investigation did not have an effect on standardized BMI after 12 months, but might have had an impact on mental well-being, metabolic health, or disordered eating behavior. If the outcomes weren’t included in the RCTs selected for this guideline, is there no way of adding research evidence on the relevance of these variables from other sources? For example, there is literature on the harmful effects of rapid weight loss, on the importance of shared prevention of obesity and eating disorders, on psychological determinants of childhood overweight...

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Commenter: Julie Bowman; julie@connectedandcalm.com

Comment: *Data for nearly all of the people the guidelines would apply to are non-existent.* The recommendation is for a broad group of youth (ages 2-18, in the 85th percentile and up), but the studies are on younger kids who are at the 98th percentile and in the fine print (page 47, line16) they note that there isn't evidence for most of the people in this broad group.

Commenter: Regina Lazarovich, PhD; Lazarovich.regina@gmail.com

Comment: I am very concerned about these guidelines due to the lack of evidence that dieting works in the long-term. In fact, there is a strong link between weight stigmatization and impaired mental health and referring a child to seek help for being an arbitrarily larger size than deemed culturally sanctioned can result in tremendous iatrogenic damage (e.g., weight cycling, low self-esteem, and eating disorders). We need more longitudinal studies of sustained weight loss in children and adolescents (beyond 12 months). I strongly urge the APA to reconsider and withdraw these proposed treatment guidelines.

Commenter: Devon Fernandes; fern1230@mylaurier.ca

Comment: Data for nearly all of the people the guidelines would apply to are non-existent. The recommendation is for a broad group of youth (ages 2-18, in the 85th percentile and up), but the studies are on younger kids who are at the 98th percentile and in the fine print (page 47, line16) they note that there isn't evidence for most of the people in this broad group. I have tried to find data on the percentage of the 85th-and-up group represented by the 98th-and-up but I think they are too small a group to have been accurately estimated. If anyone has that data, I would be grateful.

Commenter: Hilary Kinavey; hilary@benourished.org

Comment: The definition of success does not seem clinically significant especially when held against the harm that comes from focusing on weight in people, especially children, and youth.

BMI

Panel Response

The panel notes that BMI is an imperfect outcome measure yet the one that is most consistently reported in the literature. The panel added the following additional clarifying information to the text.

A Body Mass Index (BMI) is a measure of body fat adjusted for height and is calculated by weight in kilograms divided by the square of the height in meters (kg/m^2). A BMI is considered an indirect measure of body fat that is meant to screen for overweight or obesity. In children it is recommended that a BMI be calculated and plotted on the CDC BMI-for-age and sex specific growth curve at a minimum annually. A BMI could also be standardized (zBMI) so that each score represents an individual's standing relative to his or her specific age and sex group. Elevated BMI levels correlate with an individual's excess body fat, health risks such as cardiovascular risk factors, and prediction of future adiposity (Barlow, 2007).

When determining a child's risk for overweight or obesity, clinicians consider the child's BMI trajectory, growth curve, body fat distribution, diet and activity habits, familial obesity or predisposition to obesity, child and family medical risks, and, if appropriate, laboratory tests (Barlow, 2007). Benefits of a BMI include ease of obtaining and calculating, cost-effectiveness, ability to use in a clinical environment and patient and provider familiarity with the measure (Styne 2017, CDC 2015). A BMI has limitations on its precision, as it cannot differentiate muscle from adipose tissue. However, a BMI has demonstrated acceptable clinical validity and can guide weight management in children (Barlow, 2007, Styne 2017).

The guideline used zBMI as the index of overweight or obesity when available. Thus, in addition to accounting for height (and, therefore, growth), it also accounts for age and sex. zBMI is a relative not an absolute measure. As used in the systematic review and the guideline, it provided a metric commonly used across interventions and age groups that allowed relative comparisons of efficacy and effectiveness.

Furthermore, the panel searched for information on other outcomes which were inconsistently reported in studies. Future research needs to provide greater attention to psychosocial outcomes and tracking changes in healthy living behaviors.

Commenter: Mun Cho; chopohmun@yahoo.com

Comment: I am writing as a Registered Dietitian in response to your draft. I believe that using BMI as an outcome measure as a measure of efficacy is a huge misstep. I understand why BMI is being used - it is easy to measure and all studies use it.

Some children are born to be heavier. They have consistently tracked above 85% percentile on their growth curves since infancy. Using BMI cut offs alone at a single point, without looking at the child's growth trajectory over time, will classify this child as overweight or obese without acknowledging that this child is growing at his or her own genetic determination. Any intervention to undermine the child's growth will cause great harm.

Please note that using BMI alone as a outcome measure, in itself, can be seen as an act of weight bias. It is from the assumption that children weighing above certain cutoffs are "bad" and that problem needs

to be fixed (i.e. weight reduction). This is very pervasive in healthcare and it is a practice that needs to be challenged if we are serious about taking action against weight bias. Outcome measures should focus on outcomes that truly matters (e.g. psychological well-being, healthy eating behaviours, exercise behaviours, body image satisfaction etc.). I strongly urge you to reconsider using BMI as an outcome measure and send a strong message for all future research to be looking at other outcomes as mentioned above.

Commenter: Hannah Kuhlmann; hkuhlmann@gmail.com

Comment: Your definition of the term obesity seems to rely on BMI measurements, but BMI is widely understood to be an inaccurate indicator of health. Rather than using BMI or weight in pounds as an indicator of health, healthcare providers should be focusing on factors that actually indicate a child's health. It's confusing that this report seems to focus on weight or body size itself, rather than on nutrition or other factors that make up a full, holistic picture of health. There are fat and thin children who need better nutrition. By focusing on obesity as the problem, you are teaching both parents and children to see a child's body itself as problematic. The negative emotional and psychological impact of this should be obvious to any healthcare provider. The fact is, some children will still be fat or "have obesity" even if they follow the four key components recommended in this report. The components themselves should be recommended for every child. Singling out kids "with obesity" perpetuates the cruelty they are no doubt already living with in some form.

Commenter: Julie Bowman; julie@calmandconnected.com

Comment: *The definition of "success" used is clinically insignificant.* The panel asked a good starting question in "key question #1" - basically, do we even have evidence that there are interventions that work? Then they defined "work" as evidence of a tiny amount of BMI change ($>zBMI=-.25$) at 12 months into the process. The choice of that point in time rigs the whole endeavor, because we really don't have doubt that it is possible to lose a tiny amount of weight - or, in kids, to essentially slow down their growth with restriction - the questions are *whether it is possible to maintain weight loss, whether it confers any health benefits if it is maintained, and whether there are harms to the process regardless of its "success" or lack thereof that make pursuing weight loss a less desirable option than other solutions.* There are of course many other questions that could have been asked about how to support the well-being of higher-weight kids, but this panel was apparently focused on defending the status quo.

Commenter: Devon Fernandes; fern1230@mylaurier.ca

Comment: The definition of "success" they used is clinically insignificant. The panel asked a good starting question in "key question #1" - basically, do we even have evidence that there are interventions that work? Then they defined "work" as evidence of a tiny amount of BMI change ($>zBMI=-.25$) at 12 months into the process. The choice of that point in time rigs the whole endeavor, because we really don't have doubt that it is possible to lose a tiny amount of weight - or, in kids, to essentially slow down their growth with restriction - the questions are whether it is possible to maintain weight loss, whether it confers any health benefits if it is maintained, and whether there are harms to the process regardless of its "success" or lack thereof that make pursuing weight loss a less desirable option than other

solutions. There are of course many other questions that could have been asked about how to support the well-being of higher-weight kids, but this panel was apparently focused on defending the status quo.

Commenter: Ruth Hollman; ruth@shareselfhelp.org

Comment: Using the CDC averages for each age to determine overweight and obesity for children who are going thru puberty exacerbates the number of children who are classed as overweight and obese. At age 18 the charts assume everyone is now thru puberty and add an extra 10 lbs to the average charts. Telling children who have gone thru puberty that they are overweight because they are being compared to children who have not gone thru puberty starts the dieting cycle leading to long-term eating disorders. This happens at a particularly vulnerable time for these children as their bodies are changing and they have all the anxieties of puberty coupled with the average weight charts that tell them that they are overweight. Doctors and psychologists should take into account the stage of puberty a child is at before declaring them overweight or obese. The other issue that is not taken into account when the average weight charts are used for preteens and teens is that some children are highly athletic and have large muscles and little fat but are still told that they are overweight and obese. The charts need to be redone for the preteen and teen population to take into consideration whether 1) the child has matured and should be looking at the adult charts for guidance; 2) the child is an athlete; or 3) both.

Suitability of Treatment of Obesity as a Goal

Panel Response

The panel agrees that people should not be shamed for the size of their bodies or other features of their bodies. The panel also agrees that weight and BMI are not the sole or even primary indicators of health and all individuals benefit from healthy lifestyles that emphasize appropriate nutrition and physical activity (as well as sleep, positive relationships and a host of other important components for happy humans.) However, the panel remains convinced that at a population level overweight and obesity are associated with other poor physical health outcomes and that when possible, individuals should be able to access interventions that will foster healthy weights by focusing on healthy lifestyles.

Furthermore, the panel does not assert that “fatness” is a psychological disorder. The panel does assert that behavioral interventions targeting conditions of overweight and obesity are valuable considerations for those who seek such care.

Commenter: Jennifer Combs; Jennifer.combs78@gmail.com

Comment: The whole notion of psychological treatment for body size is so fucked-up. Fatness is not a mental disorder and your treatment of it as such will only serve to further reinforce the already massive stigma that larger bodies face. You all should be ashamed of yourselves for even suggesting that this is a good idea. Not to mention the overwhelming evidence that the weight loss only results in weight gain and weight cycling, which are terrible for health. My undergrad degree is in psychology and I am

embarrassed to be associated with your organization through that degree. I also have an MSW and can assure you that I will actively fight against all therapists using any recommendations that include body size reduction of our patients. You all are clearly more interested in making money than doing what is right and healthy for patients.

Commenter: Virginia Dicken; virginia.ew.dicken@wmich.edu

Comment: As somebody who has conducted research in this area, I am deeply disturbed by the proposal as a whole. Being large is not a behavior nor a behavioral disorder and is therefore not in the scope of psychological treatment. We claim to address behaviors and mental processes, but in the case of this proposal, the APA wants to treat body size.

Psychologists have solid training that would allow them to address eating behavior concerns, physical activity needs, and management of stigma. I celebrate our research that demonstrates effective ways we can engage with these issues. The proposed guidelines, however, imply that it is large-bodied people who need such (paid) intervention of psychologists, demonstrating bias on the part of the writers. It is quite possible to write guidelines about the treatment of eating, movement, and stigma concerns without devaluing of those with larger body sizes and without a goal of promoting weight loss, but the writers chose to focus on eradicating large bodies rather than supporting healthy behaviors. That choice is noteworthy.

It is imperative that we, as researchers and practitioners, think carefully about our definitions and our biases. It seems that the APA, in this case, is using "obesity" as a shorthand for "person with eating and/or physical activity behavioral problems." I am certain you are familiar with the research demonstrating that not all fat people are stereotypically lazy gluttons in need of the helpful intervention of professionals. This document, read carefully, shows that you are also familiar with the research demonstrating that no psychological treatment has ever been shown to produce longterm significant weight loss in even 1/4 of the studied population. These guidelines need to be scrapped entirely, as "Obesity treatment" is not an acceptable goal for ethical APA members. We can support people in pursuing health without promoting pseudoscientific treatments and socially acceptable prejudice.

Commenter: Emily Schell; ees1234567890@gmail.com

Comment: The idea of policing and medicalizing kid's bodies while they are still growing is abhorrent. Please don't justify fat-shaming kids as a moral, cultural or health imperative. The research does not back this up.

Commenter: Leroy Preston; leroympreston@gmail.com

Comment: You are peddling a message and doing more harm than good. Fat shaming promotes unhealthy behavior not encourages healthy behavior. All this is doing is encouraging people to be unhealthy. Diets don't cause long term weight loss for the majority and can slow metabolism and cause disease. If you want to help out our obese youths, we should encourage size acceptance and healthy eating and exercise not for the purpose of weight loss, but to be healthy and feel good about oneself.

Commenter: Carolyn Kottmeyer; carolyn@hoagiesgifted.org

Comment: Why are you addressing strict weight loss rather than the underlying solutions, getting kids moving and active, feeding them healthier foods with less carbs and sugars, and getting them Outdoors into nature daily!

There is plenty of research on the positive outcomes of getting kids outdoors:
<http://www.childrenandnature.org/research-library/>

Please included these studies and recommendations *prior to* any suggestion for weight loss during the years children are growing, as these efforts can backfire and cause developmental delay from relative starvation as well as mental disorders from their body image concerns introduced by these recommendations.

Thank you..

Concerns about measuring weight specifically

Commenter: Nichole Scott; nicholescottmedical@gmail.com

Comment: No kid should be shamed for the size of her body. Weight should be recorded only for calculating correct medication dosages. Instead of making kids feel terrible for something they most likely cannot control, stress the importance of strength, flexibility and stamina as a way to prevent disease. I recommend looking at Ragen Chastain's website, www.danceswithfat.com, for research that shows weight does NOT cause disease. You owe it to your patients.

Commenter: Sara Loftus; Saraloftusrocketmail@gmail.com

Comment: You need to realize that weight is not, in and of itself, something that anyone needs right on change about themselves. You need to get over the obsession with calling people overweight and obese in the first place. I'm obese and I'm also healthy. Ask my doctor, see my normal blood pressure and my normal blood sugar and my normal blood work. I focus on being healthy (which is not something anyone is required to do) NOT on becoming some smaller version of myself. Help kids be healthy. They can be healthy AND fat. Dieting fails 85% (or more) of the time so what you should be recommending for fat kids is that they love themselves and take care of themselves and address any ACTUAL health issues they have independent of their fatness. Free your mind. Intervening in kids weights is honestly just going to make them sad and fatter. Because the one thing intentional weight loss is almost guaranteed to do is make them gain weight.

Commenter: Laura Suess; laurasuess@gmail.com

Comment: Surely the medical community by now has enough collective intelligence to conclude that humans come in all shapes and sizes, being larger may correlate with but does not conclusively cause secondary diseases, and labeling people as obese etc is detrimental and helps no one. Jesus Christ I am sick of the labels and the obsession with a number on a scale to determine whether I am fit or healthy. There is so much more to it than that and children especially are vulnerable because they are growing and don't need the added stigma of well-intentioned but clueless medical or other professionals meddling in their lives to solve their "obesity problem". The only ones who see a person's weight as a

problem are the people who benefit from the stigma and shame associated with it in collusion with the weight loss and exercise industry. I am disgusted by this. Stay out of schools and kid's lives, you have done enough harm.

Conflicts of Interest

Commenter: Jillian Pullara; Jillpullara@gmail.com

Comment: Intellectual people are incapable of being objective but pharma professionals who have a vested interest in making money off of selling weight loss can be? That's an outright sham.

Commenter: Megan Simon; megansim@ysc.edu

Comment: That the individuals involved in this guideline are positioned to profit off its enforcement is about as gross an abuse of government as is possible. That alone is reason to chuck this draft in the trash.

Panel Response

Panel members completed a thorough disclosure of potential conflicts prior to being appointed to the panel and again when meeting to review the evidence. Review by the oversight committee determined that no panel member had actual or potential COI that would interfere with their participation in developing recommendations. The guideline itself is considered to be aspirational and APA does not enforce any of its recommendations.

Potential Harms

Panel Response

Consistent with the conclusions of the United States Preventive Services Task Force (USPSTF), the panel also concludes that the possible harms of intervention are none to minimal. The panel recognizes ongoing problems with fat shaming, bullying and stigma and supports efforts to reduce these biases in society and in providers. In fact, the panel asserts that health care providers will benefit from specific training in order to provide sensitive care to all individuals, whether it is care specific to overweight or obesity or care for any other kind of concern. Parents and caregivers can choose to pursue care as appropriate for their child or adolescent- this guideline is intended to elucidate the framework for appropriate care. Please see more detailed panel comments at the beginning of this document.

Commenter: Jillian Pullara; Jillpullara@gmail.com

Comment: This is dangerous. Nothing here suggests that the kids will necessarily become healthier (let alone thinner). The amount of weight lost is relatively insignificant, the harms don't consider things like eating disorders, bullying, etc... and says that children, who are still growing and for whom weight loss can actually be detrimental to (because they are still growing) should submit to their bullies, and as the APA you don't consider the psychological ramifications for that? That's horrible.

Commenter: Liana Derus; ljderus@gmail.com

Comment: I am concerned about the way the APA is using overweight children as a punching bag for the diet industry. I grew up overweight and the disgust and stigma that was forced on to me by classmates, teachers, PE instructors, doctors, and all other adults in my life has left me with long lasting emotional trauma, which evidently is not the key to losing weight as I am not an overweight woman. Children and adults deserve respect no matter their size. The APA should seriously reconsider this Clinical Practice Guideline before they do lasting harm to thousands of children.

Commenter: Lindsey Hoskins; Withkarate@gmail.com

Comment: This is harmful. This kind of stigmatization and shame, telling growing children that their bodies are a problem to be fixed, is a recipe for eating disorders and dangerous weight cycling behaviors. Where is your evidence that weight loss does no harm? Absence of evidence is not evidence. Weight loss is not the same as being born into a body with a naturally lower BMI. There are several known dangers associated with weight loss that you are entirely ignoring. Also, your selection of reviewers appears to be biased.

As an eating disorder survivor, a person whose genes are passed down from generations of very healthy, larger than average people, and a parent of 2 quickly growing children who are ALREADY, in kindergarden, experiencing stress related to weight stigma even though their eating and activity levels are extremely healthy and their bodies are nothing short of incredible, I am livid about these recommendations. I work in public health and I know how to critically read research, and this is poor quality and biased work leading to dangerous recommendations.

Commenter: Melody Dickson; rosewelsh44@gmail.com

Comment: Basically assuming that all fat kids have psychological problems is bogus. Sure there might be some, but most just naturally have larger bodies and will grow into them or will become large adults, with no health issues. If you have to suggest mandatory therapy I'd suggest it focus on building self-esteem, ways to deal with bullying and body appreciation. If there is even ONE mention of a diet, even for kids who are over-eating because of psychological issues, you WILL DAMAGE THEM PSYCHOLOGICALLY. Do not focus on the weight loss, that's just stupid; focus on helping them deal with the issues that make them need to self-soothe with food. And be damned sure you teach them other self-soothing techniques to replace or augment food. But DO NOT suggest dieting. That is just completely wrong and shaming.

Commenter: Kristen Nickels; Kristen.marshall@bastyr.edu

Comment: Please, please, do more research. I am a Registered Dietitian Nutritionist who specializes in eating disorders, and I'm begging you to PLEASE do more research. This is so very harmful, and there is research out there which demonstrates that this would be grossly misguided. We have to do better.

Commenter: Rhiannon Parker; Kakugori_ichigo@yahoo.com

Comment: Your research and recommendation here are highly flawed, do not mesh with the scientific data as we know it regarding weight gain, cycling, and the harmful effects of weight loss, and will further stigmatize children. I strongly encourage you NOT implement this plan.

Commenter: Tyler Havlin; tej1116@gmail.com

Comment: I think it's egregious that a respected group of professionals would adopt guidelines that condone and promote marginalizing children for any reason, much less for the purpose of forcing growing bodies to diet. For an organization that is supposed to respect careful research, you don't seem to care about evidence. Dieting is harmful, slows metabolism, and generally leads to a higher weight over time. Most people who experience significant weight loss are unable to maintain it after the first couple of years. To now be forcing this ridiculous and ineffective process onto children whose bodies will change constantly throughout childhood and adolescence is extremely unethical and unprofessional. This attitude is why fat people never go to the doctor, even if they have insurance. These guidelines are likely to lead to disordered and unhealthy relationships with food even earlier in life. Please recognize that these proposed guidelines are not evidence-based and will do more harm than good. Please don't force your biased, body-shaming ideals on young children. The media does a good job of that already.

Commenter: Kim Collier; kimmcollierphd@comcast.net

Comment: I am opposed to this APA guideline being approved. The acknowledgement of insufficient data on so many levels in this proposal and the overarching data that weight loss interventions are rarely sustained and can often trigger disordered eating in children and adolescents leads me to call for you to "do no harm" by pulling the plug on this guideline.

Commenter: Leroy Preston; leroympreston@gmail.com

Comment: Fat shaming encourages unhealthy behaviors, it encourages eating disorders. Which can lead to worsening. Dieting slows one's metabolism, it increases the chance that one has diseases. It only works short term. The vast majority of diets lead to weight regain and sometimes a little more. You shouldn't be "helping" the way our culture tells us. We should help these kids by encourage size acceptance and healthy behavior for the sake of health not for weight loss. All you're doing is making things worse, which is what the rest of our culture has done with our war on fat. We should focus on health, and accept people of different shapes and sizes in our culture.

Commenter: Julie Bowman; julie@calmandconnected.com

Comment: * There is an admission of a lack of data on possible harms.* They note that there is really no evidence about whether the process of trying to lose weight is harmful - but they don't wait to recommend weight loss. This is taking *a lack of evidence for harms* as *evidence that there are no harms,* which is a basic logical mistake and endangers the population. There is no investigation of subsequent disordered eating, frank eating disorders, higher eventual weight, weight cycling, whether

the participants or families experience the process as stigmatizing, increased depression or ineffectiveness after regain, etc. etc.

Commenter: Stef Maruch; firecatstef@gmail.com

Comment: Insufficient data on whether being forced to pursue weight loss throughout one's childhood causes long term harm such as eating disorders, rebound weight gain, yo-yo dieting, emotional distress, stigma. Insufficient data on whether being forced to pursue weight loss throughout one's childhood results in lower weight in adulthood. Insufficient justification for applying these guidelines to demographic groups which were not included in these studies.

Commenter: Hilary Kinavey; hilary@benourished.org

Comment: People of different ethnicities have different weight distributions but we continue to center a highly flawed measure of weight and use this to measure health. There is inherent racism in our assumptions here. The APA's willingness to recommend anything based on BMI is unscientific and exclusionary.

It is necessary to center healing from the effects of living in a weight biased culture - including the ways this impacts relationship with food, chronic dieting and disordered eating. Centering weight as the problem exacerbates the iatrogenic nature of weight loss efforts. This is unethical practice.

Commenter: Devon Fernandes; fern1230@mylaurier.ca

Comment: There is an admission of a lack of data on possible harms. They note that there is really no evidence about whether the process of trying to lose weight is harmful - but they don't wait to recommend weight loss. This is taking a lack of evidence for harms as evidence that there are no harms, which is a basic logical mistake and endangers the population. There is no investigation of subsequent disordered eating, frank eating disorders, higher eventual weight, weight cycling, whether the participants or families experience the process as stigmatizing, increased depression or ineffectiveness after regain, etc. etc.

Racism

Commenter: Julie Bowman; julie@calmandconnected.com

Comment: *There are very few data particularly on marginalized communities who will be most targeted by these guidelines. *They could not find sufficient evidence for any other questions - mostly, the "how" questions and the "who" questions, admitting that the research is very limited and the data sometimes do not even reveal demographic characteristics of the participants. There is a clear targeting of communities of color for these interventions but very little data. This replicates a damaging and repetitive history where the limited research is on the dominant group but is used to justify interventions on more oppressed communities.

Commenter: Julie Bowman; julie@calmandconnected.com

Comment: *There is evidence of racism in the reasoning behind the guidelines. *The weight stigma and racism of expecting bodies to be one size (and for kids, to grow at one rate), and of recommending interventions for communities of color when there is no solid data (especially of harms) replicates the existing violent patterns in our field. There is a particularly cringe-worthy section (page 48, line 2) complaining that parents don't know their kids are fat because of "cultural values" and need the "objectivity" of the healthcare providers to inform them. This is more of the same "we aren't being stigmatizing if we are nice when we tell them their bodies are wrong" drivel that is holding back real progress in moving beyond a failed paradigm.

Commenter: Leroy Preston; leroympreston@gmail.com

Comment: You are racist for stating that due to cultural differences, kids are more likely to be fat. Stating that something we claim is bad is going to happen to someone different is awful. Fat isn't the killer we make it out to be and we shouldn't be putting down people who are fat and are different.

Commenter: Harriet Brown; harriet@harrietbrown.com

Comment: These guidelines as written expect children to grow at one rate and be one size. There is strong evidence that this is unrealistic and shows implicit bias toward non-white children, whose growth patterns and ultimate body size may be different than those of white children. You must acknowledge and deal with the racism in these "one size fits all" guidelines.

Commenter: Devon Fernandes; fern1230@mylaurier.ca

Comment: There is evidence of racism in the reasoning behind the guidelines. The weight stigma and racism of expecting bodies to be one size (and for kids, to grow at one rate), and of recommending interventions for communities of color when there is no solid data (especially of harms) replicates the existing violent patterns in our field. There is a particularly cringe-worthy section (page 48, line 2) complaining that parents don't know their kids are fat because of "cultural values" and need the "objectivity" of the healthcare providers to inform them. This is more of the same "we aren't being stigmatizing if we are nice when we tell them their bodies are wrong" drivel that is holding back real progress in moving beyond a failed paradigm.

There are very few data particularly on marginalized communities who will be most targeted by these guidelines. They could not find sufficient evidence for any other questions - mostly, the "how" questions and the "who" questions, admitting that the research is very limited and the data sometimes do not even reveal demographic characteristics of the participants. There is a clear targeting of communities of color for these interventions but very little data. This replicates a damaging and repetitive history where the limited research is on the dominant group but is used to justify interventions on more oppressed communities.

Panel Response

The panel read the comments concerning possible racism in the document with concern. The panel subsequently reviewed the entire document and edited portions to be clearer about its intent regarding family patterns and perception of children's weight status. However, the panel does continue to be concerned about potential health disparities in communities of color that appear to be linked to overweight and obesity. The panel would urge any provider implementing its recommendation to do so with knowledge of contributing cultural factors.

Stigma

Commenter: Lindsay Miller; lindsaymiller18@hotmail.com

Comment: I am strongly opposed to these recommendations for interventions.

This will (unintentionally) perpetuate weight stigma and bias in children through conversations focused on weight loss.

All children can benefit from learning about healthy lifestyle behaviors without bringing weight into the picture. This has potential to cause great harm in children and could lead to dieting and disordered eating behaviors as well as eating disorders.

I ask you to please seriously reconsider the weight-based approach of this research.

Commenter: Sara Smith; vixenmoon@gmail.com

Comment: This will only be harmful to these children, and will serve to strengthen the stigma surrounding people with above average weights.

Commenter: Hilary Kinavey; hilary@benourished.org

Comment: Centering weight is stigmatizing and harmful.

Commenter: Wesley Fenza; wfenza@gmail.com

Comment: These new guidelines will increase fat stigma in children and adolescents, and will likely produce no (a) beneficial health outcomes; or (b) noticeable weight loss (which shouldn't even be a goal). Obesity is not a disease; it's a body size. There is no evidence that weight loss (as opposed to exercise and diet interventions that benefit health but do not cause weight loss) produces any beneficial health outcomes.

Commenter: Lauren Munro; munro.lauren@gmail.com

Comment: These guidelines don't appear to have anything to do with helping people who need psychological treatment. The report urges people providing interventions to be educated about weight stigma but fails to understand that intervening itself under these conditions is stigmatizing. If there were

any guidelines to be released to practitioners as it relates to fat bodies, it should be material that a) reminds professionals not to perpetuate weight stigma in their own practice, b) acknowledges the experiences of oppression that fat people face, and c) challenges healthism and weight stigma within the health professions (and beyond!). Weight loss is not a solution for weight stigma.

Panel Response

The panel is aware of research indicating that health professionals have discussed matters of weight poorly with their patients and that can contribute to shame and stigma. However, the panel is not aware of evidence suggesting that the sensitive provision of appropriate care, which may include efforts to modify weight through the fostering of healthy nutrition and activity, has contributed to stigma and bias. The panel agrees that emphasis of intervention on developing healthy habits of activity and nutrition is critical and that changes in weight or BMI are not ideal outcomes yet recognizes that BMI is consistently measured and does provide some indication of whether behavior change is occurring. The panel also agrees that energy balance (taking in the appropriate nutrients for the body and one's activity) is the appropriate target and not caloric restriction nor weight loss and believes that well delivered interventions have this focus. Similarly, the panel prefers the zBMI as this measure does account for potential changes in growth.

Eating Disorders

Commenter: Otavia Propper; otavia_propper@williamjames.edu

Comment: My concern is with the lack of information on the possibility of increased eating pathology. This report concluded that there was no increased eating pathology on exactly one study of 47 families (Epstein, Paluch, Saelens, Ernst, & Wilfley, 2001). Given the small n of this study and the extremely high mortality rate of eating disorders (Smink, van Hoeken, & Hoek, 2012), I personally find it extremely concerning that these treatment guidelines would be released without extensive research into potential harm and effects.

Commenter: Melissa Carey; Mcareytherapy@gmail.com

Comment: The entirety of this article has lack of data that supports the value of these assertions and breaks the core standard of "do no harm". The damage that this will cause will be catastrophic and these children will not be able to get the long term care needed once they develop full blown eating disorders. I am outraged with the medical community's continued focus on profit and short term fixes versus using medical data and clinical research that shows this approach is not effective.

Commenter: Mun Cho; chopohmun@yahoo.com

Comment: "There was also a lack of information on potential harms of interventions, although behavioral interventions are generally viewed as not harmful" - I would challenge that this statement fails to acknowledge the increased likelihood of eating disorders as a side effect of weight-loss intervention. The guidelines are correct in saying that "harms need to be routinely assessed and reported" in future studies. Right now, many weight loss interventions targeted at children and adolescents fail to monitor for this. From experienced healthcare providers working in the field of eating disorders, the common story on how eating disorders start begins with "my doctor said I need to lose

weight". A colleague also mentioned that a well-known children's nutrition and exercise program for overweight children had to form a special group for their patients who developed "binge" eating after being in the program. Just because the harm is not being routinely measured, doesn't mean it is not present. And the harm is very serious considering that eating disorders have the highest mortality rate among all psychiatric disorders and not to mention to severity of the psychological comorbidity. I don't think your committee was diverse enough to encourage "adversarial conflict" that would have greatly benefited this draft. It did not include experts working in the field of eating disorders. Any clinical guidelines pertaining to weight management strategies in children and adolescents must be vetted from an eating disorders point of view. In the the spirit of "do no harm", the intervention must not increase the likelihood of creating another problem....a very serious problem.

Commenter: Tricia Leahey; tricia.leahey@uconn.edu

Comment: To address concerns that weight management programs may lead to eating disorders among children and adolescents, it may be worth noting that eating disorder prevention trials have found that weight control programs for adolescent girls actually yield reductions in eating disorder symptomatology (Stice, Shaw, Burton, Wade, 2006; Stice, Trost, Chase, 2003).

Panel Response

Please read detailed response at the beginning of the document regarding eating disorders. Also, note that the guideline indicates that the recommendation for a family based multicomponent intervention indicates that such intervention may need modification for individuals with eating disorders.

Thank you to Ms. Leahey and the Society of Behavioral Medicine for helpful references regarding weight management programs and eating disorder symptoms. These studies suggest that weight management programs that emphasize healthy behaviors may actually prevent or reduce disordered eating. (Austin et al., 2012; Austin et al., 2007; Austin et al. 2005; Wang et al. 2011; Stice, Shaw, Burton, Wade, 2006; Stice, Trost, Chase, 2003).

Concerns Regarding Weight Loss in Children

Commenter: Megan Simon; megansim@ysc.edu

Comment: This new proposed guideline is a tragedy in the making. Not only is it clear this guideline is backed by people who seek to make money off of government enforced regulation rather than through competent business, it is clearly lacking proper research to back the claims for why this is needed children who grow at a faster rate, like my niece, will be made to feel like their bodies are wrong. The government should not be in the business of making guidelines without proper evidence. My niece is nearly a foot taller than her classmates and this new guideline would force her into therapy for simply being tall. That added with the reality that children gain weight before a growth spurt, so the damage against growing bodies to service profit mongrels has potential to devastate a generation. We don't know enough about the miracle of life and how children grow to even know if it is out of the norm for some bodies to be in the 98th percentile before growing 2-3 feet suddenly. To create such an archaic

guideline base on feelings and bias is truly an over reach of the government. Please discard this draft, and allow science to keep exploring this issue without a government mandated guideline hovering over everything.

Commenter: Kimberlee Smith; Kimsmith11@me.com

Comment: This is an overall reaction to the recommendation that weight-loss be recommended in any manner to children and adolescents. Given that statistics bear out that one of the strongest predictors of weight gain and obesity is intentional weight loss, coupled with intentional weight loss attempts early in life also being a predictor of higher BMI as an adult and a higher risk of developing N eating disorder. This all seems counter productive and singularly focused. Perhaps there are other approaches like HAES that should be reviewed and considered in your recommendations.

Commenter: Aimee B.; Aimeebknits@outlook.com

Comment: "Family-based multicomponent behavioral treatment of children and adolescents ages 2-18 years with overweight or obesity"

At 2-15 years old children are still growing...they do this at different rates...how can you say that a 2yr old is obese & needs counseling on that...they are all growing at different rates!

Panel Response

It is precisely because children are still growing that providing an intervention is timely. The recommended intervention focuses on development of healthy eating and exercise habits and does not focus on weight loss, particularly among younger children who are still growing. Health professionals do agree that some children can be identified as overweight or obese, even while still growing, and the intention of intervention is to slow the weight trajectory while other growth continues and to foster healthy lifetime habits.

Miscellaneous

Commenter: Barbara A. Bruno; barbaraabruno@optimum.net

Comment: Correlation is not causation. Fatness does not cause PCOS, for example. Stigma adds to fatness, through stress hormones, eating to relieve stress, dieting to relieve fatness stigma and therefore getting fatter and less competent to eat intuitively as time goes on.

Commenter: Harry Minot; hminot@aol.com

Comment: Between the age of 12 and 15 I attended a boarding school. My mother *might* have loved me, but she was totally embarrassed by my fatness because her other children were "normal". She persuaded the school personnel to prevent me from having second helpings in the school's dining hall. I was served "dietetic" jello when the other boys had the regular desserts. The school nurse was instructed to weigh me each month. And the Physical Education Director was required to monitor me closely. I was under a microscope. I was judged as out-of-control, inclined toward gluttony, and far too

lazy. All of that took its toll. The feeling of being worthless led me toward a suicide attempt. So, was all of that helpful? No, it was not. Should today's kids be subjected to ritualistic oppression? No, they should not. Should health care "professionals" adhere to the "first, do no harm" notion? Ummmm, YES.

Commenter: Barbara A. Bruno; barbaraabruno@optimum.net

Comment: Deciding that all children ought to fit within artificial guidelines is racist, against heterogeneity in nature, ineffective and harmful, in my experience having (been and) treated heavier-weight young people. Eating disordered ideation is producing fatter youth. Dieting and Unhealthy Weight Control Behaviors During Adolescence: Associations With 10-Year Changes in Body Mass Index

Neumark-Sztainer, D., Wall, M., Story, M., Standish, A. January 26, 2011 - Source: Journal of Adolescent Health 50 (2012) 80–86

Children usually resemble their parents.

How would APA recommend treating "overtall" children?

Lacking evidence of long-term effectiveness, how can psychologists continue to push "treatment" of a family for not conforming? Conflict of interest between evidence and effectiveness.

Panel Response

Regarding the three comments above, the panel again asserts that IF treatment is offered to parents, multicomponent family based behavioral interventions are preferred to develop healthy life behaviors. The panel notes that it is unhealthy weight control behaviors (such as skipping meals) that are problematic and those are not the focus of the recommended interventions.

Commenter: Nadine R. Anderson; Anderson.Nadine@pburgsd.net

Comment: Why have we stopped using the term "client" and gone to the term "patient"? That is the medical model of imposition of medical views on the patient. That is not the psychological model of working with the client.

Panel Response

The panel opted to use the term patient as the recommended intervention is typically delivered by multiple providers (dietician, exercise physiologist, health behavior expert) and within that content, "patient" is the term routinely used. The panel recognizes that in other settings, "client" or other terms, may be more appropriate.

Commenter: Delrita Abercrombie; DelritaRachelle@aol.com

Comment: Very often obesity is related to life style of children. Reinforcement of schedule of activities including exercise, social activities, and creative expression are important. Children need to be reinforced for stating their feelings and experiences with the parents. Even though behavioral strategies are very effective, the parent child relationship and issues of self-esteem need to addressed.

Panel Response

Indeed, these are many of the components of multi component family interventions.

Commenter: Charles W. Rodgers, Ph.D.; ccrodgers@msn.com

Comment: Although undoubtedly warranted from the Kaiser findings, it is disappointing as well as instructive to learn that the only recommendation is the dose-related (>26) use of family-based multicomponent intervention without further specific findings.

Commenter: Tricia Leahey; tricia.leahey@uconn.edu

Comment: While it is critical to include parents when in the treatment of obesity for younger children, the literature on the importance of parental / family involvement in adolescent obesity treatment seems less clear. It may be worth acknowledging this issue.

Panel Response

The panel will provide a table indicating ages of participants in research studies and involvement of parents. The panel members discussed this issue when reviewing the evidence and determining its recommendation and will review the guideline regarding how to include in either the document itself or in materials supporting the recommendation.

Commenter: Jennie B. Rodgers; jrodgerspsy@gmail.com

Comment: Re: Items to consider for inclusion in future research--attachment styles. one limitation of the current approaches to obesity treatment is the emphasis on behavior. overeating is commonly linked to emotional experiences, and attachment styles influence how individuals regulate their emotions. treatments, therefore, must address the underlying mechanisms that contribute to obesity in children. I will happily provide a copy of my dissertation which explored the theoretical connections between attachment and overeating/obesity, with an emphasis on adolescence as a critical period. I also proposed a "family-based multicomponent intervention" that allows for adjustment of attachment patterns in the service of improving emotional regulation methods, in order to prevent excessive weight gain in adolescent clients.

Panel Response

The panel appreciates the commenters response and offer of sharing her dissertation. The panel discussed the role of early adverse events in developing obesity and much research is emerging regarding how such events lead to challenges with regulating emotions and other psychoemotional issues. Informed providers should be aware of such literature and appropriately incorporate it while delivering care.

Commenter: Committee on Legal Issues (COLI), Elaine Hart; ehart@apa.org

Comment: During its October 18, 2017 meeting, the Committee on Legal Issues (COLI) reviewed the Clinical Practice Guideline for Behavioral Treatment of Obesity and Overweight in Children and Adolescents, which are "intended to provide treatment recommendations regarding the use of family-based multicomponent behavioral interventions for overweight and obesity in children and adolescents, ages 2-18 years, based on a systematic review of the evidence."

The Guideline Development Panel (GDP) for Obesity Treatment were quite clear about the topics they were and were not addressing, and were also upfront about the process they used to arrive at their one, measured recommendation. The GDP conducted a literature review and determined that there was insufficient evidence at this time to make certain recommendations. Through their processes, the GDP

also considered potential harms, potential burdens, and how best to achieve successful implementation of their recommendation.

COLI did not identify any legal concerns. There is a disclaimer at the beginning of the draft document which clearly states that these guidelines are intended to be aspirational and not intended to be a requirement for practice.

Panel Response

The panel has added additional language indicating the role of clinician judgment, in consultation with patients, in determining care.

Commenter: Committee on Women in Psychology (CWP)

The committee appreciates that you are working with the current strength of the evidence and appreciate your description of the limitations that this places on the guidelines. CWP assumes that in part, the guidelines will call attention to the need for more research in this area.

CWP does, however, have some concerns that due to the lack of research, there has not been sufficient exploration of various research methodologies which may lead to a narrowed focus on treatment modalities in turn. Some areas that could be expanded upon in the report are:

- A clearer sense of the role of psychologists in these multidisciplinary behavioral teams;
- A discussion of parent/child autonomy and choice and the possible sense of being stigmatized by their health professional;
- The greater burden on lower SES and single parent homes in following this treatment which disproportionately affect women, poor women and minority women;
- A discussion of the impact of traumatic exposure on obesity in children (as obesity in adults and its relational to adverse childhood experiences was the starting point for the original ACE studies);
- A short discussion on eating disorders in childhood;
- The role of psychoeducation for families in clinical treatment; and,
- An expanded discussion of disability issues; obesity among women with disabilities is also disproportionately higher due to higher levels of poverty, lack of mobility, and access to basic healthcare services. There's a need to speak to the intersectionality of contextual factors.

Panel Response

Psychologists can serve in a variety of capacities with multidisciplinary teams from providing behavioral care, to educating team members about matters such as the impact of adverse experiences on the development of obesity and how to address in the context of care, to reducing possible stigma by increasing provider sensitivity and skill, to evaluating the intervention delivery and outcomes. In the systematic review, psychologists did not contribute to better outcomes over other behavioral health care providers however when serving in the role of behavioral health care provider. Thus, the panel did not elaborate on the specific role of psychologists as the recommendation focus is on the multicomponent behavioral interventions as the efficacious treatment.

Implementation materials to support the guideline will elaborate on possible concerns related to stigma and bias on the part of the health care professional.

The panel did not find different outcomes for children from different groups so therefore has one recommendation. However, the panel does recognize that a variety of social and demographic characteristics appear to be related to being overweight or obese and believes that providers should be aware of these and be prepared to address in care as needed.

The panel respectfully disagrees that a short discussion on eating disorders should be included in the guideline. The panel does acknowledge that providers should be aware of possible disordered eating and when present, appropriately modify any offered intervention. The panel also noted that ability status is an important consideration in care delivery. Finally, while numerous contextual issues, including ability status, poverty and traumatic exposure may be implicated in the conditions of overweight and obesity, a thorough review of these issues is beyond the scope of the guideline document. However, competent providers will continue to further their understanding of these issues and their contribution to weight.

Commenter: Sandra Wartski, Psy.D.; sandra@wartski.org

Comment: Just learned of a great 2 minute video within a website (entitled the Problem with Poodle Science - which compares poodles with mastiffs and makes the point that those 2 types of breeds are not supposed to be the same shape and size). Very helpful way to think about approaching the whole weight and health piece differently. My favorite line from the video which is: "Poodle centric health policy is a nightmare!" <https://thebodyisnotanapology.com/magazine/poodle-science/>

Panel Response

The panel agrees that poodles and mastiffs are not supposed to be the same size and shape. However, dogs of both breeds can become overweight or obese if they do not have appropriate nutrition and exercise.