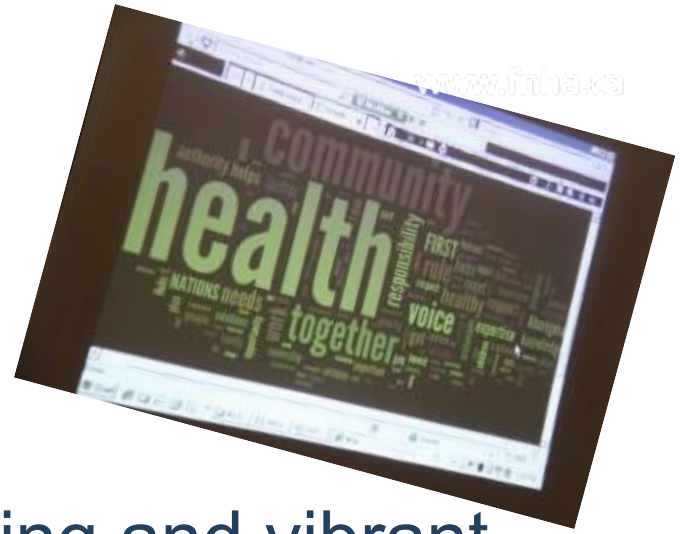
First Nations Health Authority
Health through wellness

# Eating Healthy

## Toddlers to Teens

**September 10th, 2014**

**Gerry Kasten, RD, MSc, FDC**
**Dietitian, Health Promotion and Prevention**
First Nations Health Authority




Healthy, self-determining and vibrant
First Nations children, families and communities


# Building the FNHA

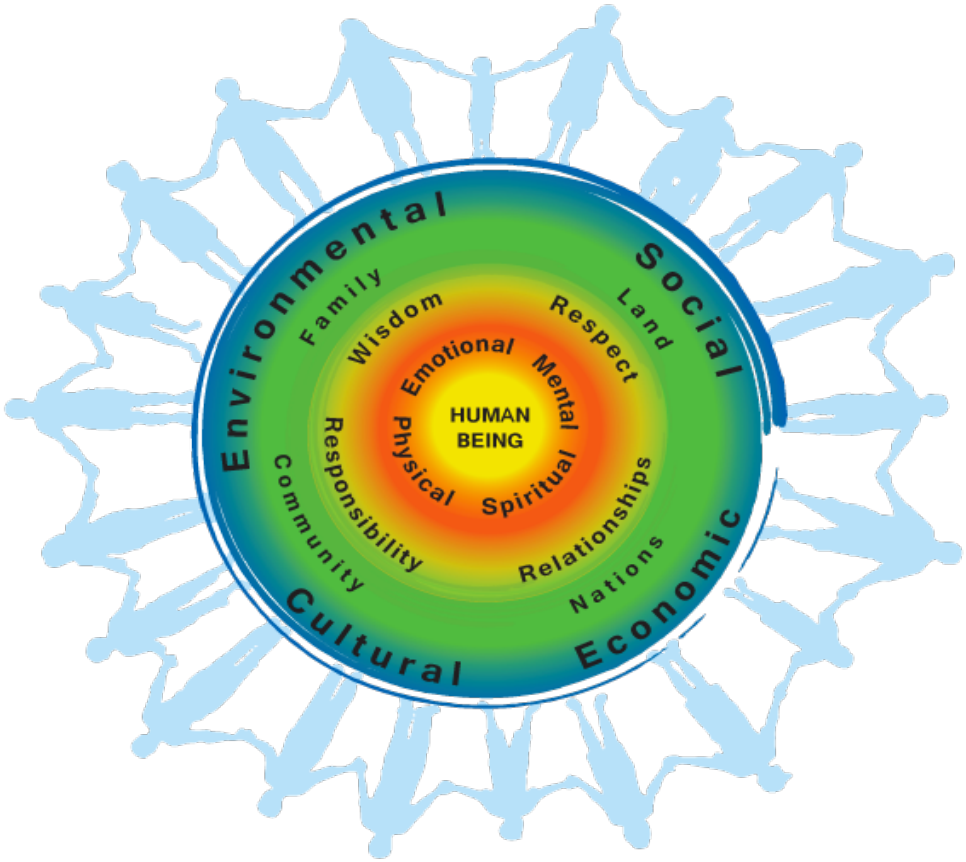
## Our Vision

Healthy, self-determining and vibrant, BC First Nations children, families and communities

## Our Values

Respect, Discipline, Relationships, Culture, Excellence & Fairness

# First Nations Perspective of Wellness




**Purpose of the image:**

- A visual image/expression of the ways First Nations express health and wellness
- It represents the way life has always been (i.e. connection, relationship, interconnection)
- It represents a First Nations approach to life
- It is cross-cultural and is adaptable to many environments

# First Nations Perspective of Wellness

FNHA developed a Wellness Approach to frame our Wellness Initiatives

**Wellness Champions** | **Wellness Partner** | **Living it!**

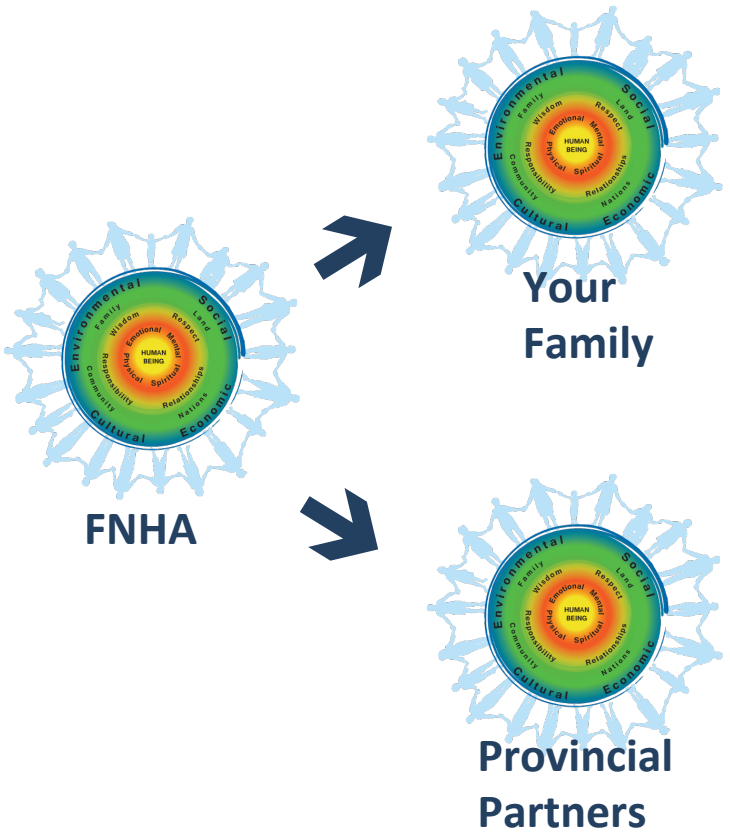
By having an approach to the way that the FNHA engages communities on Wellness, the FNHA wants to bring Wellness to the forefront of community members' minds so it is a part of our daily conversations and gets reflected in all our actions and activities.

# Wellness Champions

# Wellness Champions

Circles of Influence:

- By being a Champion, FNHA Staff emulate a First Nations' perspective on Wellness by being living examples
- Challenge & empower your circles of influence (families, communities, leaders)
- Lead by example and taking responsibility for your own health:
  - individual wellness plan, sharing your Wellness journey, having the conversations within your circles of influence, team wellness plans, etc.



# Wellness Partner

# Living It!

## WELLNESS STREAMS

Are used to express FNPoW on an individual/team/org level.

How we are Living it!

- Individual Wellness Plans
- Opening meetings with proper protocol
- Team participation in physical activity (e.g. Sun Run, Grouse Grind, Fit Nation)
- Workplace fitness
  - walking meetings, stair challenges
- Winter Challenge 2014

| | Individual | Team | Organization |
|---|---|---|---|
| **Eating Healthy** | More Water | Team Lunch Plan | Brown Bag Lunches |
| **Being Active** | Walk at lunch | Walking Meetings | Trail Markers |
| **Nurturing Spirit** | Learn Culture, History, and Traditions | Prayer Before Meetings | Elder On-Site |
| **Respecting Tobacco** | Smoking Cessation | Encouragement | Health Literature |
| **Maintaining Healthy Weight** | Decrease Sedentary Time | Stretch Breaks | Stairs Instead of Elevators Challenge |

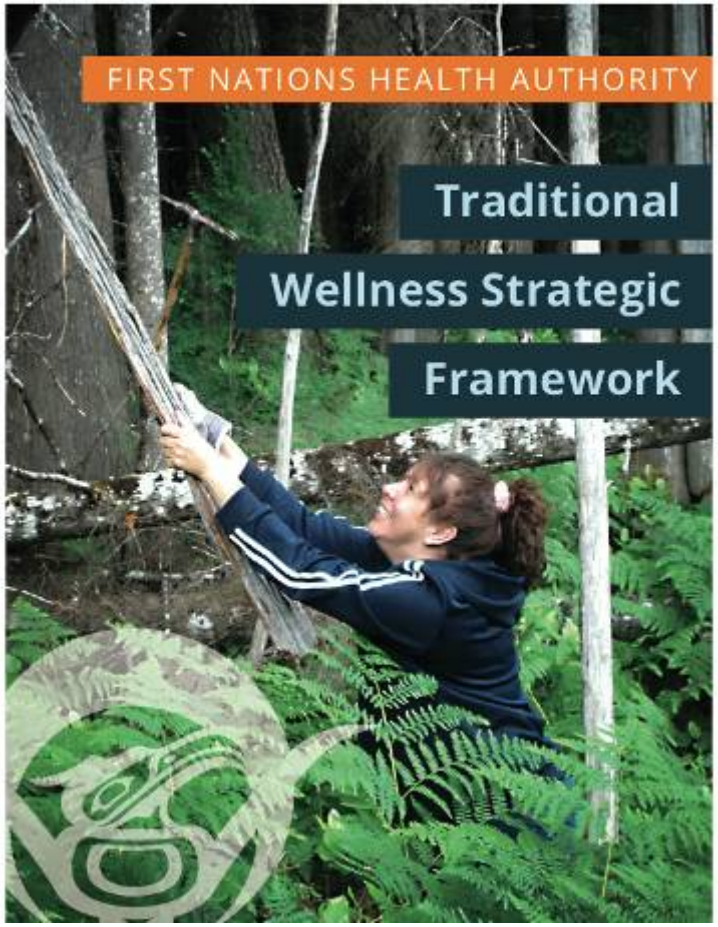
# Wellness Streams

- Common risk factors for wellness, health promotion and chronic disease prevention
- Aligns our work with our partners at the Regional Health Authorities, Province, and Health Organizations

# Traditional Wellness Strategic Framework

- 2005 TCA Action– "Support and advocate for traditional medicines and practices"
- **Directive 3:** "Protect, incorporate and promote First Nations knowledge, beliefs, values, practices, medicines and models of health and healing into all health programs and services that serve BC First Nations."

- Traditional Wellness Strategic Framework released in March 2014
  - Led/directed by engagement with leaders and community
  - Traditional healing toolkit – currently being created



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# Eating Healthy

## Toddlers to Teens

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**Dietitian, Health Promotion and Prevention**
First Nations Health Authority

# Before we start...

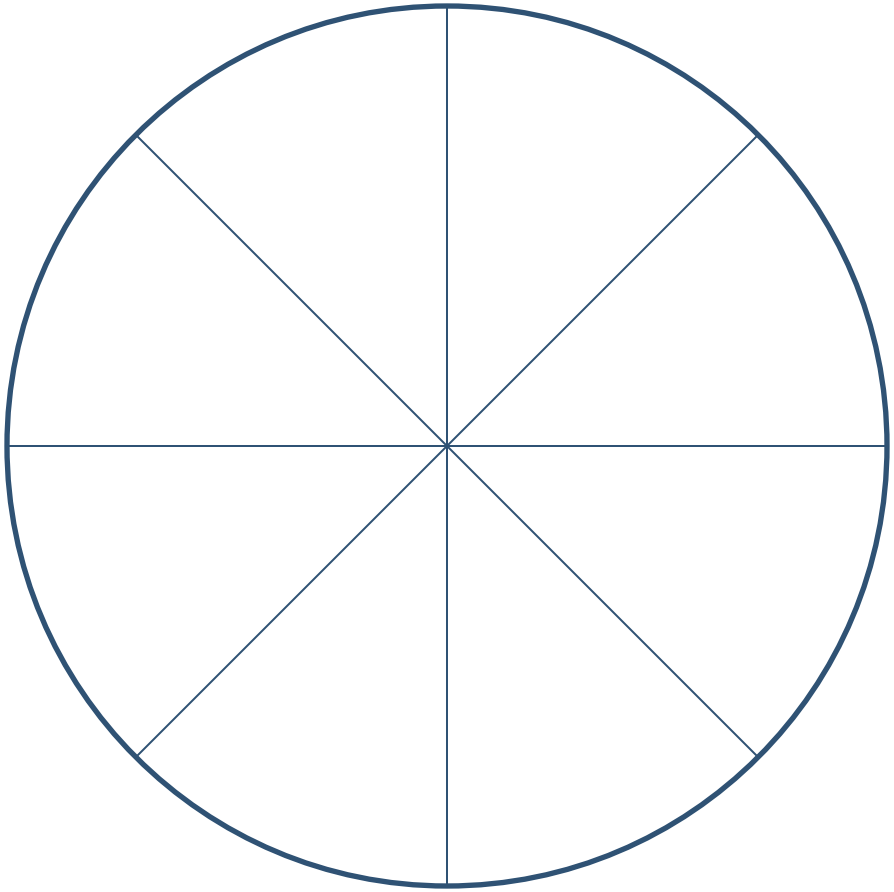
Today's presentation is based on 3 important factors:

Your child is healthy
Your family is functioning OK, and
Everyone in the family agrees about the way foods are offered.

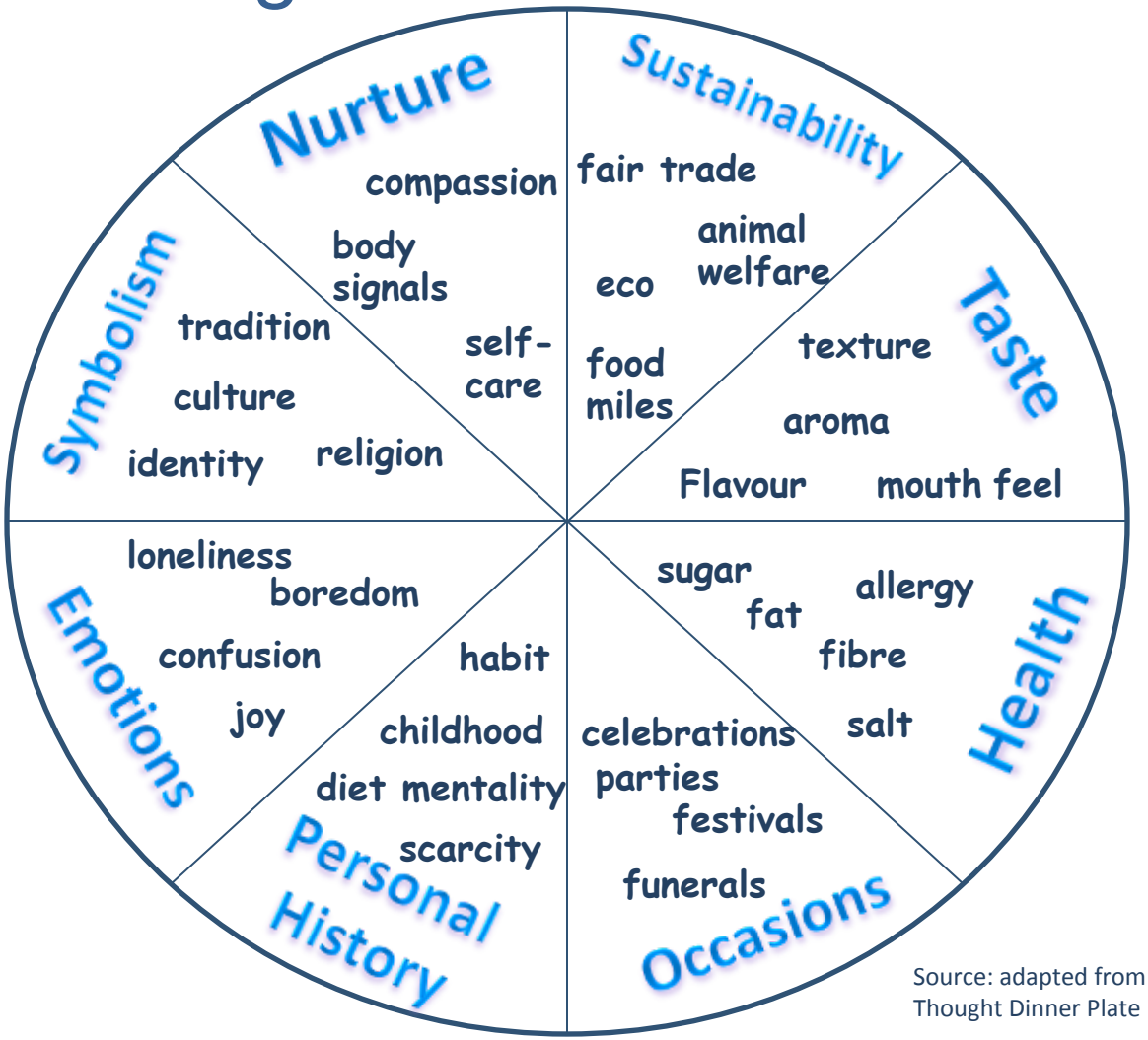
# Why do you eat food?

Draw or use words to fill in the diagram

Add in or take away sections



# Food for Thought




Source: adapted from Well Founded The Food for Thought Dinner Plate

# Externalized Eating is the Norm in North America

Breastfeeding vs infant formula

"Clean your plate"

"Just two more bites"

Gender aspects of eating

"I'm too fat" / "You're too fat"

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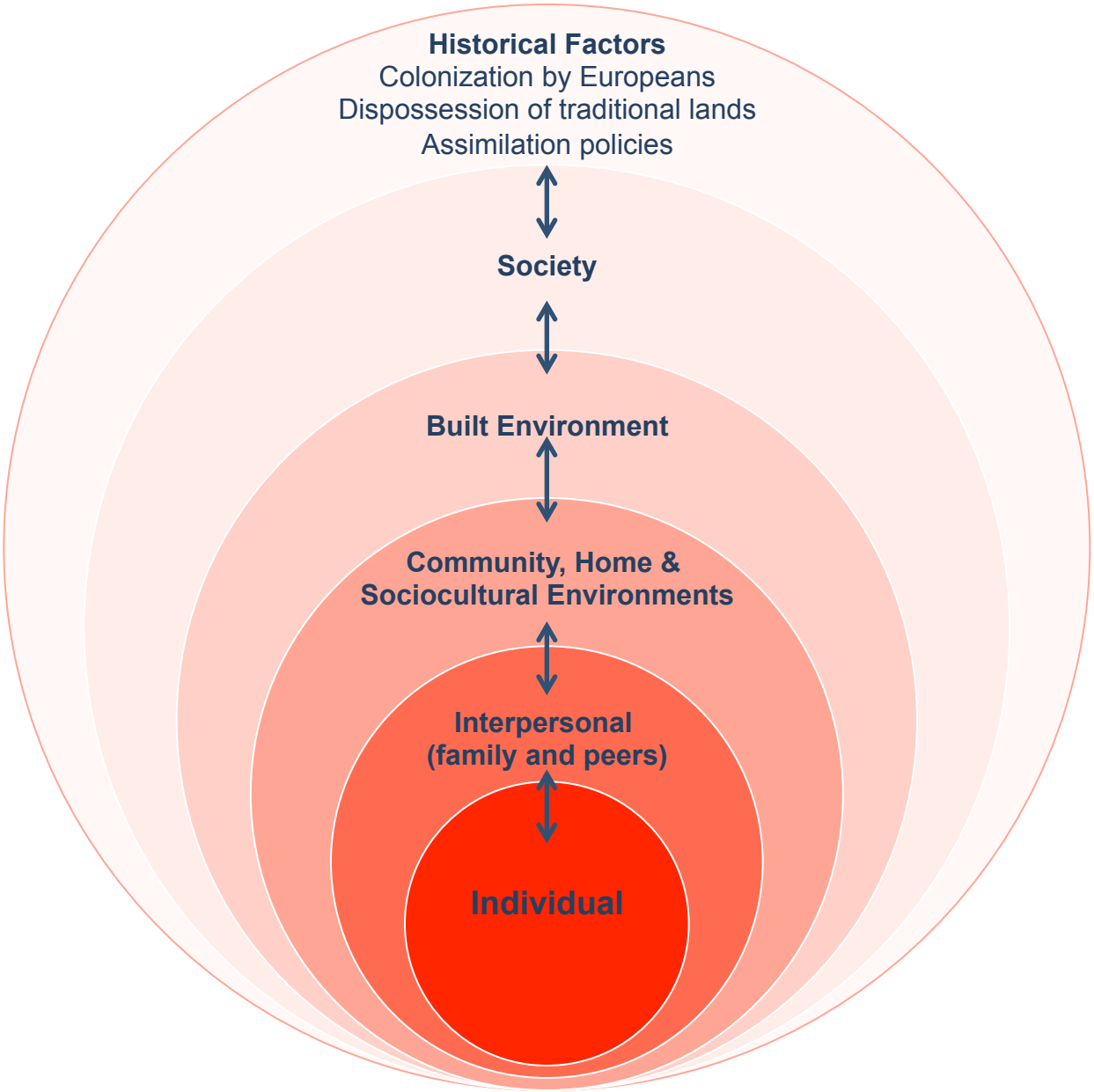
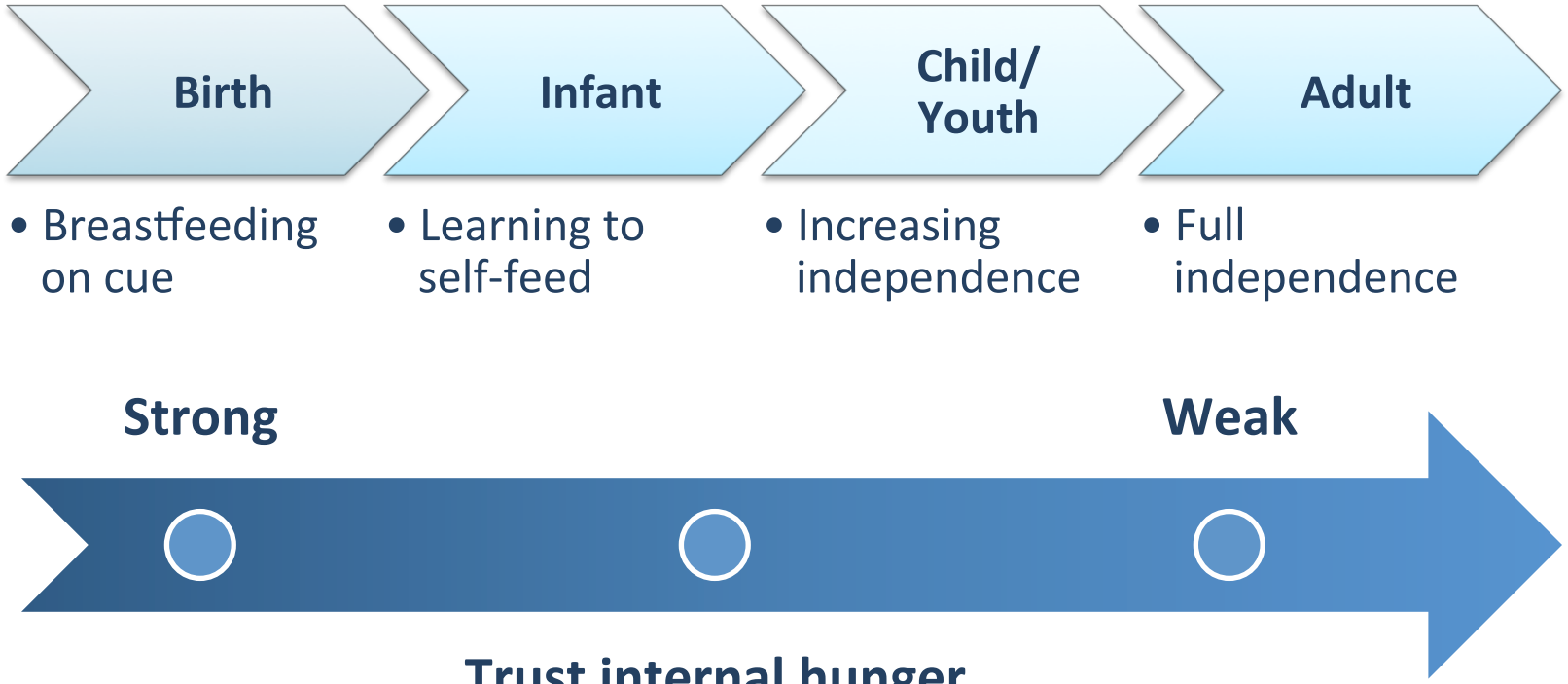
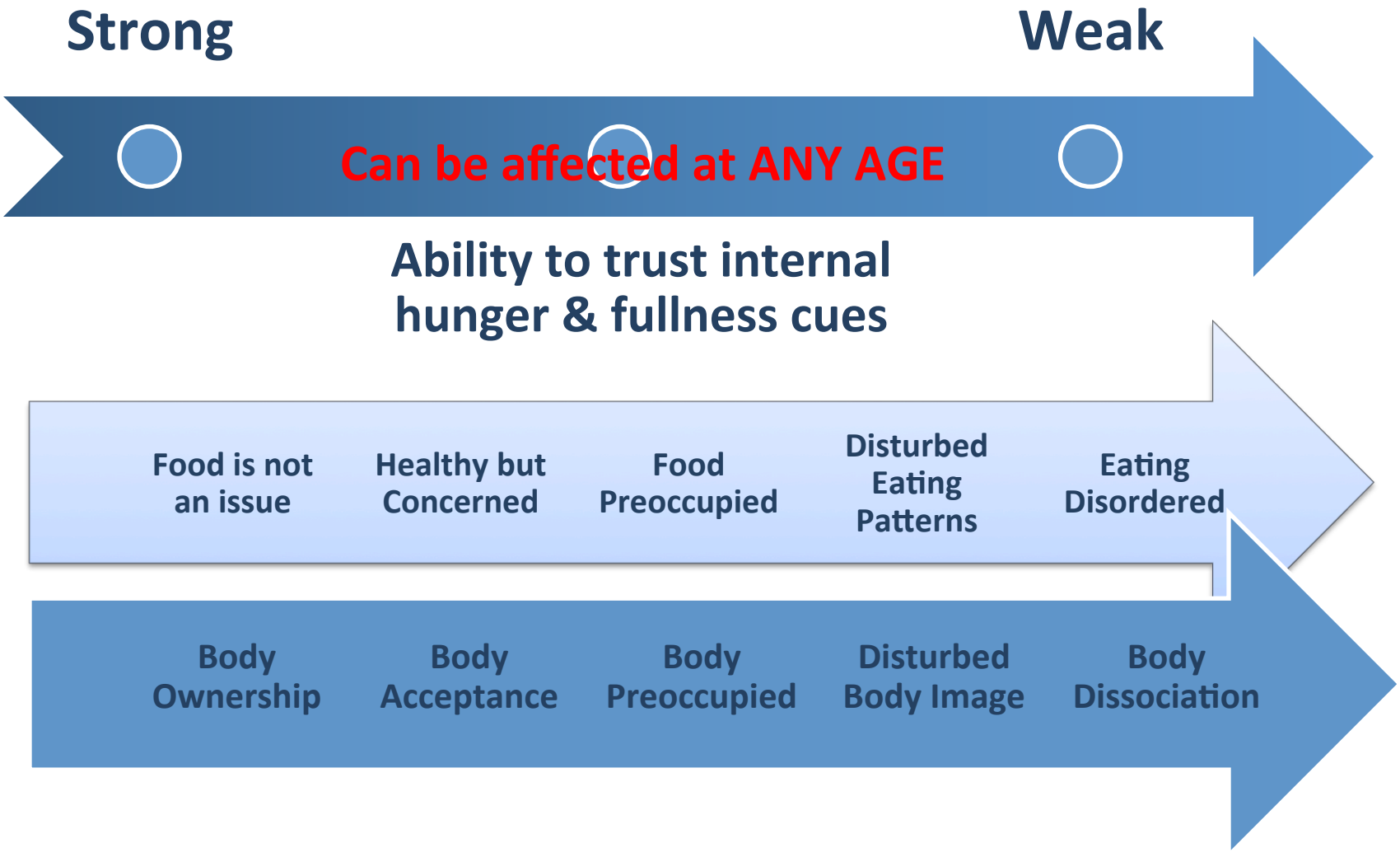
# Healthy Eating for First Nations Peoples


Historical Factors
Colonization by Europeans
Dispossession of traditional lands
Assimilation policies
Society
Built Environment
Community, Home &
Sociocultural Environments
Interpersonal
(family and peers)
Individual

# Relationship to food is about Trust

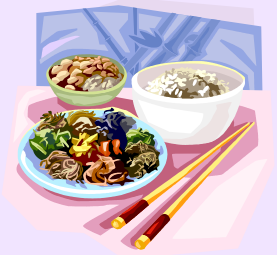


# How do we stop this continuum?



# "How" of Eating


## WHAT



Care givers decide ***what*** foods to offer

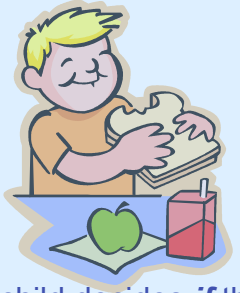
## WHEN

Care givers decide ***when*** to offer food

## WHERE

Care givers decide ***where*** to offer food


## IF



A child decides ***if*** they will eat

## HOW MUCH

A child decides ***how much*** food they will eat

# Mindful Eating

www.eatingmindfully.com

# A New You

## Clean Plate Club RESIGNATION CARD

I, _____, do hereby resign from the Clean Plate Club, now and forever more. I will honor my fullness even if it means leaving some food on my plate.

_____
Effective Date

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# The Division of Responsibility

A **Golden Rule** for the Dinner Table

# A Division of Responsibility

*Parents are responsible for* what *children are offered to eat and the* manner *in which it is presented.*

*Children are responsible for* how much *and even* whether *they eat.*

# A Division of Responsibility

*Parents are responsible for* what *children are offered to eat and the* manner *in which it is presented.*

*Children are responsible for* how much *and even* whether *they eat.*

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# Pressure *Won't* Work!

# Pressure ***Won't*** Work !

You should never force your child to eat,

nor should you try to restrict the amount your child eats

Forcing can take many forms:

- pressuring to eat is forcing
- withholding food is forcing
- pressuring to accept food is forcing

# Pressure ***Won't*** Work !

## It can be HARD not to force

Remember:

Small children are *neophobic*

# Pressure ***Won't*** Work !

Small children are *neophobic*

# Pressure ***Won't*** Work !

## It can be HARD not to force

Remember:

- Small children are *neophobic*
- Children vary in how much they eat

# Pressure ***Won't*** Work !

## It can be HARD not to force

Remember:

- Small children are *neophobic*
- Children vary in how much they eat
- Children vary in what they like

# Pressure ***Won't*** Work !

## It can be HARD not to force

Remember:

- Small children are *neophobic*
- Children vary in how much they eat
- Children vary in what they like

Even subtle forcing backfires:

- Rewarding children for eating is forcing!

# Pressure ***Won't*** Work !

"The world is full of dumb ideas about feeding, and they can mess up parents who are trying to do a good job."

When feeding is done poorly, children eat poorly and grow poorly.

Children learn from feeding what to expect from the world.

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# What is Normal Eating?

# What is Normal Eating?

Normal eating is being able to eat when you are hungry and continue eating until you are satisfied. It is being able to choose food you like and eat it and truly get enough of it - not just stop eating because you think you should. Normal eating is being able to use some moderate constraint in your food selection to get the right food, but *not* being so restrictive that you miss out on pleasurable foods. Normal eating is giving yourself permission to eat sometimes because you are happy, sad or bored, or just because it feels good.

# What is Normal Eating?

Normal eating is three meals a day, most of the time, but it can also be choosing to munch along. It is leaving some cookies on the plate because you know you can have some tomorrow, or it is eating more now because they taste so wonderful when they are fresh. Normal eating is overeating at times: feeling stuffed and uncomfortable. Normal eating is trusting your body to make up for your mistakes in eating. Normal eating takes up some of your time and attention, but keeps its place as only one important area of your life.

# What is Normal Eating?

In short, normal eating is flexible.

It varies in response to your emotions, your schedule, your hunger, and your proximity to food.

# What is Normal Eating?

Normal Eating *varies* according to:

- Temperament
- Our hunger
- How we feel about eating
- Food preferences
- Our natural tempos
- Children's capabilities

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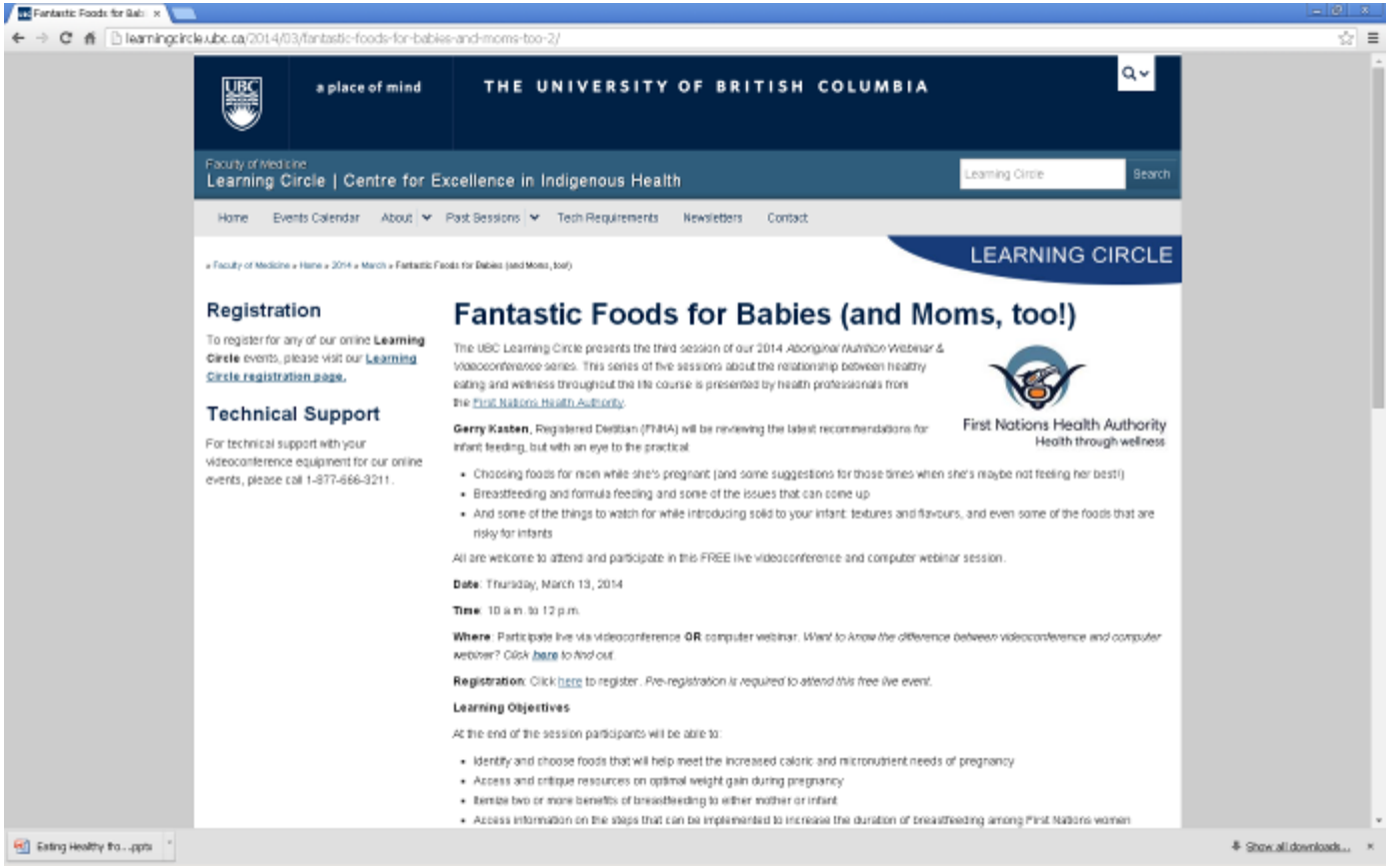
# Ages and Stages

# Ages and Stages

## Infants - Introductions



# Ages and Stages

## Infants – Introductions

Start when baby is about six months old

Start with meats or iron-fortified infant cereal

Introduce vegetables before fruit

If your family drinks milk, wait to introduce fluid milk (as the milk feeding) until about 9 months, or when baby is eating a variety of high-iron foods

Advance texture quickly and introduce *many* textures before 10 months

Feed the same foods as the rest of the family

# Safety Tips

**Always stay with your baby while he or she is eating or drinking.**

Do not give foods that can cause choking.

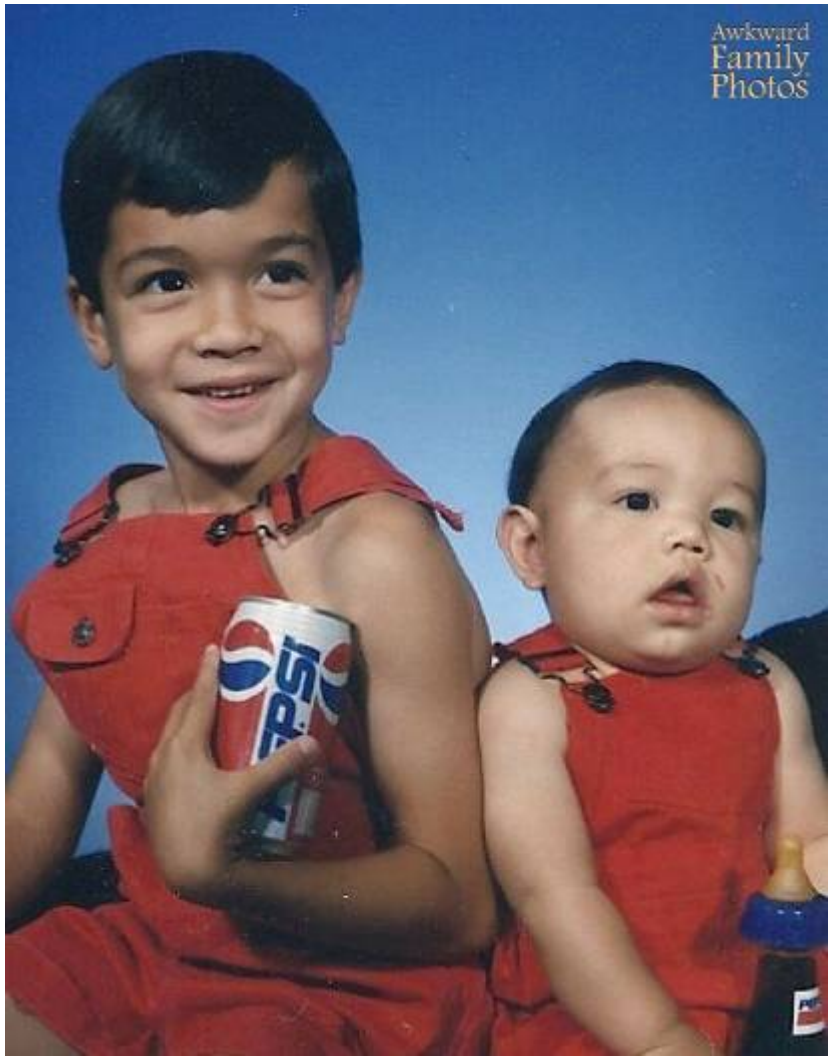
Grate raw vegetables, and slice and chop grapes into small pieces. Hot dogs and/or wieners are not a healthy choice, but if you offer these, cut them into small pieces.

Honey is not recommended for babies.

Carrots, spinach, turnips and beets should not be offered before 6 months of age.

Milk, juice and soft cheeses should be pasteurized.

Take the bones out of fish. Choose fish low in mercury.


Awkward
Family
Photos

# The Association of Sugar-Sweetened Beverage Intake During Infancy With Sugar-Sweetened Beverage Intake at 6 Years of Age


## abstract

**OBJECTIVES:** To examine whether sugar-sweetened beverage (SSB) intake during infancy predicts SSB intake at 6 years of age.

**METHODS:** A longitudinal cohort analysis of 1333 US children was conducted by using data from the 2005–2007 Infant Feeding Practices Study II and the 2012 Follow-Up Study at 6 years of age. The exposure variables were maternal-reported SSB intakes during infancy. The outcome variable was maternal-reported SSB intake at age 6 years. Multivariable logistic regression analyses were used to calculate adjusted odds ratios (aOR) for associations of SSB intake during infancy with consuming SSBs ≥1 time/day at 6 years old after controlling for baseline child's and parent's characteristics.

**RESULTS:** Based on maternal recall, approximately one-fifth of children consumed SSBs at least 1 time/day at age 6 years. Adjusted odds of consuming SSBs at age 6 years ≥1 time/day was significantly associated with any SSB intake during infancy (aOR, 2.22 vs none), age at SSB introduction (aOR, 2.33 for age ≥6 months and 2.01 for age <6 months vs never), and mean SSB intake during age 10 to 12 months (aOR, 2.72 for 1 to <2 times/week and 2.57 for ≥3 times/week vs none).

**CONCLUSIONS:** SSB intake during infancy significantly increased the likelihood of consuming SSBs ≥1 time/day at 6 years of age. Our findings suggest that infancy may be an important time for mothers to establish healthy beverage practices for their children and these findings can be used to inform intervention efforts to reduce SSB intake among children. *Pediatrics* 2014;134:S56–S62



**AUTHORS:** Sohyun Park, PhD, Liping Pan, MD, MPH, Bettylou Sherry, PhD, RD, and Ruowei Li, MD, PhD

*Division of Nutrition, Physical Activity, and Obesity, Centers for Disease Control and Prevention, Atlanta, Georgia*



**KEY WORDS**

sugar-sweetened beverage, children, Infant Feeding Practice Study II


**ABBREVIATIONS**

aOR—adjusted odds ratios
CI—confidence interval
IFPS II—Infant Feeding Practices Study II
OR—odds ratios
SSB—sugar-sweetened beverage
Y6FU—Year 6 Follow-Up

Dr Park conceptualized and designed the study, conducted the data analyses, interpreted the data, wrote the first draft of the manuscript, and took the lead in revising the manuscript; Dr Pan conceptualized and designed the study, assisted with the data analyses, and reviewed and revised the manuscript; Dr Sherry conceptualized the study and reviewed and revised the manuscript; Dr Li conceptualized and designed the study, assisted with the data analyses, reviewed and revised the manuscript; and all authors approved the final manuscript as submitted.

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.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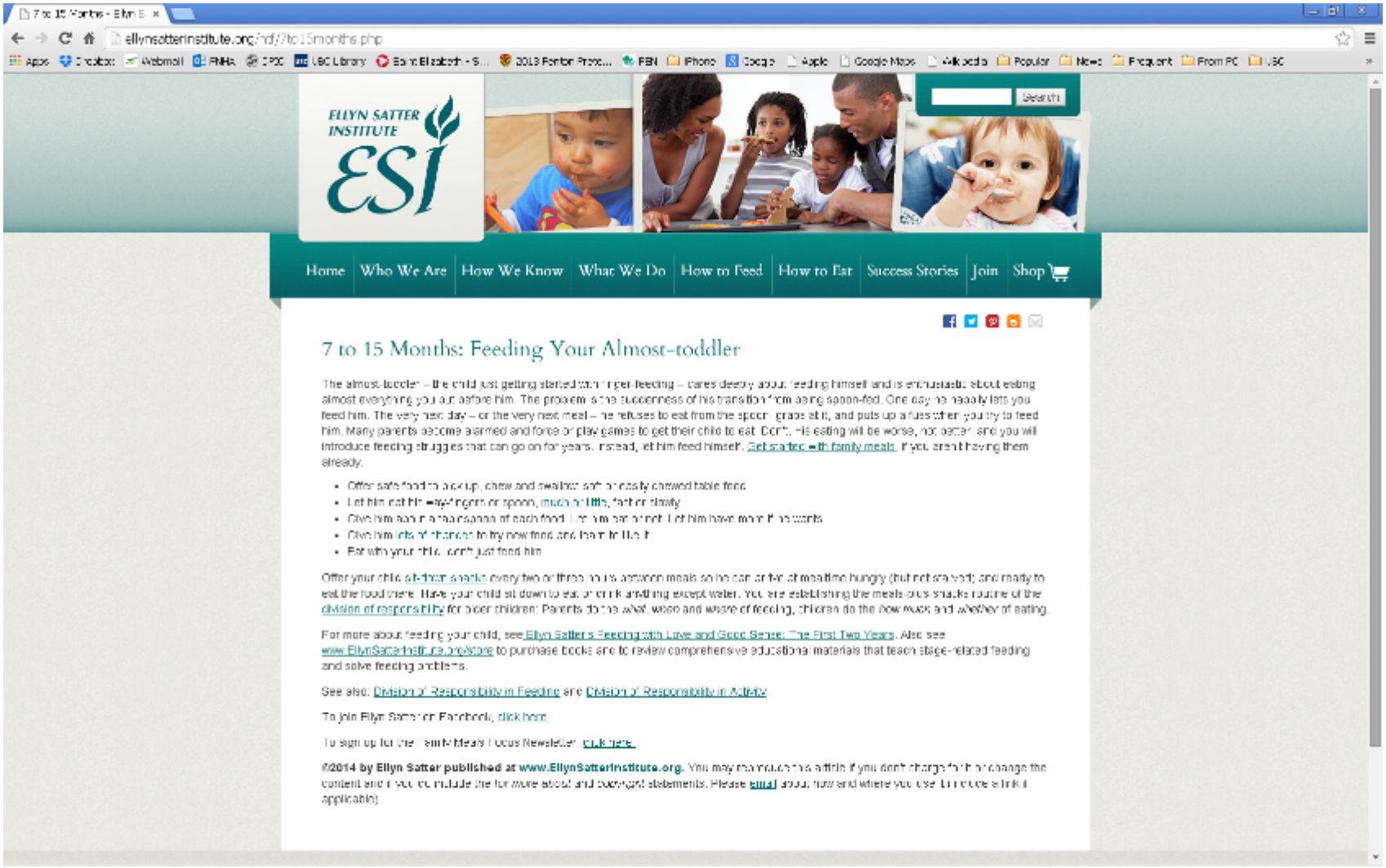
**FUNDING:** This study was funded by the US Food and Drug Administration, Centers for Disease Control and Prevention, Office on Women's Health, National Institutes of Health, and Maternal and Child Health Bureau in the US Department of Health and Human Services.


**POTENTIAL CONFLICT OF INTEREST:** The authors have indicated they have no potential conflicts of interest to disclose.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7 to 15 Months: Feeding Your Almost-toddler
The almost-toddler – the child just getting started with finger-feeding – cares deeply about feeding himself and is enthusiastic about eating almost everything you put before him. The problem is the suddenness of his transition from being spoon-fed. One day he happily lets you feed him. The very next day – or the very next meal – he refuses to eat from the spoon, grabs at it, and puts up a fuss when you try to feed him. Many parents become alarmed and force or play games to get their child to eat. Don't. His eating will be worse, not better, and you will introduce feeding struggles that can go on for years. Instead, let him feed himself. Get started with family meals, if you aren't having them already.
Offer safe foods to pick up, chew and swallow: soft or easily chewed table food
Let him eat his way: fingers or spoon, much or little, fast or slowly
Give him about a tablespoonful of each food. Let him eat or not. Let him have more if he wants
Give him lots of chances to try new food and learn to like it
Eat with your child, don't just feed him
Offer your child sit-down snacks every two or three hours between meals so he can arrive at mealtime hungry (but not starved) and ready to eat the food there. Have your child sit down to eat or drink anything except water. You are establishing the meals-plus-snacks routine of the division of responsibility for older children: Parents do the what, when and where of feeding, children do the how much and whether of eating.
For more about feeding your child, see Ellyn Satter's Feeding with Love and Good Sense: The First Two Years. Also see www.EllynSatterInstitute.org/store to purchase books and to review comprehensive educational materials that teach stage-related feeding and solve feeding problems.
See also: Division of Responsibility in Feeding and Division of Responsibility in Activity
To join Ellyn Satter on Facebook, click here.
To sign up for the Family Meals Focus Newsletter, click here.
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# Ages and Stages

## Toddlers & Eating - Setting Limits

Toddlers are discoverers - they are exploring their world and learning that they are separate people.

“NO!” - The toddler’s anthem.

Toddlers need limits.

You are not responsible for getting food *into* your child, only for getting it *to* your child


The French Rejection 26
God of Cricket 40
TIME
ARE YOU
MOM
ENOUGH?
Why attachment parenting drives some mothers to extremes—and how Dr. Bill Sears became their guru
BY KATE PICKERT
Jamie Lynne Grumet, 26, and her 3-year-old son

# Breastfeeding Duration Is Associated With Child Diet at 6 Years


## abstract

**BACKGROUND AND OBJECTIVE:** Breastfeeding has been associated with early infant food preferences, but less is known about how breastfeeding is associated with later child diet. The objective of this study was to assess whether any and exclusive breastfeeding duration are associated with child diet at 6 years.

**METHODS:** We linked data from the Infant Feeding Practices Study II and Year 6 Follow-Up. We used approximately monthly questionnaires throughout infancy to calculate any and exclusive breastfeeding duration ($n$ = 1355). We calculated median daily frequency of intake of water, milk, 100% juice, fruits, vegetables, sugar-sweetened beverages, sweets, and savory snacks at 6 years from a dietary screener and examined frequency of consumption of each food or beverage group by any and exclusive breastfeeding duration. We used separate multivariable logistic regression models to calculate odds of consuming more than the median daily frequency of intake of food or beverage items, adjusting for confounders.

**RESULTS:** Intake of milk, sweets, and savory snacks at 6 years was not associated with any or exclusive breastfeeding duration in unadjusted analyses. Frequency of consumption of water, fruits, and vegetables was positively associated, and intake of sugar-sweetened beverages was inversely associated with any and exclusive breastfeeding duration in adjusted models; 100% juice consumption was inversely associated with exclusive breastfeeding duration only.

**CONCLUSIONS:** Among many other health benefits, breastfeeding is associated with a number of healthier dietary behaviors at age 6. The association between breastfeeding and child diet may be an important factor to consider when examining associations between breastfeeding and child obesity and chronic diseases. *Pediatrics* 2014;134:S50–S55



**AUTHORS:** Cria G. Perrine, PhD,[a,b] Deborah A. Galuska, PhD,[a] Frances E. Thompson, MPH, PhD,[c] and Kelley S. Scanlon, PhD, RD[a]

[a]*Division of Nutrition, Physical Activity, and Obesity, Centers for Disease Control and Prevention, Atlanta, Georgia;* [b]*US Public Health Service Commissioned Corps, Atlanta, Georgia; and* [c]*Division of Cancer Control and Population Sciences, National Cancer Institute, Bethesda, Maryland*



**KEY WORDS**

breastfeeding duration, exclusive breastfeeding, diet, fruits, vegetables, sugar-sweetened beverages


**ABBREVIATIONS**

CI—confidence interval
DGA—Dietary Guidelines for Americans
IFPS II—Infant Feeding Practices Study II
OR—odds ratio
YSFU—Year 6 Follow-Up

Dr Perrine contributed to the analytic study design, conducted the analysis, and drafted the manuscript; Dr Galuska contributed to the analytic study design; Dr Thompson contributed to development of the dietary screener; Dr Scanlon contributed to development of the dietary screener and contributed to the analytic study design; and all authors reviewed and approved the final manuscript as submitted.

The findings and conclusions in this report are those of the authors and do not necessarily represent the official positions of the Centers for Disease Control and Prevention or the National Institutes of Health.


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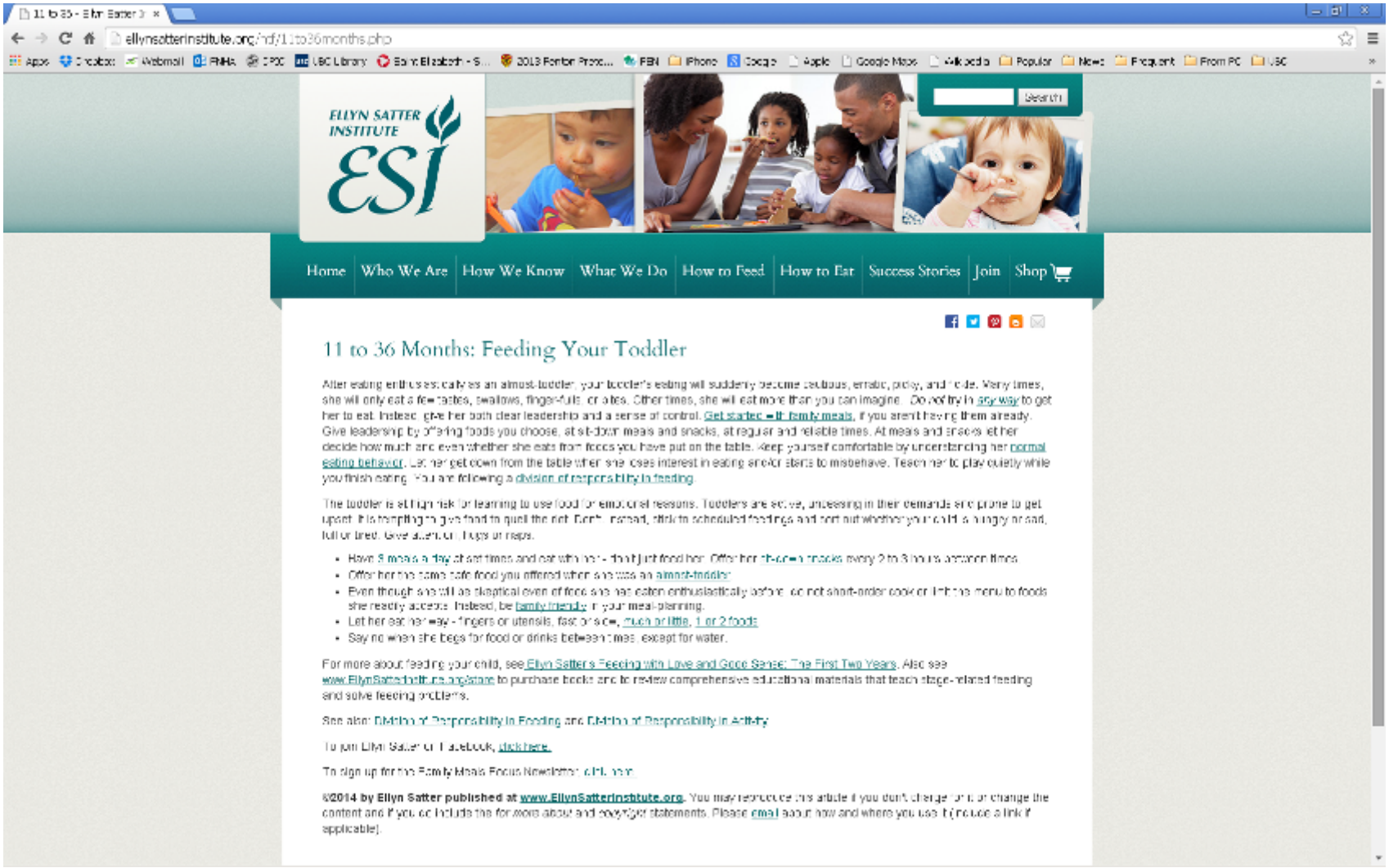
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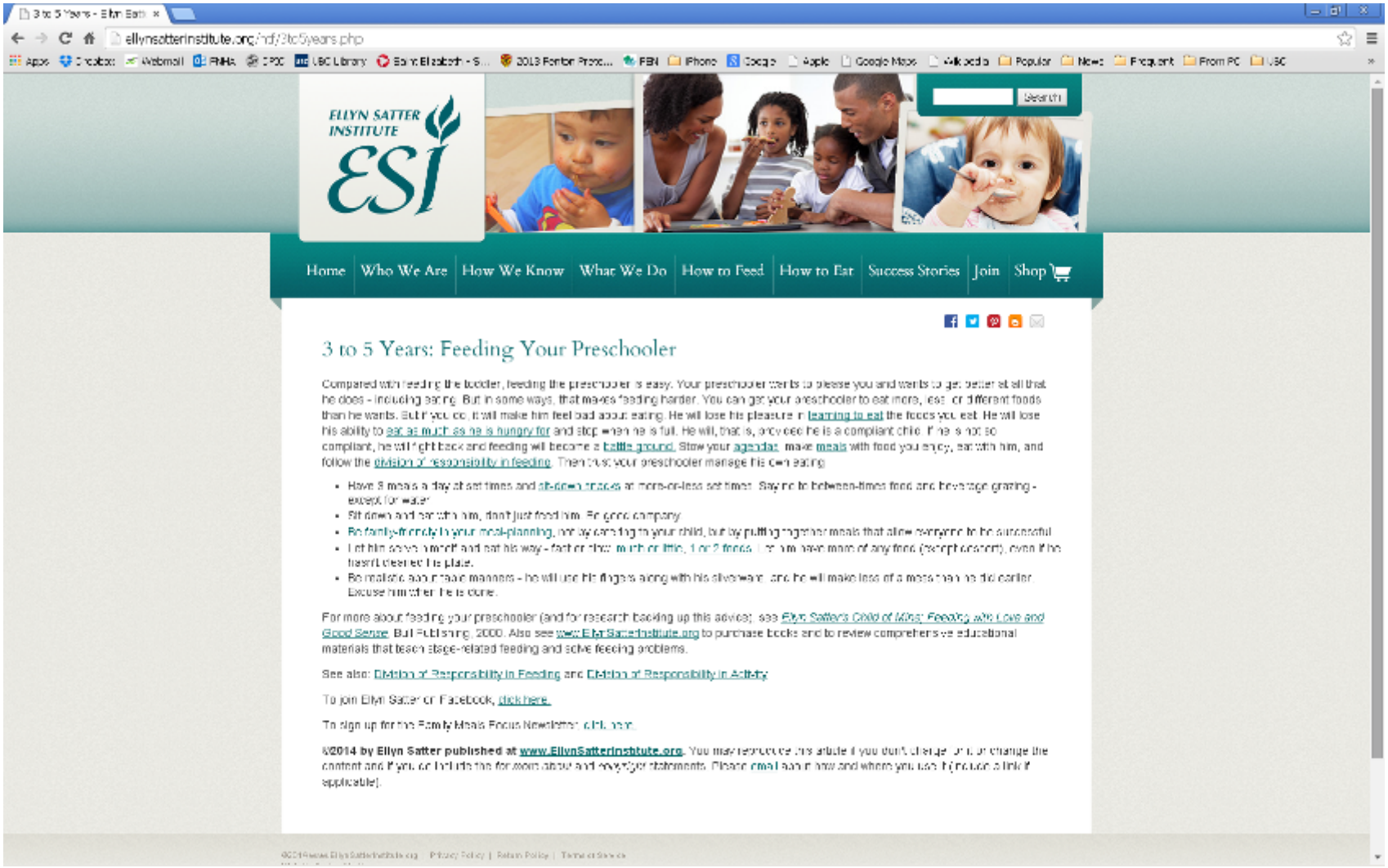
# Ages and Stages

## Preschoolers & Eating - Structure !

The preschooler knows what she's doing - she can chew and swallow, she's less neophobic, she's learned to be neater.

Structure becomes more important. A parent's responsibility is choosing foods, serving them at meal & snack times and modeling eating behaviour.

Kids *still* know how much they can eat.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3 to 5 Years: Feeding Your Preschooler
Compared with feeding the toddler, feeding the preschooler is easy. Your preschooler wants to please you and wants to get better at all that he does - including eating. But in some ways, that makes feeding harder. You can get your preschooler to eat more, less or different foods than he wants. But if you do, it will make him feel bad about eating. He will lose his pleasure in learning to eat the foods you eat. He will lose his ability to eat as much as he is hungry for and stop when he is full. He will, that is, only see he is a compliant child. If he is not so compliant, he will fight back and feeding will become a battle ground. Stow your agendas, make meals with food you enjoy, eat with him, and follow the division of responsibility in feeding. Then trust your preschooler manage his own eating.
Have 3 meals a day at set times and sit-down snacks at more-or-less set times. Say no to between-times food and beverage grazing - except for water.
Sit down and eat with him, don't just feed him. Be good company.
Be family-friendly in your meal-planning, not by catering to your child, but by putting together meals that allow everyone to be successful.
Let him serve himself and eat his way - fast or slow, much or little, 1 or 2 foods. Let him have more of any food (except dessert), even if he hasn't cleared his plate.
Be realistic about table manners - he will use his fingers along with his silverware, and he will make less of a mess than he did earlier. Excuse him after he is done.
For more about feeding your preschooler (and for research backing up this advice), see Ellyn Satter's Child of Mine: Feeding with Love and Good Sense. Bull Publishing, 2000. Also see www.EllynSatterInstitute.org to purchase books and to review comprehensive educational materials that teach stage-related feeding and solve feeding problems.
See also: Division of Responsibility in Feeding and Division of Responsibility in Activity
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# Ages and Stages

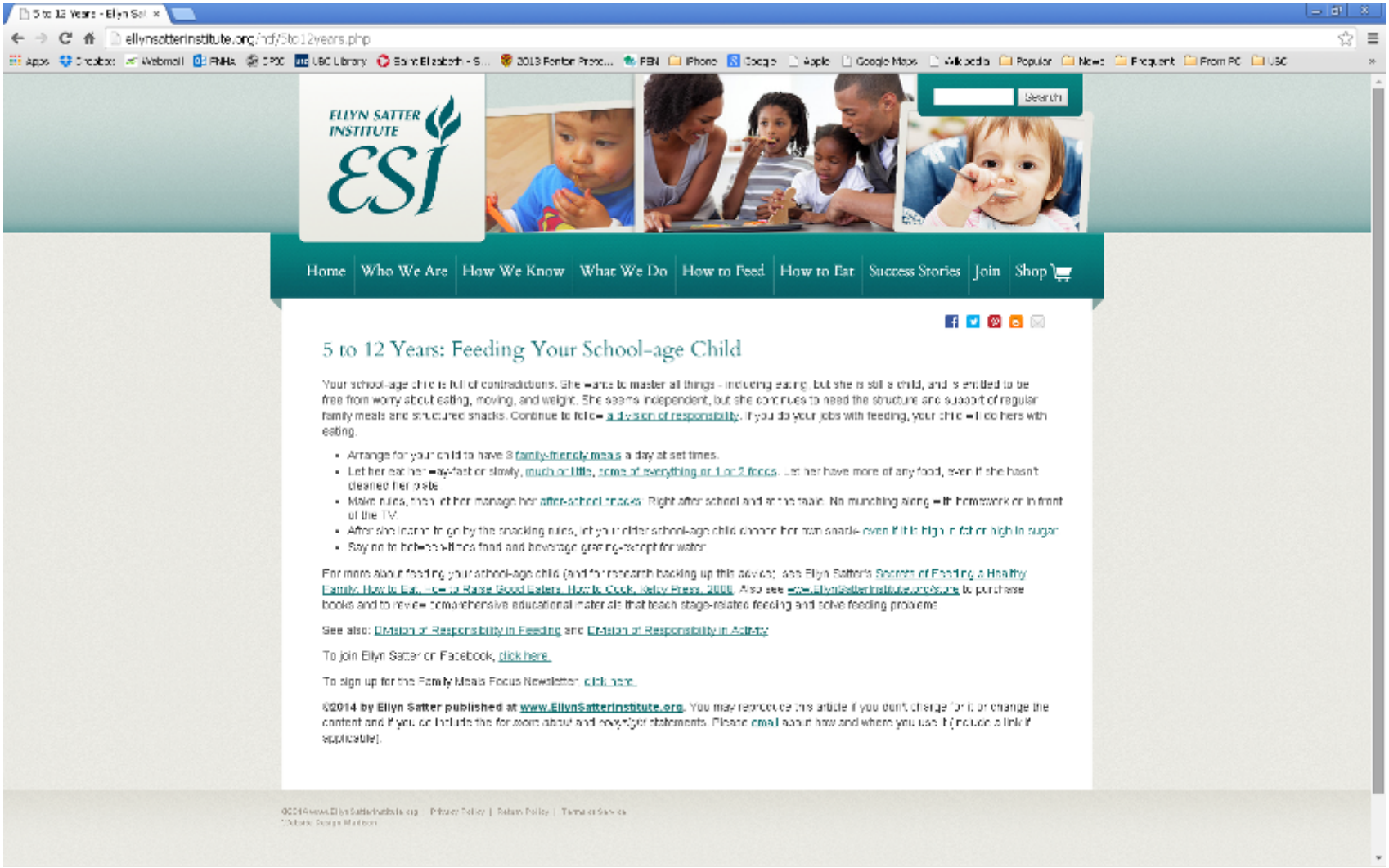
## School Aged Kids - Supporting Choices

School-agers are learning to be independent. They are making more choices for themselves.

Friends become more important.

Eating at home is the same, but...

For eating away from home, you can only offer advice, support & backup. Kids are learning to make their own choices.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5 to 12 Years: Feeding Your School-age Child
Your school-age child is full of contradictions. She wants to master all things - including eating, but she is still a child, and is entitled to be free from worry about eating, moving, and weight. She seems independent, but she continues to need the structure and support of regular family meals and structured snacks. Continue to follow a division of responsibility. If you do your jobs with feeding, your child will do hers with eating.
Arrange for your child to have 3 family-friendly meals a day at set times.
Let her eat her way-fast or slowly, much or little, some of everything or 1 or 2 foods. Let her have more of any food, even if she hasn't cleaned her plate.
Make rules, help out her manage her after-school snacks. Right after school and at set times. No munching along with homework or in front of the TV.
After she learns to go by the snacking rules, let your older school-age child choose her own snacks- even if it is high in fat or high in sugar.
Stay out of battles with food and beverages other-except for water.
For more about feeding your school-age child (and to research backing up this advice), see Ellyn Satter's Secrets of Feeding a Healthy Family: How to Eat, How to Raise Good Eaters, How to Cook, Jelly Press, 2008. Also see www.EllynSatterInstitute.org/store to purchase books and to review comprehensive educational materials that teach stage-related feeding and solve feeding problems.
See also: Division of Responsibility in Feeding and Division of Responsibility in Activity
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# Healthy Food Guidelines

## For First Nations Communities

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# Ages and Stages

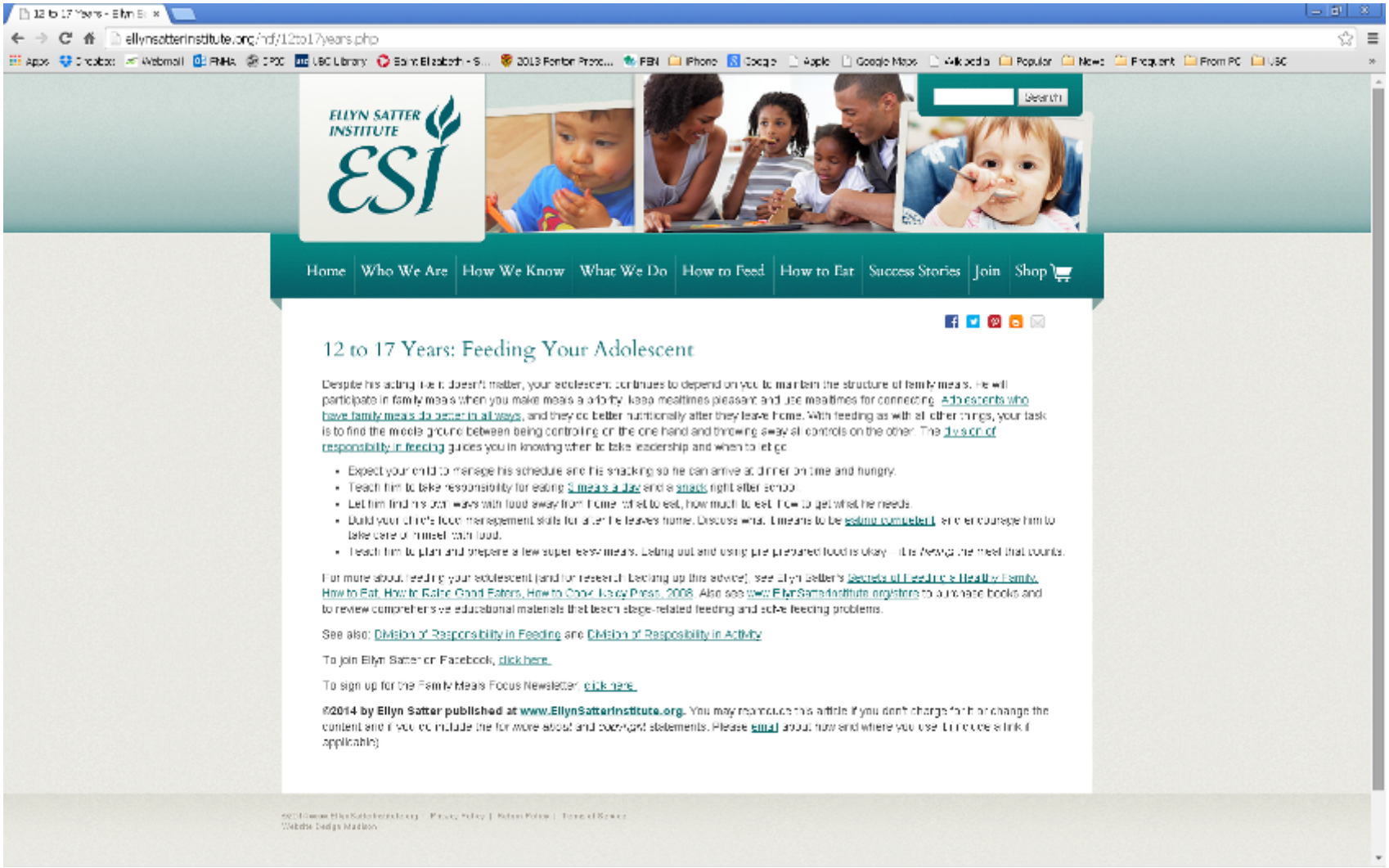
## Teenagers - Letting Go ! !

By now, your work is mostly done.

Your task is food for the home, not outside it. Kids will make their own choices there, & those will have little to do with nutrition.

The structure still needs to be there, but won't earn you any thanks.

Boys will be into eating, girls will be into dieting.


ellynsatterinstitute.org/nf/12to17years.php
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What We Do
How to Feed
How to Eat
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12 to 17 Years: Feeding Your Adolescent
Despite his acting like it doesn't matter, your adolescent continues to depend on you to maintain the structure of family meals. He will participate in family meals when you make meals a priority, keep mealtimes pleasant and use mealtimes for connecting. Adolescents who have family meals do better in all ways, and they do better nutritionally after they leave home. With feeding as with all other things, your task is to find the middle ground between being controlling on the one hand and throwing away all controls on the other. The division of responsibility in feeding guides you in knowing when to take leadership and when to let go.
Expect your child to manage his schedule and his snacking so he can arrive at dinner on time and hungry.
Teach him to take responsibility for eating 3 meals a day and a snack right after school.
Let him find his own ways with food away from home: what to eat, how much to eat, how to get what he needs.
Build your child's food management skills for after he leaves home. Discuss what it means to be eating competently, and encourage him to take care of himself with food.
Teach him to plan and prepare a few super easy meals. Eating out and using pre-prepared foods is okay. It's how he eats that counts.
For more about feeding your adolescent (and for research backing up this advice), see Ellyn Satter's Secrets of Feeding a Healthy Family, How to Eat, How to Raise Good Eaters, How to Cook Your Kid's Eat, 2008. Also see www.EllynSatterInstitute.org/store to purchase books and to review comprehensive educational materials that teach stage-related feeding and solve feeding problems.
See also: Division of Responsibility in Feeding and Division of Responsibility in Activity
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"Dieting *ratchets* your weight higher and higher…"

# What We Know

Weight loss is independent of diet composition

Amount of weight loss is variable

Individuals who diet reduce energy intake

Weight loss is associated with decreased blood lipids, improved glycemic control, and decreased blood pressure, irrespective of fuel source

# What we Know

## Weight Loss studies may overstate results:

"Results indicate that 8.9% of studies have overreaching conclusions with a higher percentage in 2011 compared to 2001. Unfunded studies were more likely to have an overstatement of results of the type described here. In contrast, those with a greater number of coauthors were significantly less likely than those with four or fewer authors (the reference group) to have overstated results"

### Overstatement of Results in the Nutrition and Obesity Peer-Reviewed Literature

Nir Menachemi, PhD, MPH, Gabriel Tajeu, MPH, Bisakha Sen, PhD, Alva O. Ferdinand, JD, DrPH, Chelsea Singleton, MPH, Janice Utley, MPH, Olivia Affuso, PhD, David B. Allison, PhD

**Background:** Scientific authors who overreach in presenting results can potentially, without intending to, distort the state of knowledge and inappropriately influence clinicians, decision makers, the media, and the public.

**Purpose:** The goal of the study was to determine the extent to which authors present overreaching statements in the obesity and nutrition literature, and whether journal, author, or study characteristics are associated with this practice.

**Methods:** A total of 937 papers on nutrition or obesity published in 2001 and 2011 in leading specialty, medical, and public health journals were systematically studied to estimate the extent to which authors overstate the results of their study in the published abstract. Focus was placed on overreaching statements that may include (1) reporting an associative relationship as causal; (2) making policy recommendations based on observational data that show associations only (e.g., not cause and effect); and (3) generalizing to a population not represented by their sample. Data were compiled in 2012 and analyzed in 2013.

**Results:** Results indicate that 8.9% of studies have overreaching conclusions with a higher percentage in 2011 compared to 2001 (OR=2.14, risk difference=+3.9%, $p$=0.020). Unfunded studies (OR=2.41, $p$=0.039) were more likely to have an overstatement of results of the type described here. In contrast, those with a greater number of coauthors were significantly less likely than those with four or fewer authors (the reference group) to have overstated results (seven or eight authors: OR=0.30, risk difference=−6.1%, $p$=0.008; ≥9 authors: OR=0.41, risk difference=−4.0%, $p$=0.037).

**Conclusions:** Overreaching in presenting results in studies focused on nutrition and obesity topics is common in articles published in leading journals. Testable strategies are proposed to reduce the prevalence of such instances in the literature.

(Am J Prev Med 2013;45(5):615–621) © 2013 American Journal of Preventive Medicine

**Introduction**

A critical responsibility of scientists is to unambiguously and accurately communicate the methods, findings, and limitations of their work. Departures from this form of presentation have the potential to distort the state of knowledge and inappropriately influence clinicians, decision makers, the media, and the public; they may also undermine the credibility of future scientific work. For example, authors may deliberately or unintentionally overstate the findings of their work. Such overstatements can include reporting an associative relationship as causal; making policy recommendations based on observational data that show associations only (e.g., not cause and effect); and inappropriately generalizing to a population not represented by the sample studied. While the reasons underlying such overstatements have not been established, such statements have the potential to erode the credibility of the scientific community. They also have the potential to be amplified and disseminated to a larger audience when they are reported by journalists, who are a key source for public information about scientific

From the Department of Health Care Organization and Policy (Menachemi, Tajeu, Sen, Ferdinand, Utley), the Department of Epidemiology (Singleton, Affuso), the Office of Energetics (Allison), School of Public Health and Nutrition Obesity Research Center, University of Alabama at Birmingham, Birmingham, Alabama

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0749-3797/$36.00
http://dx.doi.org/10.1016/j.amepre.2013.06.019

# What We Don't Know

- Long-term Metabolic Effects
  - –Bone Changes
  - –Renal Function
  - –Blood lipids-changes due to weight loss or fuel source
- Why is weight loss so variable
  - –Differences in effectiveness of diet?
  - –Differences in acceptability?
- How weight loss can be maintained

International Journal of Obesity (2012) 36, 456–464

0307-0565/12
www.nature.com/ijo

## ORIGINAL ARTICLE

# Does dieting make you fat? A twin study

KH Pietiläinen[1,2,3], SE Saarni[2,4], J Kaprio[2,3,4] and A Rissanen[1]

[1]*Obesity Research Unit, Department of Medicine, Division of Internal Medicine and Department of Psychiatry, Helsinki University Central Hospital, Helsinki, Finland;* [2]*Finnish Twin Cohort Study, Department of Public Health, Hjelt Institute, University of Helsinki, Helsinki, Finland;* [3]*Institute for Molecular Medicine, Helsinki, Finland and* [4]*Department of Mental Health and Substance Abuse Services, National Institute for Health and Welfare, Helsinki, Finland*

**Objective:** To investigate whether the paradoxical weight gain associated with dieting is better related to genetic propensity to weight gain than to the weight loss episodes themselves.
**Subjects:** Subjects included 4129 individual twins from the population-based FinnTwin16 study (90% of twins born in Finland 1975–1979). Weight and height were obtained from longitudinal surveys at 16, 17, 18 and 25 years, and number of lifetime intentional weight loss (IWL) episodes of more than 5 kg at 25 years.
**Results:** IWLs predicted accelerated weight gain and risk of overweight. The odds of becoming overweight (body mass index (BMI) $\geq 25\,kg\,m^{-2}$) by 25 years were significantly greater in subjects with one (OR 1.8, 95% CI 1.3–2.6, and OR 2.7, 1.7–4.3 in males and females, respectively), or two or more (OR 2.0, 1.3–3.3, and OR 5.2, 3.2–8.6, in males and females, respectively), IWLs compared with subjects with no IWL. In MZ pairs discordant for IWL, co-twins with at least one IWL were $0.4\,kg\,m^{-2}$ ($P=0.041$) heavier at 25 years than their non-dieting co-twins (no differences in baseline BMIs). In DZ pairs, co-twins with IWLs gained progressively more weight than non-dieting co-twins (BMI difference $1.7\,kg\,m^{-2}$ at 16 years and $2.2\,kg\,m^{-2}$ at 25 years, $P<0.001$).
**Conclusion:** Our results suggest that frequent IWLs reflect susceptibility to weight gain, rendering dieters prone to future weight gain. The results from the MZ pairs discordant for IWLs suggest that dieting itself may induce a small subsequent weight gain, independent of genetic factors.
*International Journal of Obesity* (2012) **36**, 456–464; doi:10.1038/ijo.2011.160; published online 9 August 2011

**Keywords:** weight loss; weight regain; longitudinal studies; genetic; twins

## Introduction

'Dieting makes you fat' is the provocative title of a diet book published 25 years ago[1] and the subject of several articles thereafter.[2,3] Ample clinical data also confirm that most dieters rapidly re-gain any achieved weight loss or even more. In prospective studies, weight control efforts have predicted future weight gain[4–8] even after adjustment for potential confounders such as age, body mass index (BMI) at baseline, smoking, alcohol use and social class.[9] A 3-year follow-up study of adolescents[10] showed that baseline dieting behaviours predicted an increased risk for obesity, and that weight reduction efforts were likely to result in weight gain rather than weight loss. A 5-year follow-up study in adolescents found this to be partly due to the adoption of deleterious behavioural patterns (breakfast skipping, lower levels of fruit and vegetable consumption, and lower physical activity, and binging) that are counterproductive for weight management.[11] The long-term result of dieting thus may paradoxically be the opposite of the desired goal.

There are at least three possible explanations for the paradox. First, restrictive dieting may lead to preoccupation with food and trigger overeating.[12] Second, suppression of metabolic rate and loss of lean mass by the negative energy balance may facilitate post-dieting weight-rebound.[13] These 'defensive' reactions (psychological or physiological) to dieting work so as to restore any weight lost through dieting and could in theory persist beyond the point of weight restoration. In the worst case, net weight gain would be accompanied by undesirable changes in body composition, with a disproportionate replenishment of fat stores.[14] The third explanation, the so-called 'obesity paradox' reverses the direction of causality between dieting and weight gain that is, dieting is seen simply as a reaction to the propensity of weight gain rather than vice versa.[3]

Both BMI and the number of intentional weight loss (IWL) episodes have substantial genetic components, 75% and

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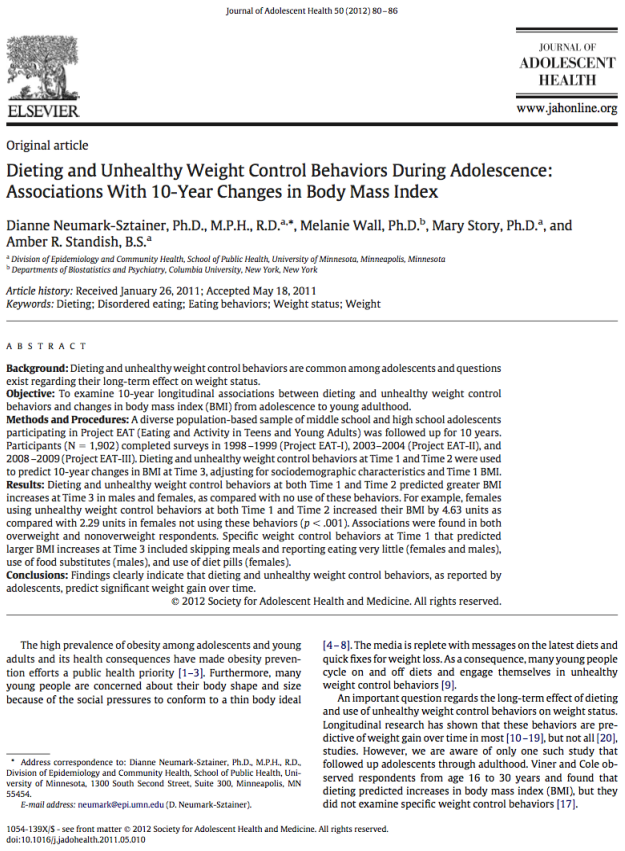
Received 17 December 2010; revised 16 May 2011; accepted 24 June 2011; published online 9 August 2011

# Dieting DOES Make You Fat

"Dieting and unhealthy weight control behaviors at both Time 1 and Time 2 predicted greater BMI increases at Time 3 in males and females, as compared with no use of these behaviors.

For example, females using unhealthy weight control behaviors at both Time 1 and Time 2 increased their BMI by 4.63 units as compared with 2.29 units in females not using these behaviors."



Journal of Adolescent Health 50 (2012) 80–86

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Original article

## Dieting and Unhealthy Weight Control Behaviors During Adolescence: Associations With 10-Year Changes in Body Mass Index

Dianne Neumark-Sztainer, Ph.D., M.P.H., R.D.[a,*], Melanie Wall, Ph.D.[b], Mary Story, Ph.D.[a], and Amber R. Standish, B.S.[a]

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[b] *Departments of Biostatistics and Psychiatry, Columbia University, New York, New York*

*Article history:* Received January 26, 2011; Accepted May 18, 2011
*Keywords:* Dieting; Disordered eating; Eating behaviors; Weight status; Weight

ABSTRACT

**Background:** Dieting and unhealthy weight control behaviors are common among adolescents and questions exist regarding their long-term effect on weight status.
**Objective:** To examine 10-year longitudinal associations between dieting and unhealthy weight control behaviors and changes in body mass index (BMI) from adolescence to young adulthood.
**Methods and Procedures:** A diverse population-based sample of middle school and high school adolescents participating in Project EAT (Eating and Activity in Teens and Young Adults) was followed up for 10 years. Participants (N = 1,902) completed surveys in 1998–1999 (Project EAT-I), 2003–2004 (Project EAT-II), and 2008–2009 (Project EAT-III). Dieting and unhealthy weight control behaviors at Time 1 and Time 2 were used to predict 10-year changes in BMI at Time 3, adjusting for sociodemographic characteristics and Time 1 BMI.
**Results:** Dieting and unhealthy weight control behaviors at both Time 1 and Time 2 predicted greater BMI increases at Time 3 in males and females, as compared with no use of these behaviors. For example, females using unhealthy weight control behaviors at both Time 1 and Time 2 increased their BMI by 4.63 units as compared with 2.29 units in females not using these behaviors ($p < .001$). Associations were found in both overweight and nonoverweight respondents. Specific weight control behaviors at Time 1 that predicted larger BMI increases at Time 3 included skipping meals and reporting eating very little (females and males), use of food substitutes (males), and use of diet pills (females).
**Conclusions:** Findings clearly indicate that dieting and unhealthy weight control behaviors, as reported by adolescents, predict significant weight gain over time.


The high prevalence of obesity among adolescents and young adults and its health consequences have made obesity prevention efforts a public health priority [1–3]. Furthermore, many young people are concerned about their body shape and size because of the social pressures to conform to a thin body ideal [4–8]. The media is replete with messages on the latest diets and quick fixes for weight loss. As a consequence, many young people cycle on and off diets and engage themselves in unhealthy weight control behaviors [9].

An important question regards the long-term effect of dieting and use of unhealthy weight control behaviors on weight status. Longitudinal research has shown that these behaviors are predictive of weight gain over time in most [10–19], but not all [20], studies. However, we are aware of only one such study that followed up adolescents through adulthood. Viner and Cole observed respondents from age 16 to 30 years and found that dieting predicted increases in body mass index (BMI), but they did not examine specific weight control behaviors [17].

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doi:10.1016/j.jadohealth.2011.05.010

# Healthy Eating & Fun Activity DOES Make You Healthy

"Weight… turns out to be an inadequate proxy for health outcomes. Given that weight loss appears to be elusive for the majority of dieters, measuring health outcomes is the only way to detect improvements in individuals…

Indeed, it may be the case that weight loss is simply unnecessary for health improvements."

*Social and Personality Psychology Compass* 7/12 (2013): 861–877, 10.1111/spc3.12076

## Long-term Effects of Dieting: Is Weight Loss Related to Health?

A. Janet Tomiyama[1], Britt Ahlstrom[1] and Traci Mann[2]*
[1]*UCLA*
[2]*University of Minnesota*

Abstract
"Success" in dieting interventions has traditionally been defined as weight loss. It is implicit in this definition that losing weight will lead to improved health, and yet, health outcomes are not routinely included in studies of diets. In this article, we evaluate whether weight loss improves health by reviewing health outcomes of long-term randomized controlled diet studies. We examine whether weight-loss diets lead to improved cholesterol, triglycerides, systolic and diastolic blood pressure, and fasting blood glucose and test whether the amount of weight lost is predictive of these health outcomes. Across all studies, there were minimal improvements in these health outcomes, and none of these correlated with weight change. A few positive effects emerged, however, for hypertension and diabetes medication use and diabetes and stroke incidence. We conclude by discussing factors that potentially confound the relationship between weight loss and health outcomes, such as increased exercise, healthier eating, and engagement with the health care system, and we provide suggestions for future research.

When physicians recommend that their patients go on diets, their implicit goal is unlikely to be to help these patients improve their appearance or body image. The assumption in recommending diets is that losing weight will lead to improved health, and yet, it is far less common for studies of the effectiveness of diets to directly measure health outcomes than to measure weight. There is ample evidence that diets do not lead to long-term weight loss in the majority of people (Mann et al., 2007), but what does this mean for health? Is losing weight closely tied to health benefits? In this paper, we attempt to answer this question by reviewing evidence on the long-term effects of weight-loss diets on health outcomes.

### Traditional Definitions of Dieting Success

Historically, the criterion that diets – defined as a change in eating, most often a reduction in calories with a goal of weight loss – have been judged on has been weight loss. The necessary amount of weight loss, however, has been somewhat arbitrary and has changed dramatically since dieting first started being routinely studied. The original standard weight recommended by physicians was based on the Metropolitan Life Insurance Tables requiring particular weights for any given height and body frame size. For example, the tables designated 134 lb as the expected weight for an average-height woman (5′5″) of medium body frame. Whatever her starting weight, 134 lb would be her goal (Metropolitan Life Insurance Company, 1942).

Obese dieters, however, rarely achieved these standards (Stunkard & McLaren-Hume, 1959). Researchers turned to what they considered to be the more realistic goal of 20% weight loss, but only 5% of obese dieters succeeded by that definition (Stunkard & McLaren-Hume, 1959). Over the next 30 years, reviews of diet studies showed that individuals tended to lose an average of about 8% of their starting weight on most diets (Bennett, 1987; Wadden, 1993;

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# Making Changes…

# Making Changes… at home

To change a problem with feeding relationships or with activity:

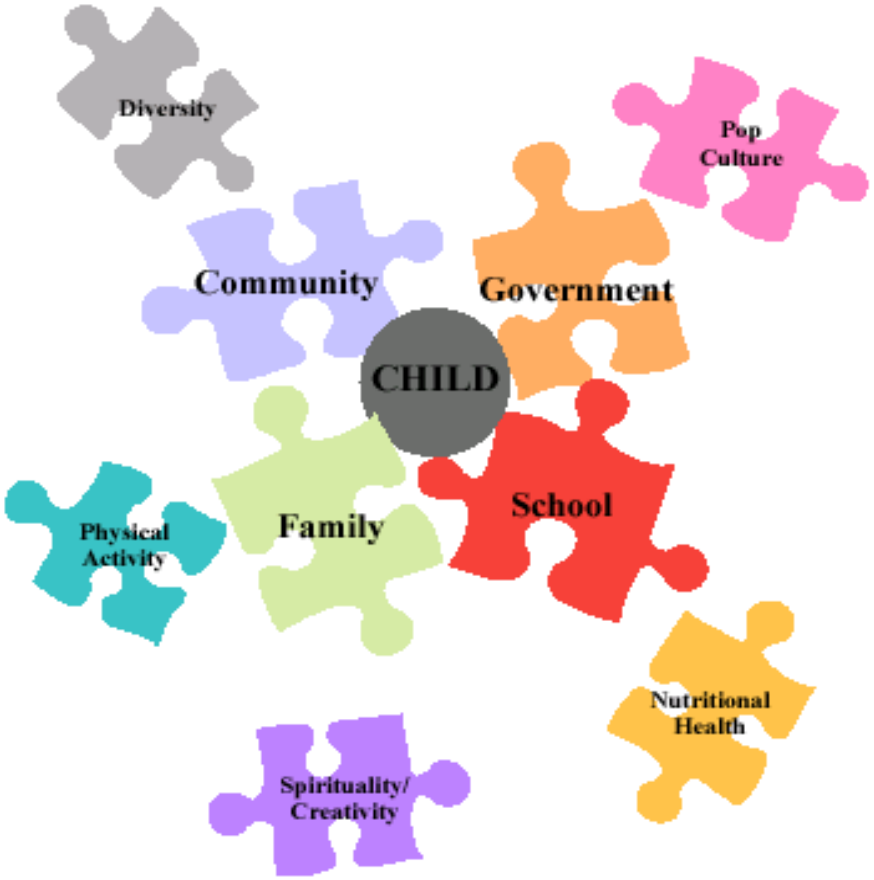
The family needs make changes together -

change the foods that are offered, or

change the activities the family does as a group,

Or, quite possibly, *BOTH*...

# Making Changes… A Child's Environment



# What To Do??

## Family

- Breastfeeding
- Non-restrictive eating
- Division of Responsibility
- No dichotomous language
- Eat together, Eat better
- Eating mindfully
- Dieting Mothers, Dieting Daughters
- Dissolving conflict
- Role Modeling

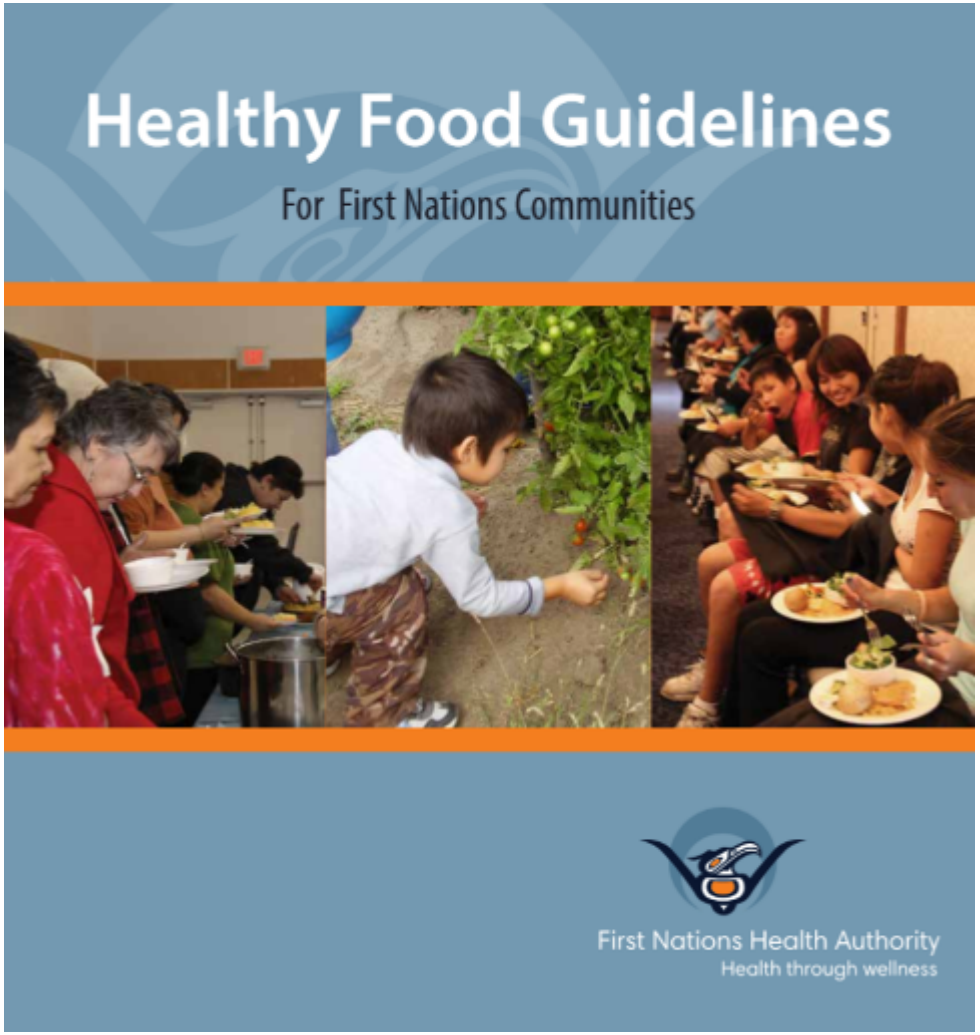
# What To Do??

## School

- Vending machines
- Time to eat lunch
- Physical Education
- Agriculture in the Classroom
- Teach critical thinking
- Bullying policies and action
- Diverse focus of learning
- Additional opportunities for activity
- Child involvement

# What To Do??

## Communities



# How much should kids eat?

According to the Division of Responsibilities:

"*Children are responsible for* how much *and even* whether *they eat.*"

Without pressure, children can *and will* eat enough to grow.

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# Sound Nutrition Practices

# Sound Nutrition Practices

## Menu planning

- more likely to meet Canada's Food Guide
- more likely to shop for food
- lower food costs
- less likely to consume higher fat foods

## Menu Planning:

Planning ahead

1 week in advance - 6%

2 or 3 days in advance - 12%

1 day in advance - 24%

The same day - 48%

At the last minute - 10%

# http://www.bettertogetherbc.ca/learn/tips/get-organized

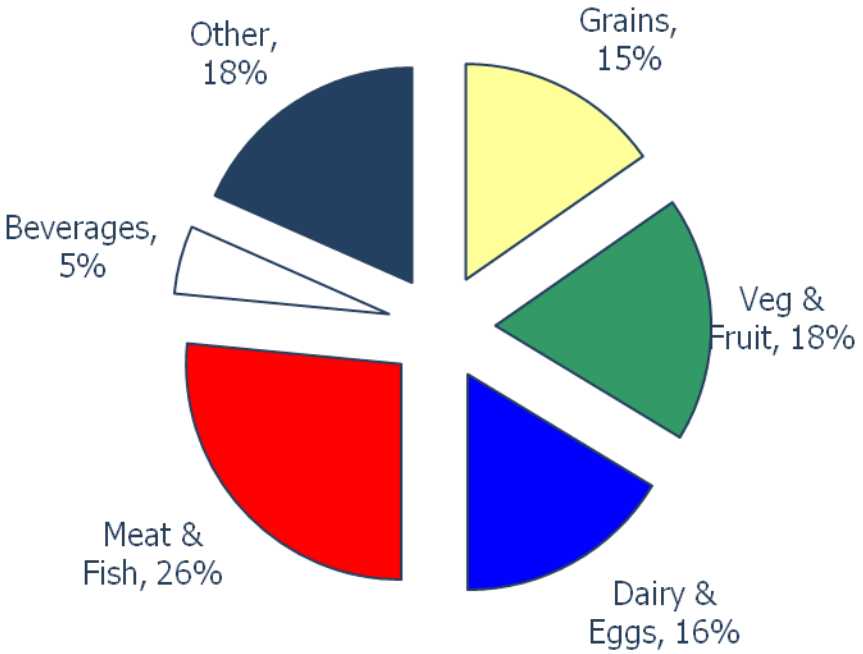
BetterTogether

## Meals This Week

| | Day | Meal | Task | Person |
|---|---|---|---|---|
| | Monday | Mac and cheese with broccoli and ranch dip | Make mac and cheese<br>Cut broccoli<br>Make dip | Mom and Jack<br>Paul<br>Paul |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

# Sound Nutrition Practices

## Weekly Food Purchase $$




## Shopping trips/wk

- 1 trip - 38%
- 2 trips - 31%
- 3 or more - 31%

## Shopping lists

- 23% write one out and stick to it
- 30% write one out but don't stick to it
- 27% write out a partial list

# Sound Nutrition Practices

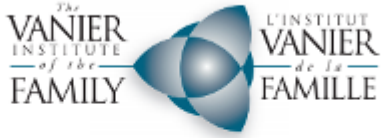
Eating Breakfast

- 74% of Canadians do!
- more likely to meet CFG Recommendations
- better performance at school (and on the job!)

# Eating Together

Recent studies link regular family dinners with many behaviors that parents want:

- lower rates of substance abuse, teen pregnancy and depression
- higher grade-point averages and self-esteem.
- a potent vocabulary-booster
- helps children build resilience.
- lower rates of disordered eating




# Contemporary Family Trends

## Rediscovering the Family Meal

Bernard Roy, Nurse, PhD; Judith Petitpas, BSc

June 2008

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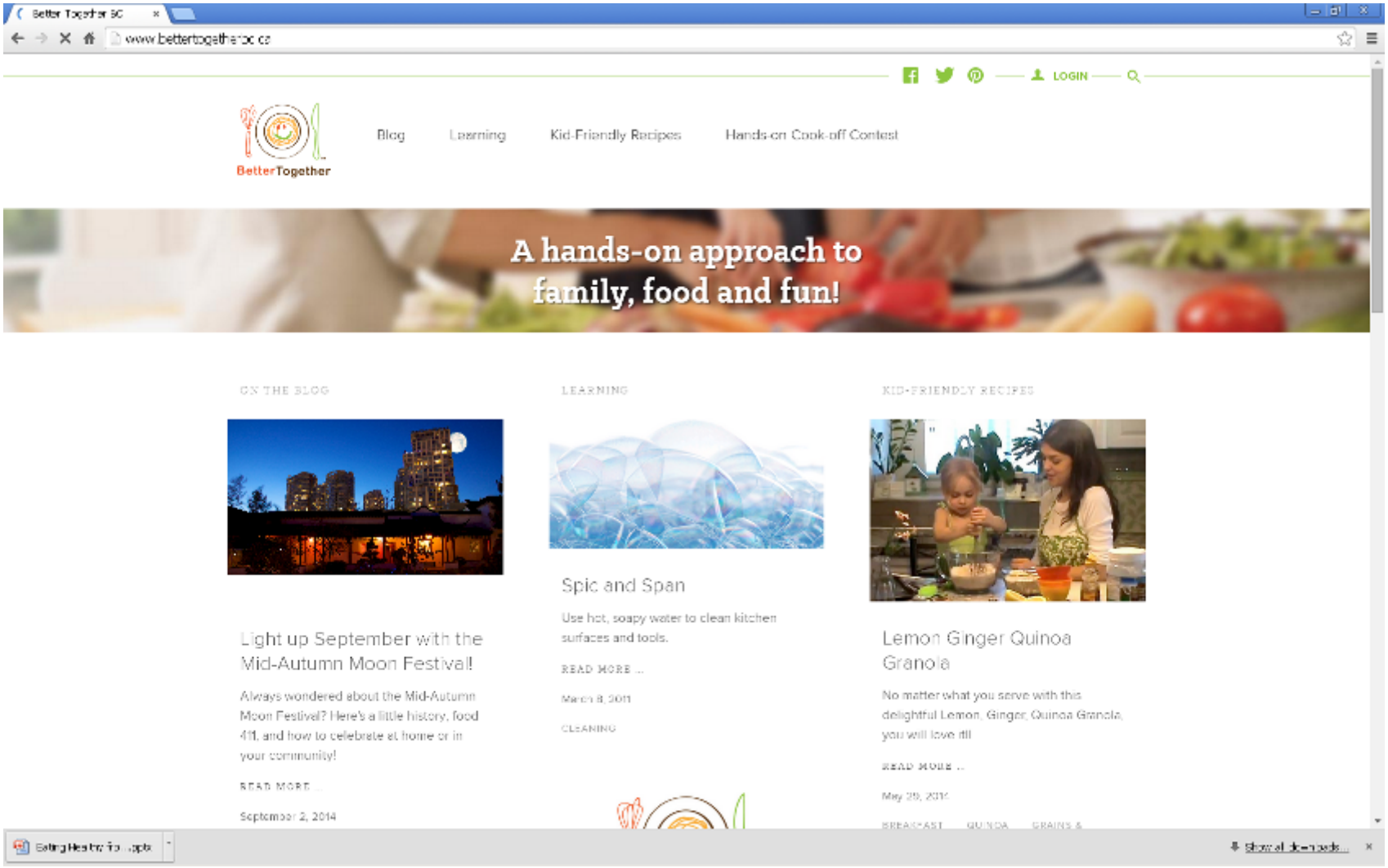
# Eating Together

## But what do we talk about?

[Conversation starter cards]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Kid-Friendly Recipes
Hands-on Cook-off Contest
A hands-on approach to family, food and fun!
ON THE BLOG
Light up September with the Mid-Autumn Moon Festival!
Always wondered about the Mid-Autumn Moon Festival? Here's a little history, food 411, and how to celebrate at home or in your community!
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LEARNING
Spic and Span
Use hot, soapy water to clean kitchen surfaces and tools.
READ MORE ...
March 8, 2011
CLEANING
KID-FRIENDLY RECIPES
Lemon Ginger Quinoa Granola
No matter what you serve with this delightful Lemon, Ginger, Quinoa Granola, you will love it!
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# Kids and Bodies

Helping children accept differences in body sizes

# Kids and Bodies

You are not responsible for the size and shape of your child's body.

But...

# Kids and Bodies

You *can* help your child like his body !

# Kids and Bodies

Help your child learn that:

Different people have different body types.

Different body types do things in different ways.

People can excel, no matter what the size or shape of their bodies.


I ROLL
FOR SOLIDARITY AT EVERY SIZE,
BECAUSE WE NEED EACH OTHER.
Stop weight bigotry.
Health At Every Size®


I STAND
FOR LETTING ALL CHILDREN KNOW
THEIR WORTH IS COMPLETELY
INDEPENDENT OF THEIR WEIGHT.
Stop weight bigotry.
Health At Every Size®


I STAND
TURNING STEREOTYPES UPSIDE
WN AND SHAKING THEM LOOSE.
Stop weight bigotry.
Health At Every Size®


I STAND
FOR NEVER LETTING YOUR SIZE KEEP
YOU FROM FOLLOWING YOUR DREAMS.
Stop weight bigotry.
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FOR MAKING MOVEMENT ABOUT
FUN & HEALTH,
NOT SHAME & PUNISHMENT.
Stop weight bigotry.
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FOR A FUTURE FREE FROM BODY SHAMING
FOR CHILDREN OF ALL SIZES.
Stop weight bigotry.
Health At Every Size®


I STAND
FOR STRENGTH IN EVERY BODY
AND EVERY HEART.
Stop weight bigotry.
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# Role modelling

# Role Models

Adults need to ask what kinds of behaviours they are modelling:

Am I dissatisfied with my body size and shape?

Am I on “a diet”? Who knows when I’m on a diet, and how do they know?

Do I express guilt when I eat certain foods, or do I refuse to eat foods while commenting that I am dieting to lose weight?

# Role Models

Adults need to ask what kinds of behaviours they are modelling:

Do I talk about being unhappy with my body? Whom do I talk to, and who might overhear what I have to say?

Do I make negative comments about other peoples sizes and shapes?

Are my friends of differing sizes and shapes?

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# What Have We Learned?

# What Have We Learned??

A Division of Responsibility

- Parents: What; Kids: How much

Pressure Won't Work

- Nothing you do or say will make your child eat less food, without making them feel bad about it.

What is Normal Eating?

- Normal eating is *flexible*

# What Have We Learned??

Ages and Stages

Children first need to know they will be trusted. They start out needing limits, followed by structure, and ending with letting go...

How Should I Choose Foods?

Use Canada's Food Guide, and let your child decide how much to eat.

# What Have We Learned??

Kids and Bodies

- You are not responsible for the size and shape of your child's body.
- Children can excel no matter what the size or shape of their body is
- Families need to make changes together

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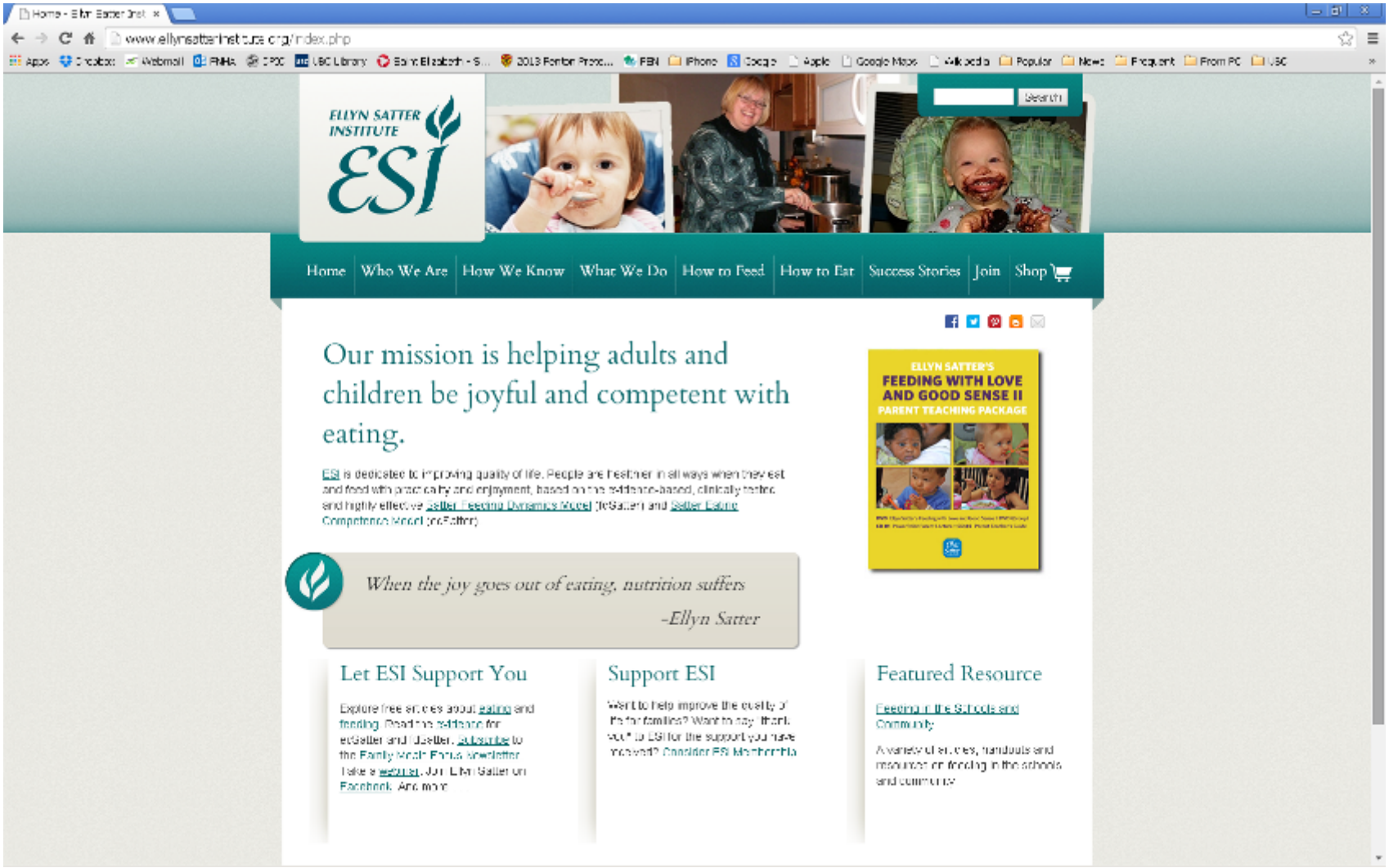
# Resources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Our mission is helping adults and children be joyful and competent with eating.
ESI is dedicated to improving quality of life. People are healthier in all ways when they eat and feed with pleasure and enjoyment, based on the evidence-based, clinically tested and highly effective Satter Feeding Dynamics Model (ToSatter) and Satter Eating Competence Model (ecSatter).
When the joy goes out of eating, nutrition suffers
-Ellyn Satter
ELLYN SATTER'S
FEEDING WITH LOVE AND GOOD SENSE II
PARENT TEACHING PACKAGE
Let ESI Support You
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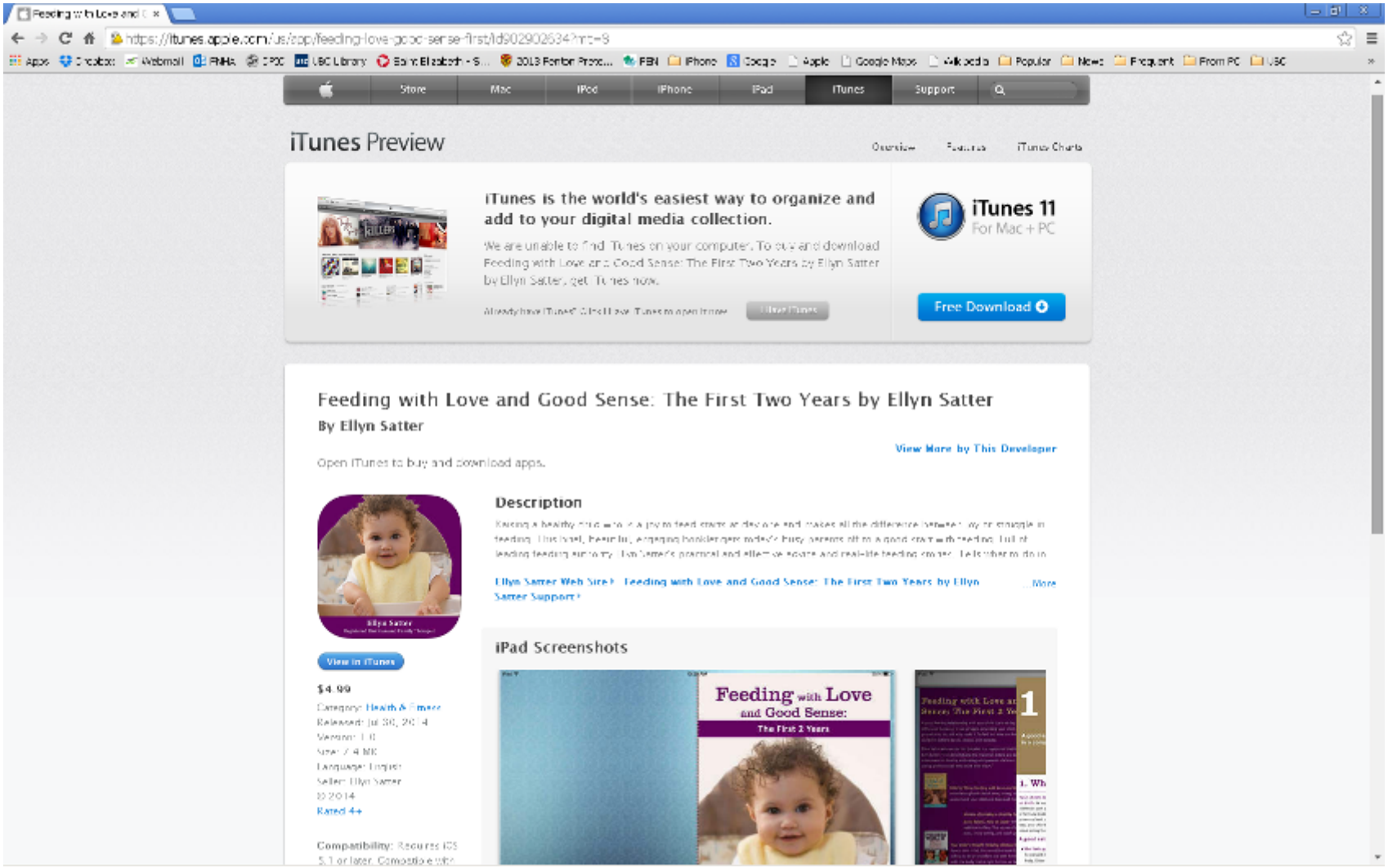
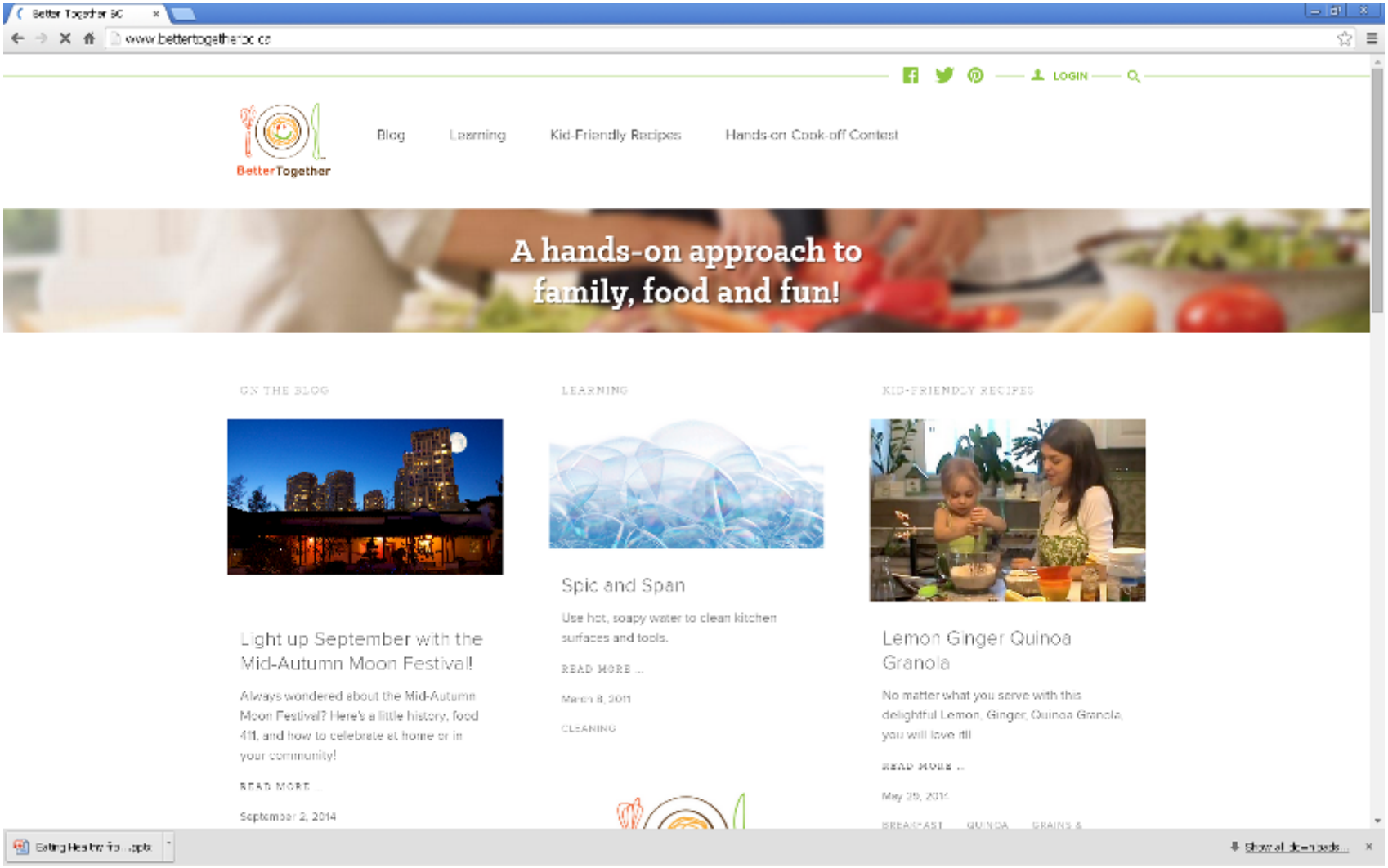
Featured Resource
Feeding in the Schools and Community
A variety of articles, handouts and resources on feeding in the schools and community.

# There's an App for that...

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Bonding with Your Child
Forming a Secure Attachment
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How Children Learn
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How You Can Support Learning


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In this issue:
Why are Fathers Important?
Learning How to Be a Father
Different Situations, Different Approaches

# First Nations
## Traditiona
## FACT SH

# Eulachon

EULACHON; OOLICAN, OOLICHAN, OOLIGAN, HOOLIGAN, ULICHAN, OULACHEN AND HOLLIKAN.

HISTORY OF USE: GENERAL TO BC

For thousands of years, eulachon have been prized for th
trade items. There were numerous grease trails connectin
the largest trading centre on the Nass River. Many of the
for museums in the early 19th century still have a shiny p
candle fish, eulachon have historically spawned in rivers
Klamath River in Northern California. Areas of the Nass, K
are well-known for their eulachon runs.

| NUTRIENT CONTENT | PREPARA | |
|---|---|---|
| | FRESH | COOKED |
| Excellent Source (provides 25% or more of daily need) | | Protein<br>B Vitamins<br>(various) |
| Good source (provides 15-24% of daily need) | Protein | Calcium |
| Fair source (provides 5-14% of daily need | Fat<br>Iron<br>Niacin | Fat<br>Protein<br>Iron<br>Riboflavin |

# Recipes

*Old and New ways to prepare traditional foods highlighted in the traditional foods fact sheets.*

**SALMON SOUP**

4 cups (1 l) water
¼ lb (125 g) salmon roe
1 lb (500 g) fresh salmon, cubed
½ lb (250 g) potato, diced
1 stalk celery, diced
1 medium onion, diced
Salt and pepper to taste
Pinch curry powder
1 bay leaf
1 tbsp vegetable oil
Dry seaweed for garnish

In a large soup pot, sauté onion, celery and potato in oil. Add water and bring to a simmer. Heat salmon roe in a small saucepan and add to soup stock. Add salmon, salt, pepper, curry powder and bay leaf. Bring to a boil. Simmer over low heat until potatoes are just tender. Discard bay leaf. Ladle into soup bowls and sprinkle with dry seaweed.

**ROAST DEER***

The hind quarter of a young deer is often oven roasted. The method is as follows:

1. Season the meat with salt.
2. Rub the top of the roast with shortening or oil and place in a tightly covered roaster. Cook the meat twenty to twenty-five minutes per pound, in a 350°F oven.
3. Potatoes, onions and carrots may be added one hour before the end of the cooking time.
4. Pour the juices over the meat (no thickening added) and serve with the cooked vegetables.

**BAKED FISH HEADS***

The heads of spring, sockeye and coho salmon are used. Chum salmon are considered too tough for baking. The eyes or scales need not be removed, but some people like to remove the gills and lower part of the head before baking. Split the heads lengthwise and open them like a book with the inner surface facing up. Season with salt and pepper and cover the pan. Bake in a 350° oven for half an hour or until brown. The cheeks and nose are the parts eaten.

**SMOKED EULACHONS***

Preparation for Smoking

1. Wash the eulachons well under running water.
2. Place the fish in a barrel of fresh water to which has been added enough coarse salt to float a potato (about 2 cups [500 mL] coarse salt in 3 gallons [12 Litres]
3. Soak for about ½ hour to 1 hour or until their eyes turn white.
4. Hang the eulachons for smoking by threading on cedar sticks. Push the strip of red cedar in through the gills and out through the mouth. Usually 12-25 eulachon are put on each stick.
5. Hang the eulachon heavy sticks from the rafters in the in the smokehouse, making sure the fish are not touching each other. There needs to be enough space between each rack and the fish so that the smoke is even.
6. Start the fire after the eulachon finish dripping. Use alder wood for smoking.
7. Smoke the eulachon for 2-6 days. Smoke longer for drier fish.

Half smoked eulachons (i.e., left one to two days in the smokehouse) may be canned.

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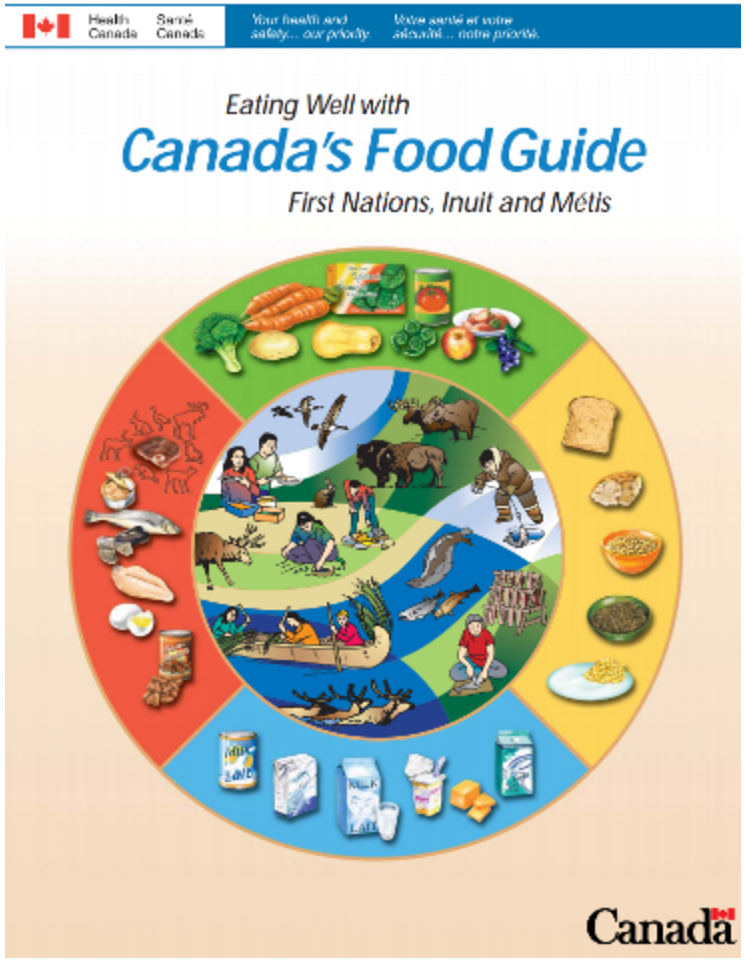
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Santé Canada
Your health and safety... our priority.
Votre santé et votre sécurité... notre priorité.
Eating Well with
Canada's Food Guide
First Nations, Inuit and Métis
Canada

# Resources

## Community Resources

The First Nations Health Authority Dietitians:

nutrition@fnha.ca

or, to contact me directly -

(604) 693-6763 or gerry.kasten@fnha.ca

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# Thanks!!

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