

# Psychological prevention and intervention strategies for body dissatisfaction and disordered eating

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**B**ody image problems and eating disorders sit on a continuum which ranges from healthy body image and eating patterns through disordered eating and eating behaviours, and ultimately to more severe diagnosable clinical eating disorders. In our culture, body image problems (or body dissatisfaction) are associated with concerns about shape and weight, although they may also relate to concerns about other physical features or body parts. Disordered eating refers to eating behaviours that are associated with psychological distress and physical ill-health but are not of a severity to warrant a clinical eating diagnosis. These include use of extreme weight loss behaviours (e.g., crash dieting, excessive exercise and self-induced vomiting) and binge eating. Clinically diagnosable eating disorders include: anorexia nervosa, in which relentless dieting leads to a starvation state; bulimia nervosa, in which there is regular binge eating and use of compensatory behaviours; and eating disorders not otherwise specified (EDNOS), in which eating symptoms are clinically significant but do not fit criteria for anorexia or bulimia nervosa. The most frequently occurring EDNOS is binge eating disorder in which there is regular binge eating without compensatory behaviours. Although not currently recognised as an eating disorder in its own right in DSM-IV, it most likely will be in DSM-V.

It is important to note that although all these eating-related disturbances fall on a continuum, body image problems are not in all cases the major reason for development of an eating disorder, for example, food may have become an emotional comfort or be used as a means to gain a sense of control. However, judging one's worth by one's appearance and experiencing body dissatisfaction is very frequently a key issue underlying disturbed eating behaviour. The focus of this article is on examining body image and disordered eating problems to enhance our understanding of the psychology of eating disturbances.

## Prevalence of body dissatisfaction and disordered eating

The extent of body dissatisfaction in our society is alarming. In Australia, more than 70 per cent of girls wish to be thinner and an equivalent number of boys want to be either thinner or bigger (Ricciardelli & McCabe, 2001). In adolescents, more severe body dissatisfaction has been reported in about 46 per cent of girls and 26 per cent of boys. In the most recent Mission Australia Youth Survey of over 50,000 young Australians, 34.0 per cent of female and 27.4 per cent of male participants indicated that body image

was their number one personal concern. Body dissatisfaction remains at a high level into midlife, with one study reporting 43 per cent of a sample of midlife women being dissatisfied with their bodies.

Weight loss is widely believed to be the solution to body image problems and, indeed, to other sources of unhappiness in our lives. Consequently, many Australians resort to quick fix fad diet solutions and extreme weight loss behaviours that are detrimental to health, ineffective, and associated with the development of binge eating, bulimic disorders and obesity. In a representative Australian male and female sample of 15-24 year olds, 20.0 per cent reported strict dieting or fasting, 29.3 per cent reported binge eating, and 13.6 per cent reported purging for weight control. Importantly, these disordered eating behaviours continued to be observed at similarly high levels up until people were aged in their mid-fifties. Of 45-54 year old respondents, 21.4 per cent reported strict dieting or fasting, 17.4 per cent reported binge eating, and 28.6 per cent reported purging for weight control (Hay, Mond, Buttner & Darby, 2008).

## Weight bias and discrimination

To understand much of the distress associated with body image and eating, we first need to consider our society's rigid beauty ideals. Our society currently enthusiastically endorses a very thin beauty ideal for women and a lean and athletic ideal for men. These physical attributes are believed to be associated with attractiveness, success, happiness, control and moral virtue.

On the other hand, very negative attitudes about overweight and obesity prevail. Overweight and obesity are not eating behaviours or eating disorders although they are often considered as such. Rather, these terms describe the presence of high levels of adipose tissue that may occur for a multitude of genetic, environmental and behavioural reasons, only one of which is the amount a person eats. Although there is an increased risk of morbidity associated with high levels of adiposity, this is a health issue rather than one of moral worth.

Despite this obvious fact, psychological research confirms discrimination against larger people in employment, health care, education and social settings as a result of the negative stereotypes that overweight people are unattractive, lazy, incompetent and lacking in self-control (Puhl & Heuer, 2009). Discrimination and stigma also extend to larger children who are more likely to be teased and socially isolated than their thinner peers. Our recent research shows that, even in 3-5 year old

children, positive qualities (e.g., good child) are associated with a thin body size, while negative qualities (e.g., mean child) are associated with larger body sizes. It is clear that these stereotypes are established early in life, creating a framework by which to judge not only others but also the self.

### **Risk factors for body dissatisfaction and disordered eating**

Social stereotypes about body size are filtered to the individual through the media, families and peers. Not surprisingly, exposure to these judgemental attitudes contributes to a strong desire to conform to the social appearance ideals. When a person endorses these ideals but perceives that they do not meet them (whether this is true or not), body image problems are likely to arise.

Environmental, individual and physical factors increase risk for the development of body image and eating problems. Environmental factors that have been shown to be particularly important are perceived pressures from peers and the media. Australian research has shown that, in 5-8 year old girls, perceived peer desire for thinness and exposure to appearance on television inversely predict appearance satisfaction one year later (Dohnt & Tiggemann, 2006). In teenage years, peer appearance conversations, friend dieting and appearance teasing have also been observed to be risk factors for the development of body image concerns and disordered eating. Further, experimental research confirms that exposure to idealised media images typically reduces body satisfaction (Wertheim, Paxton & Blaney, 2009).

In both females and males, research identifies two important links between social appearance pressures and body dissatisfaction and disordered eating: (1) internalisation of the social or media ideal; and (2) body comparison. Internalisation of the social ideal denotes the extent to which a person endorses our society's appearance ideals. Body comparison refers to the extent to which a person compares his or her own body with the bodies of others. Social pressures increase internalisation of social ideals and body comparison tendencies, and both these attributes increase the likelihood of body dissatisfaction – especially weight and shape concerns – and disordered eating, independent of a person's actual size. Weight and shape concerns have been identified as the strongest predictors of clinical eating disorders (Jacobi & Fittig, 2011).

Other individual attributes also increase risk for these problems. In particular, low self-esteem, depressive symptoms and perfectionistic tendencies have been observed to increase risk for body dissatisfaction and disordered eating. Individuals of larger body size are also at risk, not because of being larger per se, but rather because they are more likely to be exposed to our society's negative judgements, as described above.

### **Interventions for body image and subclinical eating disorders**

There are now psychological therapies available that are quite effective for the majority of body image and eating disorders problems, and the outlook for individuals who engage in an evidence-based treatment is good (Paxton & McLean, 2009).

For body image and subclinical eating disorders, colleagues and I have developed and evaluated manualised group

interventions, facilitated by a therapist, for girls and women in different life stages. These interventions are based on cognitive behavioural principles and address factors that contribute to and maintain these problems. *My Body, My Life* is a six-session intervention for teenage girls who are experiencing body image and disordered eating. It provides skills for understanding and counteracting peer and other social pressures as well as ways to normalise eating patterns. The program has been evaluated using a very well received synchronous online delivery, but a face-to-face delivery approach could also be used in individual or group settings (Heinicke, Paxton, McLean, & Wertheim, 2007).

*Set Your Body Free* is an eight-session intervention specifically for young adults (Paxton et al., 2007). As well as developing healthy eating patterns, participants learn to question appearance ideals, reduce body comparison behaviours, and counteract avoidant behaviours associated with body dissatisfaction. Marked improvements in body dissatisfaction and disordered eating have been found using an internet delivery, but even greater improvements in these areas as well as in self-esteem and depressive symptoms were made when a group met face-to-face.

Most body image and disordered eating interventions specifically focus on the needs of young women. However, as indicated in data provided earlier, these problems continue into midlife during which the needs of women are somewhat different. In particular, lifestyles built around looking after and feeding families, as well as working, are not well suited to looking after one's own self-care needs such as eating regular meals and having regular physical activity. Consequently, we developed *Set Your Body Free – Midlife* which specifically addresses these issues, and again on evaluation clinically significant gains have been demonstrated (McLean, Paxton & Wertheim, in press). These interventions are readily translated into a range of therapy settings and demonstrate the power of psychological interventions to make a real difference to the lives of women. (Manuals are available on request).

### **Prevention programs for body dissatisfaction and eating disorders**

In light of the severity of body image and eating disorders, it would be ideal if effective prevention strategies could be identified. The major principle guiding recent prevention approaches is that if the development of influential risk factors for body image and eating disorders can be prevented or reduced, then movement along the continuum from health to disorder is less likely. Consequently, recent prevention interventions have sought to teach skills to manage social appearance pressures, and to reduce internalisation of appearance ideals, body comparison, body dissatisfaction and use of extreme weight loss behaviours.

In the mental health area, three kinds of prevention approaches are usually identified. Universal prevention is prevention provided to the general public or whole population without consideration of the presence of risk factors (e.g., billboard advertising or programs delivered to a whole school). Selective prevention targets at-risk population subgroups (e.g., teenage girls), but does not target participants on the basis of presence of individual risk factors. Indicated prevention is specifically for high risk individuals who are showing early

◀ symptoms of the problem (e.g., a program for girls with body image or eating concerns).

A universal prevention program for delivery in co-educational early high school classes that had particular promising outcomes is a media literacy program, *MediaSmart* (Wilksch & Wade, 2009). A universal approach is particularly useful in schools as it does not require the class to be divided and enables all students to be involved. *MediaSmart* aims to raise awareness of the unrealistic, manipulative nature of media images in an interactive way, and thereby reduce the risk factor internalisation of the media ideal.

A selective prevention program specifically for early high school girls that has positive outcomes is a peer risk factors focused program, *Happy Being Me* (Richardson & Paxton, 2010). The goal of this program is to help participants learn about the negative impact of appearance conversations and appearance teasing on internalisation of the thin ideal and self-esteem, and to learn ways to change these environmental risk factors.

Indicated prevention approaches have been shown to be especially helpful in later teen years. In these programs, young women with elevated body dissatisfaction and eating concerns are invited to participate. A cognitive dissonance approach – in which participants engage in exercises to argue against attitudes about the importance of thinness which they themselves hold – has been shown to be effective in reducing internalisation of the thin ideal, body dissatisfaction and eating disorder symptoms at a two year follow-up (Stice, et al., 2008).

### Public policy approaches to prevention

Public policy refers to actions at local, State or federal levels of government. Avenues open to governments to bring about change include legislation, promotion of non-binding industry codes, social marketing, and providing financial support for community and school-based initiatives. In Australia, no legislative approaches have been used. However, the Victorian and Federal Governments have promoted voluntary media and industry codes of conduct. Media and fashion leaders have been asked to endorse a code to not digitally alter images and to promote diversity of body shapes within their industry. Although non-binding codes clearly don't bring about rapid change and industry endorsement has been modest at best, they do serve an awareness raising role and popular teen magazines have altered the ways in which they present many images. One magazine has taken the initiative to identify unaltered images (of which there are a reasonable number) with a symbol stating 'Retouch Free Zone'. Actions such as this may serve a media literacy role.

The Victorian Government has promoted two social marketing campaigns. The first was a billboard campaign, backed with website information, named 'Fad Diets Won't Work'. The campaign aimed to raise awareness of the dangers of fad dieting, with one caption reading 'Fad dieting helped me go from a size 14 to a size 12, back to a size 16'. Although an excellent message, the campaign only ran for one month in 2007 and consequently had very low reach. Another creative social marketing campaign by the Victorian Government ran on MySpace and was titled 'Real life doesn't need retouching: Take a stand against digital manipulation'. In an innovative series of images, glamorous advertising images were contrasted with the real worlds of young people. Although it had potential as a tool for media literacy, it

was also only shown for one month and could not be expected to have had much impact in this time.

Importantly, the Federal Government is currently supporting the development of evidence-informed prevention resources for distribution to schools. In the future, public policy initiatives such as this may have a widespread impact.

### Conclusion

While extremely rigid weight and shape body image ideals prevail, a large proportion of the population will compare themselves with these ideals, find themselves wanting, engage in disordered eating, and develop subclinical and clinical eating disorders. Looking ahead, we need to find ways to reduce pressure to conform to these ideals and ensure that the risks associated with extreme weight loss behaviours are well understood. We need to work to achieve a society that is accepting of diversity of body weights and shapes. In the meantime, psychologists can play very positive roles in guiding prevention and providing evidence-based interventions for body dissatisfaction and disordered eating. ■

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# What kind of illness is anorexia nervosa? A clinical update

By Professor Stephen Touyz FAPS, Professor of Clinical Psychology, School of Psychology, and Director of the Centre for Eating and Dieting Disorders, Boden Institute of Obesity and Nutrition, Exercise and Eating Disorders, University of Sydney, and Co-Director, Beumont Centre for Eating Disorders, the Hills Private Hospital

*Anorexia nervosa is a mental and physical disease that was recognised in France in the 19th Century, usurped for England by Queen Victoria's physician, and subsequently adopted by many thousands of Americans. (Beumont, 1991)*

According to those grand narratives embodied in DSM-IV and ICD-10, anorexia nervosa (AN) is merely regarded as part of the spectrum of eating disorders. This categorisation not only distorts what we have since come to know and understand about the nature of this debilitating disease, but also trivialises its seriousness (Beumont & Touyz, 2003). There is now a general consensus that AN must be regarded as one of the most serious chronic diseases of adolescent girls and young women. This is a rather profound assertion to make but there is growing evidence to support it.

Anorexia nervosa meets most of the criteria which one would normally associate with the seriousness of a disease. These include its prevalence, mortality, chronicity, the impact it has on the sufferer's life, family dysfunction and its effects on society at large. On each of these measures, AN is very severe. Its point prevalence for girls aged 15-19 years is 0.05 per cent, and about half as much for women aged 20-24 years. In these groups it is ten times as common as insulin dependent diabetes mellitus. The lifetime risk of a woman developing AN is half that of schizophrenia. Long-term follow-up studies of more than 20 years duration have reported mortality rates of approximately 20 per cent. This is clearly not an acceptable state of affairs for a disease which, after all, usually starts around adolescence.

The following facts should remove any lingering doubts as to whether AN should be construed as just another eating disorder or within a transdiagnostic framework of eating disorders.

## Why anorexia nervosa is a serious psychiatric disorder

- Mortality rate is 5 times that of the same population in general
- Death from natural causes (cardiac arrhythmia, infection, starvation) is 4 times greater than expected
- Risk of successful suicide is 32 times that expected for major depression, in which deaths from suicide are 21 times greater than expected
- Average duration of illness is 7 years
- Many of those whose symptoms improve over time fail to make a full recovery and return to normal health

Unfortunately, those who do not go on to make a full recovery are likely to suffer from major, persistent physical abnormalities, including osteoporosis and anovulation, as well as psychiatric sequelae such as chronic dysthymia or major depressive disorder and obsessive compulsive symptoms. In addition there are debilitating and sometimes profound psychosocial handicaps, including isolation and failure to establish autonomy and independent living. The social handicap experienced by so many of these more chronic patients is as great as that found in schizophrenia. The burden that AN places on society is often underestimated and furthermore places a considerable load on existing hospital services, which often lack the highly specialised treatment services that such patients are entitled to. The National Eating Disorders Collaboration, which is funded by the Commonwealth Government, has as one of its key objectives to identify the gaps in providing treatment for patients with AN.

Professor Michael Strober, the editor of the *International Journal of Eating Disorders*, has provided us with a sober reminder as to what we can expect when AN is not treated or does not respond to existing treatments and goes on to develop a chronic course.

*Sadly, it is only a matter of time before even the strongest bond to the person chronically ill with AN withers, frayed by years of fury, despair, and resignation, unable to hold firm against the unrelenting defense of ideas for which there is no single shred or truth or evidence. It will come when the family has endured what they consider to be the final, painful offense, when the seductive strand of hope is declared lost to madness forever. It will start as before, how she is now ready to consider her poor health with a more reasoned mind, and that she truly wishes an end to the misery brought on her by her illness. It is not that the wish for change at this particular moment is contrived, or that the dialogue in which sorrow for the agony she has caused is not reflected honestly. But when AN advances to this chronic state, the possibility that one day these splits in consciousness will cohere has passed. And so, too, will the moment of hope slip away yet again, flattened by the same well-worn litany of worries about becoming fat, of there being too much oil on her food. But no longer will anyone truly care. (pp. 227-228)*

### ◀ So what is anorexia nervosa? Psychological, behavioural and physical features

AN is an illness which is primarily defined by excessive self-induced weight loss and is characterised by an intense drive for thinness. This develops rapidly into an intense fear of weight gain, normal weight and 'fatness'. This is usually associated with a body image disturbance where the sufferer is unable to accept that there is no need for weight loss and experiences herself as 'fat'. Since the 1970s, these two psychological components have been conceptualised as central to, and invariably causal of, the pathological behaviours that ensue in AN (Maquire, 2009). These components, along with weight loss, have formed the central core of diagnostic criteria for this illness. Ancillary psychological features are present in a majority of cases but are not imperative for a diagnosis to be made. These include perfectionism, obsessionality, depression, an egosyntonic attachment to the illness like no other and a poor motivation for recovery. All these need to be taken into account when developing a comprehensive treatment approach.

Behaviourally, AN expresses itself with extreme dietary restriction often accompanied by compensatory behaviours designed to further reduce weight. These include self-induced vomiting, laxative abuse and excessive exercise. In some cases patients also engage in a more generally disordered eating pattern including binge-eating. Such patients are often referred to as having the binge-purge subtype of AN.

AN is associated with a number of worrisome physical sequelae. Relationships between the extent and nature of the core behaviours of the illness and its physical sequelae have been well established. The direct relationship between the intensity with which restrictive and compensatory behaviours are used and weight loss of course is at the heart of this illness. Physical symptoms include loss of menses, electrolyte imbalances, as well as cardiac and thyroid dysfunction.

Behaviours and the psychological distortions become reinforced over the passage of time. This comes about as a result of the interplay between the core symptoms which become more complex. These are driven by the anxiolytic effects of not only weight loss and purging but the induced effects of starvation as well. As a result, the patient engages in an ever-increasing escalation of weight inducing behaviours with the likelihood of serious adverse medical consequences.

The interplay of psychological, behavioural and physical symptoms differs between patients and results in a heterogeneity in the presentation of such patients. Symptoms vary in both kind and intensity although the significance of such variations is still the subject of much debate. With the introduction of DSM-V in 2013 and looking ahead at DSM-VI, we felt that AN would be better served if it was staged as an illness. Although staging is not commonplace in psychiatric illness, it would more accurately reflect the heterogeneity of presentations between patients.

We have now developed the Clinician Administered Staging Instrument for Anorexia Nervosa (CASIAN) (Maguire et al., 2011) to assess the severity (not unlike cancer) in AN within a four-stage model of illness severity (Stages 1-4). The CASIAN has been found to be a reliable instrument that appears to demonstrate validity and promising signs of prognostic value.

### Staging anorexia nervosa

Those patients that are given a Stage 1 or 2 category by the CASIAN are likely to be treated as outpatients or day patients, whereas those with Stage 4 are hospitalised. The staging assessment also allows those with a sub-threshold presentation to be correctly diagnosed with Stage 1 illness rather than an Eating Disorder Not Otherwise Specified (EDNOS), as this often lulls both the patient and the family into a false sense of security that they do not have AN. Early identification and treatment is of the absolute importance and staging allows this to occur.

The four-stage model has the potential to provide a system of classification for eating disorders on the anorexic spectrum that can for the first time reliably deal with the full spectrum of illness presentations. Furthermore and perhaps more importantly, it has the potential to provide the framework for the development of tailored treatment approaches in AN so as to improve the outcomes for those who suffer from this most debilitating psychiatric illness, and the families and carers that support them.

### Tailoring the treatment in patients with AN

There has unfortunately been little controlled treatment research on AN. Why should this be for such a serious illness that we have known about for over 100 years? One of the major difficulties that nearly all researchers have encountered is the inability to recruit sufficient subjects into their treatment trials. More importantly, most trials are dogged by poor compliance, with patients either being withdrawn from treatment as they become too ill or they themselves drop out. However, there is one notable exception to this: family-based therapy for adolescents with AN. This treatment was developed at the Maudsley Hospital in London and has now been written up in a manual format.

This treatment is based upon the work of innovative family therapists such as Minuchin, but is radically different in that it elicits the parents' aid in getting the patient to eat and then gradually releasing the control of eating back to the patient. Thereafter, the therapist works with the family to help the adolescent negotiate the developmental challenges of adolescence (Lock, le Grange, Agras & Dare, 2001). There are now several multisite, collaborative randomised control trials that provide support for the efficacy of such family-based treatment. With the absence of the effective treatments for patients with AN, patients and their families are desperate to hear of a treatment that works. Positive findings are often greeted with overenthusiastic claims of overall success. Unfortunately, there is a need to dampen the claims of a panacea, in that only around 60 per cent of adolescent patients fully recover from such family-based treatment and only if they are usually treated within 3.5 years of becoming ill.

Such findings provide further support for our staging model as early identification, diagnosis and treatment is likely to be crucial in the vast majority of patients who go on to fully recover. However, what about the 40 per cent of patients who fail to

respond or who present with treatment after suffering from this illness for four years or more? There is also emerging evidence that 20-30 per cent of AN patients have a more malignant form of the disease which may not respond to current treatments. Unfortunately the evidence to date regarding the treatment of such patients has been at best sobering, but all this might just be at the point of change.

### The clinical imperative: We need to treat

Despite the absence of an effective evidence-based treatment for patients with AN (other than the Maudsley family-based approach), it is important to recognise 'insufficient evidence' and 'no evidence' are not synonymous with 'evidence of ineffectiveness' (Carney, Tait, Touyz, Ingvarson, Saunders, & Wakefield, 2006). The Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for AN have argued that, "in the absence of evidence, clinical consensus is a legitimate basis for action". These guidelines propose a multidisciplinary team for optimal treatment. They recommend the team include a specialist in physical medicine (i.e., a general practitioner/family physician or paediatrician depending on the patient's age), a clinical psychologist, dietitian, nurse (if in hospital), and other allied health practitioners such as occupational therapists and physiotherapists. Irrespective of who treats the patient or what treatment is provided, there is one golden rule that should never be compromised.

### The golden rule in treating patients with anorexia nervosa

If one is to successfully treat a patient with AN then the restoration of nutrition is an essential first step. It is imperative to curb weight loss and then reverse it.

### New insights, new therapies

There is now a smorgasbord of options for treating adult patients, including well established outpatient treatments, innovative day hospital programs and highly specialised inpatient units (Touyz, Polivy & Hay, 2008). Such programs use a combination of techniques including nutritional counselling (often by very experienced dietitians working exclusively in the field of eating disorders), behavioural experiments (interventions), cognitive techniques, exercise counselling and family interventions.

Most clinicians work within a CBT framework and clinicians who already have experience or expertise in the delivery of CBT will find the principles involved to be similar, but with one major exception. Most patients with AN view their symptoms as egosyntonic and are not only petrified by the thought of change but actively plot and work against it. As a result, working with such patients poses unique challenges that ultimately make treatment both an interesting and rewarding experience.

Researchers have started to look at the newer, exciting third wave therapies such as acceptance and commitment therapy, a recent mindfulness-based behaviour therapy which

has been shown to be effective with a diverse range of clinical conditions. However the evidence for its effectiveness in AN is yet to be determined. Others are going back to behavioural experimentation and in the words of Glenn Waller, a well known expert in this field, "putting the B back into CBT". Therapy is not only about 'talking the talk' but rather 'walking the walk'. Patients who are often academically very bright are prone to intellectualise without making any substantial changes in their behaviours.

Perhaps it will come as no surprise to many that Australia is now leading the world in investigating what works in the psychological treatment of AN. There are at least four major RCTs underway funded by the National Health and Medical Research Council. All four have strong international collaboration. Some of these have interesting acronyms such as SWAN (Strength Without AN), LEAP (Loughborough Eating and Activities theraPy) and C-AN (Chronic AN) and will dominate the eating disorder research landscape over the coming years not only in Australia but the world at large. We eagerly await the outcomes of these seminal studies.

With new knowledge emanating out of neuroimaging studies and being applied directly to treatment such as cognitive remediation therapy, interesting and exciting times lie ahead. There is much hope riding on these and other related trials abroad to find new effective ways to treat patients with AN. MANTRA (Maudsley AN Treatment for Adults) has been based on years of extensive research at Kings College London and the Maudsley Hospital, and comprises treatment on brain research and neuropsychology. There are clearly exciting developments in store as our understanding grows as to how undernutrition may impact on the brain. We are likely to witness new strategies to include in our armamentarium to more effectively treat patients with AN and alleviate the intense suffering of those afflicted as well as their carers. ■

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# Empowering parents to tackle children's obesity

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It is estimated that 23 per cent of Australian children and adolescents are above their healthiest weight (Commonwealth Scientific Industrial Research Organisation, 2008) and rates of overweight are expected to rise to 35 per cent by 2025 (Haby & Markwick, 2008). Childhood overweight and obesity are higher in low-income families, Indigenous and specific ethnic and cultural groups (e.g., Pacific Islander, Middle Eastern and Mediterranean).

The increasing prevalence of overweight and obesity is largely attributed to our obesogenic environment, which encourages the consumption of dense foods and larger portion sizes, resulting in increased energy intake. It has also led to a reduction in both organised and incidental physical activity and an increase in sedentary time, resulting in reduced energy expenditure.

Overweight and obese children have a greater risk of becoming overweight and obese adolescents and adults. Childhood obesity also increases the risk of chronic diseases such as type 2 diabetes, heart disease and some cancers. Physical disorders that impact on quality of life such as respiratory, skin and musculoskeletal disorders are also associated with child and adolescent overweight and obesity (Lobstein, Buar, & Uauy, 2004).

The social and psychological consequences of child and adolescent obesity can be both immediate and long term. Overweight and obese children and adolescents are subjected to teasing, exclusion and discrimination. These negative experiences are associated with psychosocial difficulties, including low self-esteem, body dissatisfaction, disordered eating, depression and anxiety. Overweight and obese young people are also at increased risk of developing binge eating disorder, bulimia nervosa and depression in adulthood (Lobstein, Buar & Uauy, 2004).

## Prevention and treatment

Obesity prevention efforts are typically based in the school/preschool setting and target dietary education and/or physical activity. Results of a recent review of high quality studies indicated that interventions targeting dietary education alone and those targeting dietary education and physical activity were largely ineffective in preventing obesity, although physical activity interventions may reduce overweight in the short term (Summerbell et al., 2009).

There is also a need for effective treatment of those children and adolescents who are already above their healthiest weight. Treatment approaches found to be effective can be broadly categorised as focusing on physical activity and sedentary behaviour, diet or behaviourally oriented treatment programs (Oude Luttikhuis et al., 2008). Behavioural lifestyle interventions have been found to be more effective than standard care, and the success of these interventions is largely attributed to the role of parents in supporting behaviour change (Epstein et al., 2007).

Available research suggests that these approaches do not have a negative impact on psychosocial wellbeing and may actually improve it (Carter & Bulik, 2008). There is a need for research examining the predictors of treatment success and strategies to improve clinician-family interactions (Oude Luttikhuis et al., 2008).

## The role of parents

Parents can mediate the impact of the prevailing obesogenic environment on their own family environment. The role of parents has been studied extensively and they have been shown to have a powerful influence on their children's eating and activity habits and level of body satisfaction in the following ways (for a review, see Golan & Crow, 2004).

- Parental nutritional knowledge and concern for disease is associated with child diet quality.
- Parents can control the food made available and food preparation methods in the home, thus influencing children's food preferences. Children choose to eat foods served most often at home and prefer what has been available and acceptable at home.
- Parents can control the frequency and selection of food purchased outside the home. More parental control of these decisions is associated with better child diet quality.
- The presence of parents at family meals can promote a positive atmosphere and model appropriate food-related behaviours and healthy food choices. In combination, these factors are associated with improved child diet quality. Children and adolescents with more independence have unhealthier meal patterns and food choices.
- Parents can influence their children's eating habits and food choices via modelling. Children are more likely to eat foods eaten by their parents, and family members have similar food choices and attitudes towards food.
- Parents who are physically active themselves or who encourage and facilitate their child being physically active have more physically active children.
- Parents with unhealthy eating habits tend to use more controlling feeding strategies such as pressure to eat and overt restriction to encourage their children to develop healthy habits. These controlling feeding strategies seem to be counterproductive, interfering with children's ability to self-regulate and adversely affecting children's eating habits and weight.
- Parents also influence their children's body dissatisfaction and disordered eating behaviour. Daughters are at increased risk of body dissatisfaction and disordered eating when their mothers model these behaviours and their fathers' attitudes to weight and shape are negative. Little is known about the impact of parents on their son's body dissatisfaction and disordered eating.

## Targeting parents in childhood weight management intervention

As demonstrated above, the family environment is the most important influence on children's eating and physical activity habits. Multifaceted family-based intervention approaches that promote sustainable healthy eating and physical activity behaviours, and positive psychosocial wellbeing, can achieve long-lasting improvements in child weight and health (Epstein et al., 2007). Ideally, family-based interventions include parenting skills, behavioural modification, behavioural therapy, problem solving and strategies to assist children to manage the psychosocial consequences of excess weight.

While initially these interventions target both children and parents, more recently there has been a move towards use of parents as the sole agents of change. This approach was introduced to improve treatment retention and maintain behaviour change, and reduce stigmatisation, food obsession and disordered eating in children. Targeting parents as the sole agent of change results in better child weight loss and greater improvements in the home environment and health behaviours compared to targeting both parents and children, or children alone (Golan, Kaufman, & Shahar, 2006). There is growing evidence of this approach in obesity treatment and preliminary evidence of its effectiveness in obesity prevention.

This treatment approach is health rather than weight centered, and includes four key components: (1) improved nutritional knowledge and practice; (2) enhanced parenting skills; (3) provision of a healthy home environment; and (4) parental modelling of healthy behaviours. The nutritional component emphasises healthy eating patterns and decreased exposure to obesogenic foods, establishing regular family meals and modelling healthy food behaviours. The parenting skills component promotes an

authoritative feeding style encompassing responsiveness (e.g., warmth, nurturing) and demandingness (e.g., setting limits, expecting age appropriate behaviour). Parents are encouraged to make all decisions about what food is purchased and provided, while children determine the amount they will eat.

This approach is consistent with the division of responsibility or 'parent provide, child decide' model of child feeding promoted by Satter (2011). Satter proposes that parents provide eating *structure, support, and opportunities*. They decide *what* food is provided. Children choose *how much* and *whether* to eat from what the parents provide. This means that parents are responsible for choosing and preparing food and providing regular meals and snacks. They are responsible for making mealtimes pleasant and modelling what they want their children to learn about food and mealtime behaviours. Parents are also responsible for not allowing their children to 'graze' between scheduled meals and snacks. This model proposes that "if parents do their jobs with respect to *feeding*, children do their jobs with respect to eating". Thus, if parents follow the feeding guidelines children will eat, eat enough, eat a variety of food, and learn to behave at the table. Importantly, this model proposes that if parents allow their children to grow into the body that is right for them, then children will grow predictably.

Targeting parents as the sole agent of change in childhood overweight and obesity prevention and treatment may improve treatment outcomes and reduce risks of harm. This approach provides a practical way to assist parents to learn about both what to do and how to do it. It provides a positive and proactive way to help parents be part of the solution to childhood obesity. ■

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### PARENTING PROGRAM FOR CHILDHOOD OBESITY: LIFESTYLE TRIPLE P (West et al., 2010)

Lifestyle Triple P is an Australian lifestyle intervention for childhood obesity that targets parents as the exclusive agents of change. It aims to reduce childhood overweight and obesity by increasing parenting skills and parental confidence to manage children's weight-related behaviour. The 12 group sessions and three individual phone call sessions address nutrition, physical activity and positive parenting strategies.

A recently published trial of the program included 101 families of children 4-11 years old. Treatment resulted in significant reductions in child BMI for age and sex z-score following treatment and further improvements at six-month follow up. Parents also reported improvements in children's weight-related problem behaviour, in addition to increased confidence and competence in using positive parenting strategies to manage this. These changes were maintained at six-month follow-up.

This is the first childhood obesity study to assess changes in children's weight-related problem behaviour and the use of parenting practices. The authors suggest that treatment outcomes may be further improved if the program includes more sessions over a longer period of time.

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# Current approaches to weight management: Time for a change

By Louise Adams MAPS, Principal Clinical Psychologist, Self Essentials

Increased rates of overweight and obesity are viewed as major health concerns in Australia and the developed world, and people are typically advised to lose weight in order to alleviate associated metabolic problems. As a consequence, the diet industry is booming, and we are bombarded with increasingly urgent messages to lose weight in order to improve our health. But how effective is dieting in terms of lasting weight loss?

It appears that long-term weight loss is unachievable for most people, as demonstrated in a review of 31 studies with greater than two-year follow up periods that found no evidence to support significant weight loss through dieting (Mann et al., 2007). In fact, two thirds of people weighed more after the diet than they did at baseline. Generally, weight loss through dieting peaks at around six months, after which weight regain begins. The more restrictive the diet, the quicker the weight regain (Cooper et al., 2003). Weight regain occurs even if people adhere to calorie controlled diets and exercise regimes. Pharmaceutical interventions and weight loss surgery slow weight regain, but the pattern remains. It is clear that long-term weight loss is no more than a pipe dream for most people.

In response to the failure of dieting, defendants locate the problem as one of individual 'willpower'. This attitude is endemic in the nutrition industry and the obesity field, and, not surprisingly, even amongst the clients who may present to psychologists for help. But the willpower explanation fails to take into account a myriad of factors known to influence weight

Research over the past twenty years has painted a more complex picture than any simple idea of 'calories in/calories out'. The regulation of human body weight includes genetic predisposition, as well as sophisticated biofeedback mechanisms designed to maintain homeostasis. In short, our bodies fight to maintain stable body weight and react to decreasing fat cells as a threat to survival. In response to such a threat, metabolism slows down, and a range of hormonal changes occur, invoking powerful messages to eat and regain fat cell mass (Friedman, 2009).

## The dangers of dieting

The psychologically harmful effects of dieting are well established. Dieting is a known risk factor for developing eating disorders, particularly amongst young people. When people diet, they are essentially given a set of 'food rules'. The specific rules differ from diet to diet, and variously involve attention to the 'points' value of a given food, or eating pre-prepared meals, or adhering to specific carbohydrate/protein/fat/sugar rules, or abstaining from eating whole food groups (or even not eating at all, as in liquid diets).

Dieting creates disordered eating and restrained eating patterns. People are directed to ignore their bodies and eat according to certain rules, as depicted by 'head eating' in Figure 1. Having food rules makes people feel deprived, and sets up a preoccupation with the very foods they are trying to avoid. Food

becomes 'good' or 'bad', and the bad food is so very seductive. Before long most people break the rules in some manner, and this can lead to over-eating the bad food.

When people have broken their food rules, they blame themselves for their lack of willpower, and feelings of guilt and shame arise. The more often people have been through the cycle of restriction/blow out, the more hopeless and out of control they feel. This negative self evaluation further undermines self esteem, motivation and self confidence.

Dieting also evokes a range of negative physical side effects. Concerns have been raised regarding the risks of 'yo-yo' dieting, in which people lose and regain weight over time. Because virtually everyone will regain weight after dieting, the effects of weight cycling on health has become an important area of research. Although firm conclusions are yet to be drawn, well controlled studies indicate a link between weight cycling and mortality risk (Andres et al., 1993; Pamuk et al., 1993). From the perspective of staying alive, it may well be more beneficial to health to maintain body weight rather than cycle up and down.

Given the serious physical and psychological consequences of dieting, and its ultimate ineffectiveness at achieving long-term change in weight, an increasing number of commentators are expressing concern about continuing to pursue dieting as a reasonable solution to the problem of increasing weight.

## Re-focus on health rather than body size

Most of the current approaches to weight management focus on weight loss as the primary outcome, but there is ample evidence that metabolic health may be achieved even in the absence of weight loss. Many of the reported changes in key metabolic

### HEAD EATING

- All about food rules
- I should/shouldn't be eating that
- That's a "good/bad" food
- How much fat is in that?

### BODY EATING ('Mindful eating')

- How hungry am I?
- How will that food taste in my mouth?
- Will this food satisfy me?
- How full am I?

Figure 1. Head eating versus body eating

areas (such as blood insulin levels) observed during weight loss interventions occur in the early stages, *before* significant weight loss is observed (Bacon & Aphramor, 2011). This suggests that changes in lifestyle, such as physical activity and eating habits, may be more important factors in metabolic health than weight loss itself.

A growing non-dieting movement – exemplified in books such as *If not dieting, then what* (Kausman, 1998) and the *Health at every size* (HAES) approach (see [www.haescommunity.org/](http://www.haescommunity.org/)) – is challenging traditional weight focused interventions. The non-dieting approach shifts focus from body weight and conceptualises metabolic health as the desired outcome. The non-dieting movement emphasises body acceptance and diversity of body size rather than viewing anyone with a Body Mass Index (BMI) over 25 as 'unacceptable'.

A recent review of non-dieting approaches examined six randomised controlled trials and reported statistically significant and clinically relevant improvements in physiological measures such as blood pressure and lipids, as well as improvements in behaviours related to health, such as increased physical activity and reduced eating disorder pathology (Bacon & Aphramor, 2011). In addition to this, the non-dieting interventions resulted in improved self esteem and body image. It seems that a non-dieting approach can offer meaningful and sustainable health benefits without the damaging effects observed in dieting approaches.

### A non-dieting psychological approach to weight management

Psychologists are strongly positioned to play an important role in helping clients struggling with their weight to change their focus from weight to health. Clients presenting for weight issues are typically disempowered, demotivated and worried, and tend to have poor body image and low self efficacy (i.e., they don't think they can change). The overarching aim of working with such clients is to improve their sense of self efficacy and motivation to take care of themselves – in short, to become empowered to look after their health.

#### PSYCHOLOGICAL TREATMENT PLAN FOR WEIGHT MANAGEMENT USING A NON-DIETING APPROACH

- Education about why dieting doesn't work (outlining the physiological and psychological consequences of dieting)
- Encouraging clients to let go of dieting and food rules
- Encouraging flexible thinking rather than 'all or nothing' patterns
- Teaching mindful eating skills
- Reducing the focus on body weight as the outcome of interest
- Identifying health and wellness values as the primary outcome
- Improving body image
- Building self compassion (as described by Neff, 2003)

Those of us who treat eating disordered clients know that central to the eating disorder is an unhealthy fascination with body weight, with weighing and measuring food intake and in counting calories. Psychological recovery from the eating disorder requires clients to reduce this focus and learn a more relaxed attitude towards food. It seems odd, then, that when people present with weight concerns, we would suddenly advise them to become more vigilant and aware of things such as body weight, calorie counting, or weighing and measuring food. Yet this type of focus is just what is advised in many cognitive behavioural treatment manuals for obesity.

The last thing psychologists want as an outcome is to create an eating disordered client. These people have been bombarded with 'food rules', often without this advice leading to lifestyle change. Reiterating such messages will simply serve to demotivate the client further. Rather than reinforcing diet thinking to clients, the focus of treatment from a non-dieting perspective is to encourage them to let go of food rules and learn the principles of mindful eating, as illustrated in Figure 1.

An effective non-dieting psychological approach to weight management, using cognitive behavioural principles alongside mindfulness and values-based strategies from acceptance and commitment therapy, is presented in the boxed information. This approach is currently the subject of outcome research at our practice to determine its effectiveness in changing lifestyle habits, health indicators and measures of psychological wellbeing. Anecdotally, the approach has been described by clients as 'liberating' and 'empowering', with people beginning to live their lives in a more engaged manner without waiting to lose weight. As a result of this, they take better care of their bodies. In sum, the non-dieting approach seems to provide the elusive ingredient missing in dieting approaches – lasting motivation to engage in self-care. ■

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## APs highlights psychological factors in addressing eating disturbances

*Over the last few years, the APS has made some significant contributions to addressing the problems of eating disturbances which are increasingly prevalent in our community. These have highlighted psychological interventions for obesity, the impact of advertising 'junk food' to children, and psychological factors involved in the development of body image problems in young girls. To provide a forum to raise awareness of the importance of psychological factors and the role of psychologists in addressing eating disturbances, an APS Interest Group was established in 2010.*

### Behaviour change in obesity

The APS made a submission and presentation to the Parliamentary Inquiry into Obesity in Australia in 2008, arguing that obesity can usually only be effectively addressed with significant behaviour change often involving psychological understandings and interventions. An information booklet on a weight management model of psychological care has been developed in conjunction with the APS College of Health Psychologists, outlining psychological interventions for the prevention, treatment and relapse management of overweight and obese problems. The material was finalised for distribution at the Australian and New Zealand Obesity Society (ANZOS) 2009 conference in Melbourne. The APS has also developed media releases in this area, and the *Herald Sun* published an article in January this year, "Thinking about weighty matters", featuring health psychologist Dr Helen Lindner. Earlier this year the APS provided a submission to the *Draft report for the review of MBS items: Items for the surgical treatment of obesity*, highlighting the need for behaviour change interventions to be trialled before any surgical intervention.

### Junk food advertising to children

The APS made a submission to the *Protecting children from junk food advertising (Broadcasting amendment) Bill 2008*, arguing that inappropriate advertising of such food has the potential for a range of psychological effects on children. The submission concluded that comprehensive, multi-faceted prevention approaches must be adopted, and that increased regulation was likely to have the greatest impact on reducing levels of food-related harm. The 2008 Bill was not passed, the industry's self-regulation has been ineffective, and public health and medical organisations are once again stepping up calls for an end to advertising of junk to children. The APS is ready to add its voice to any subsequent inquiries or calls for an end to junk food advertising.

### Encouraging positive self image in children

Over the past few years, the APS has contributed to debates about the effects of sexualised images on the wellbeing of young people through formal submissions to government inquiries, media releases and resources. Submissions have presented the research that links sexualisation with a common mental health problem of girls and women – eating disorders – and have called

for media education for children in schools to establish critical viewing skills, among other recommendations. The APS has developed a Tip Sheet, *Helping girls develop a positive self image*, which presents information and advice to parents to encourage their girls to develop positive body images ([www.psychology.org.au/publications/tip\\_sheets/girls\\_positive\\_image/](http://www.psychology.org.au/publications/tip_sheets/girls_positive_image/)).

### APS Psychology of Eating, Weight and Body Image Interest Group

This APS Interest Group was established in 2010 as there are few professional forums that encompass eating disorders and disordered eating, overweight and obesity, and body image. The importance of psychological factors and the role of psychology are often overlooked in these areas. Additionally, despite the high and increasing prevalence of eating, weight and body image disorders, the recognised importance of prevention and treatment efforts, and the identified need for improved professional training, there are relatively few opportunities for professional training and support. The Interest Group aims to provide health professionals and students who have an interest in eating, weight and body image with the opportunity to share information, network with others with similar interests, and undertake professional development.

In response to a survey of its members' interests and professional needs, the Interest Group has this year held a networking dinner with a seminar on health behaviour change and motivational interviewing techniques, and will hold a changing eating behaviours workshop in November. A mini-conference is also being planned for November as a forum for researchers, clinicians and students to present their eating, weight and body image-related work. More information on these activities can be found in the Interest Group's latest newsletter ([www.groups.psychology.org.au/Assets/Files/PEWBIG-newsletter-June-2011.pdf](http://www.groups.psychology.org.au/Assets/Files/PEWBIG-newsletter-June-2011.pdf)).

**Further information and application forms to join the APS Psychology of Eating, Weight and Body Image Interest Group can be found at [www.groups.psychology.org.au/pewbi/](http://www.groups.psychology.org.au/pewbi/) ■**