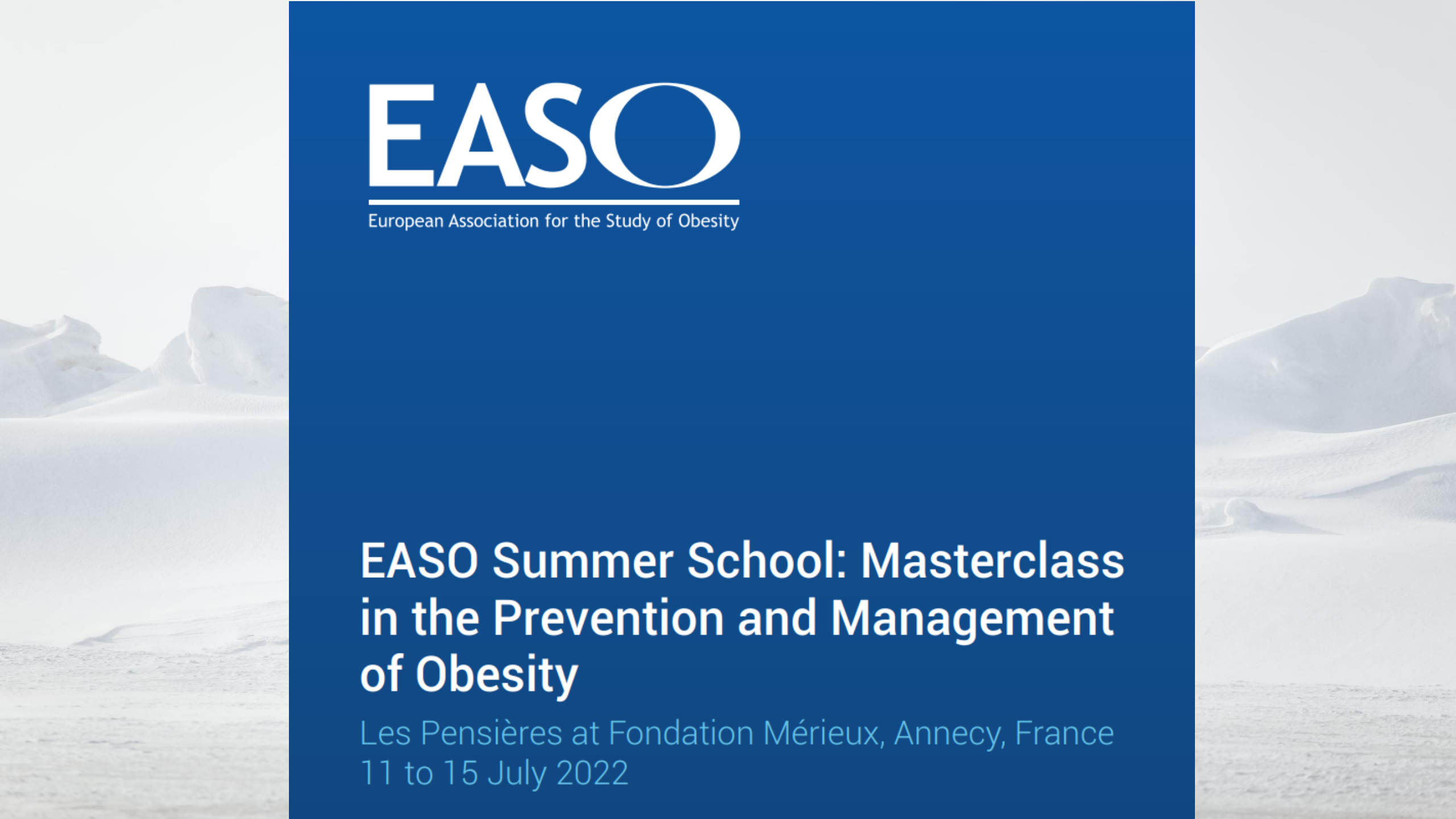


The background of the slide is a photograph of a snowy mountain landscape. The image is split vertically by a solid blue band that contains the text. The snowy peaks and ridges are visible on both the left and right sides of the blue band.

EASO

European Association for the Study of Obesity

EASO Summer School: Masterclass in the Prevention and Management of Obesity

Les Pensières at Fondation Mérieux, Annecy, France
11 to 15 July 2022



Communication and Pedagogy Breaking Down the Barriers

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Head of Research

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and

The Novo Nordisk Foundation Center for Basic Metabolic Research,
University of Copenhagen, Denmark

Co-chair of The Childhood Obesity Task Force (EASO)



Disclosures

- Lecture fees and honoraria from Novo Nordisk
- Board member; Danish Association for the Study of Obesity
- Member Obesity Committee; Danish Paediatric Society
- Co-chair; The Childhood Obesity Task Force EASO
- Ex-Officio Executive Committee EASO
- Dr Holm Ltd provides training and treatment

E66.01 and Our Culture of Shame Scott Hagan NEJM December 16 2021

- Patient story: a patient has been committed to structured weight loss for the previous year
 - Initial success
 - Most pounds came back *"I have been bad lately"*
- GLP-1 analogue requires ICD-10 diagnosis "morbid obesity **due to** excess calories"
 - Discussion of "due to" → reflects a simplistic belief among clinicians — one that fuels such shame.

"The consistent theme in these notes is that it's up to the patient to decide to lose weight, and he will do so when he acknowledges the health risks associated with obesity and changes his lifestyle."

- Discussion of the neuroendocrine system and caloric restriction
 - Diet and exercise interventions alone fail to help most people with obesity to maintain substantial weightloss
 - Weight regain is common within one year
 - Numerous of diets are thriving in society despite the statistics
- Fight weight bias → professions need to transform themselves from adversaries of patients with obesity to allies
- Changing the language of a problematic ICD-10 code description!

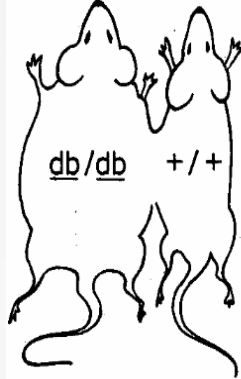
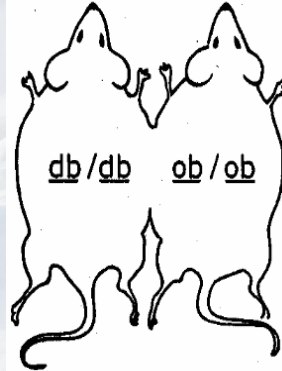
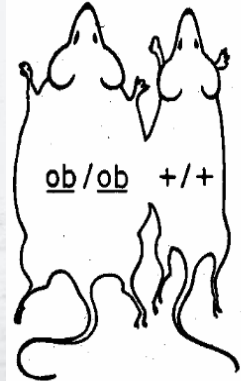
Implications of understanding obesity as a chronic disease

- The healthcare professional is committed by the Hippocratic oath or the obligation as a doctor to take responsibility of treatment
- Prioritisation of patients with diagnostic procedures and investigations and subsequent treatment in clinical practice
- The health care professionals has the competences whereas the patients have the disease
- Impact on communication and pedagogy in multiple ways



Phenotypes of the ob/ob and db/db mice

- Hungry
- Obese
- Insulin resistant
- Impaired growth
- Hypothermic
- Hypoactive
- Infertile
- Cortisol $\uparrow$, T3/T4 $\downarrow$
- Immune-incompetent

Experiments	Results
 db/db +/+	Lean $\downarrow$ insulinemia $\downarrow$ blood sugar Death by starvation Diabetes $\uparrow$ body weight $\uparrow$ adipose tissue mass
 db/db ob/ob	Obese $\downarrow$ body weight $\downarrow$ adipose tissue mass $\downarrow$ insulinemia $\downarrow$ blood sugar Death by starvation Diabetes $\uparrow$ body weight $\uparrow$ adipose tissue mass
 ob/ob +/+	Lean no change Obese $\downarrow$ food intake $\downarrow$ insulinemia $\downarrow$ blood sugar

Coleman DL. Diabetologia 1978;14:141-8.

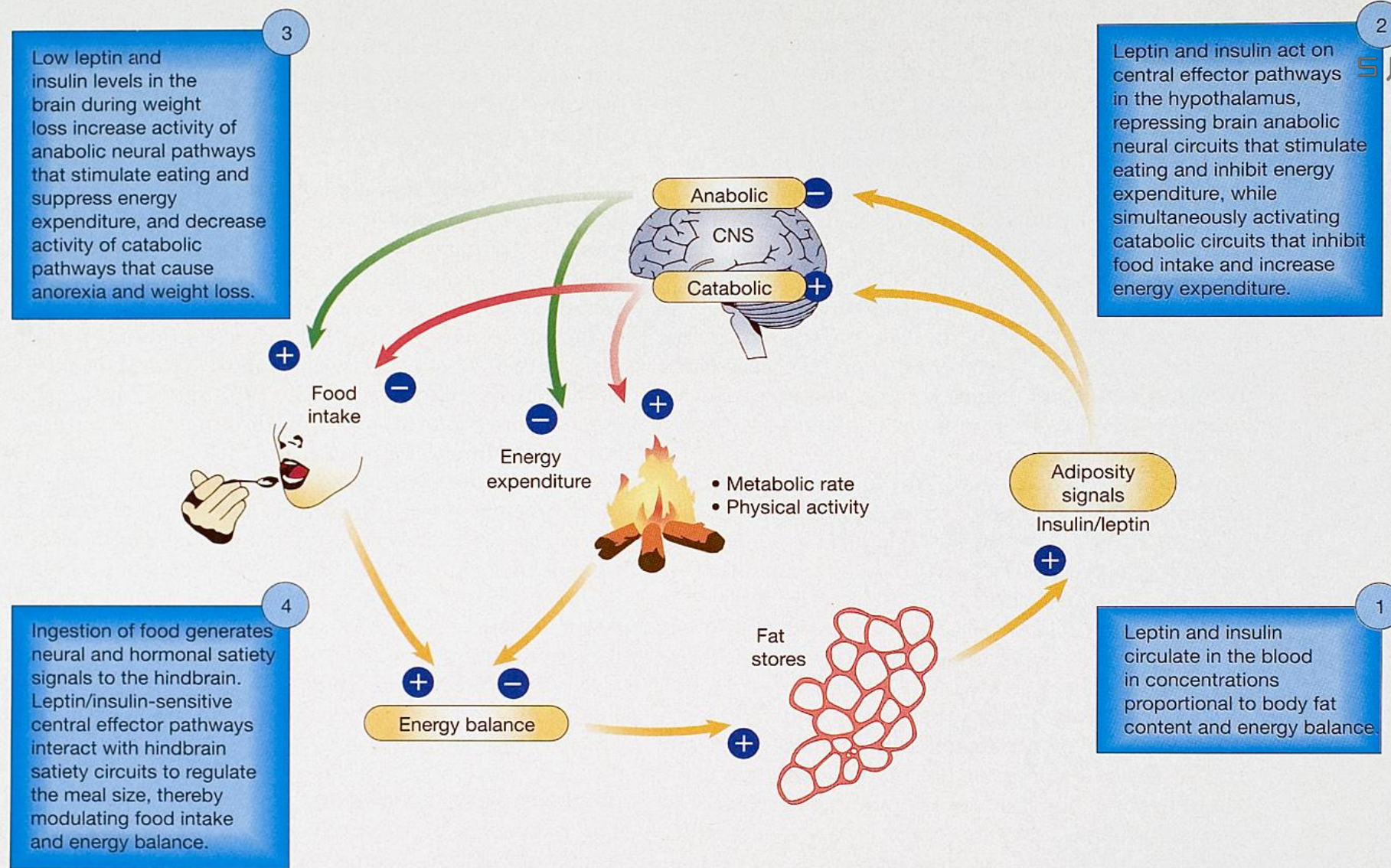


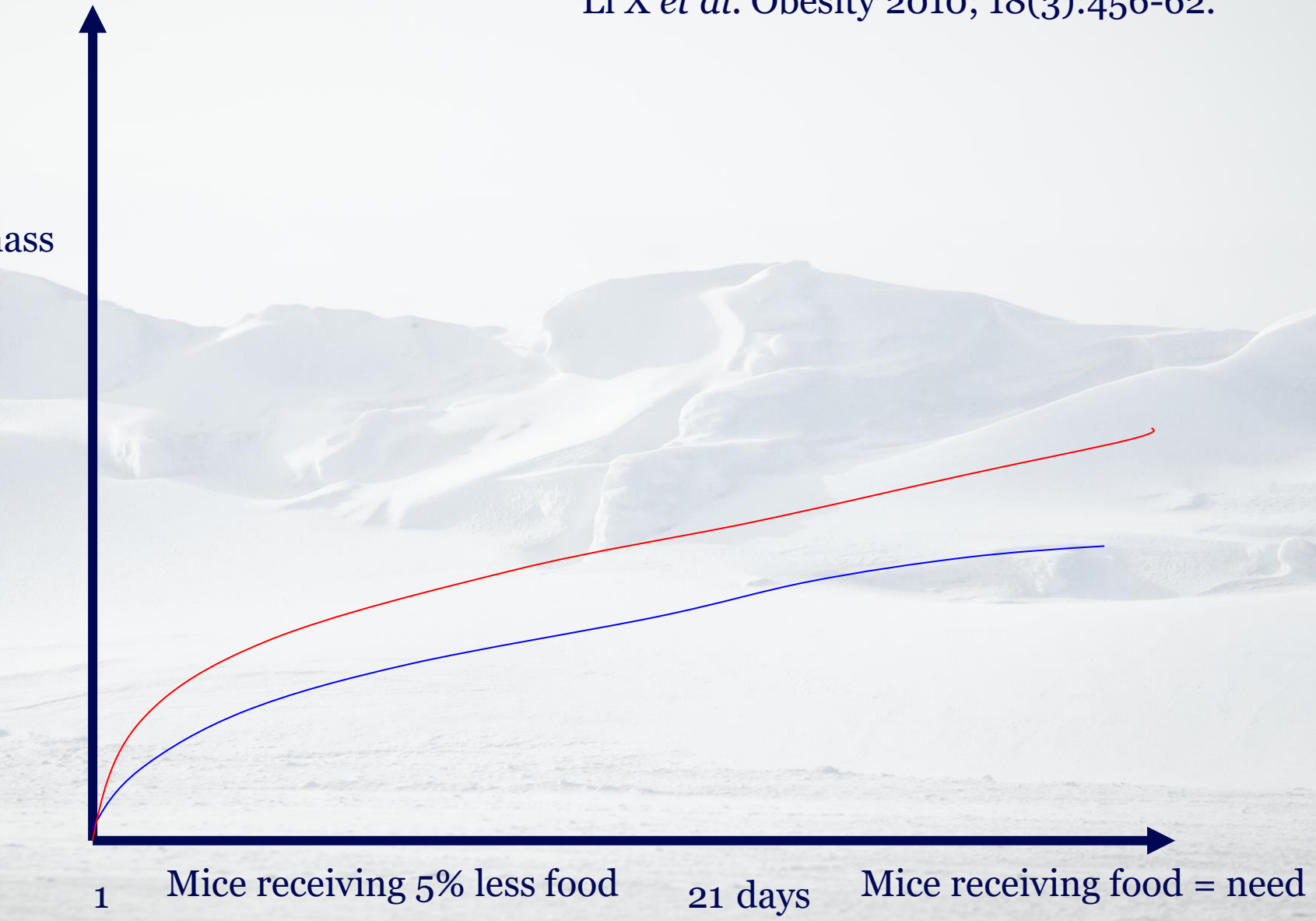
Figure 1 Model showing how a change in body adiposity is coupled to compensatory changes of food intake. Leptin and insulin are adiposity signals, secreted in proportion to body fat content, which act in the hypothalamus to stimulate catabolic, while

inhibiting anabolic, effector pathways. These pathways have opposing effects on energy balance (the difference between calories consumed and energy expended) that in turn determines the amount of body fuel stored as fat.



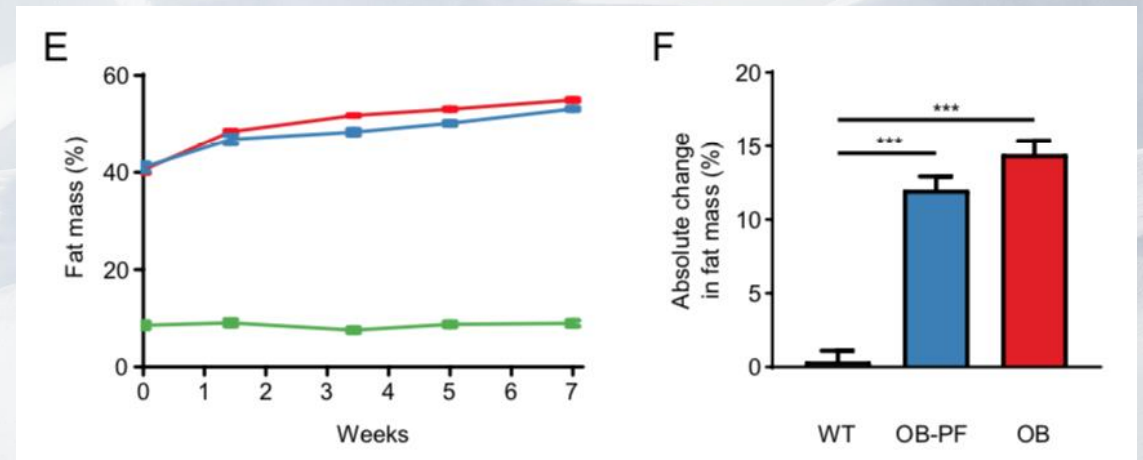
Li X *et al.* Obesity 2010; 18(3):456-62.

Fat mass



Impaired glucose metabolism and altered gut microbiome despite calorie restriction of ob/ob mice

- Pair-fed ob/ob mice exhibited even more compromised glucose metabolism and maintained strikingly similar high body fat percentage at the cost of lean body mass.

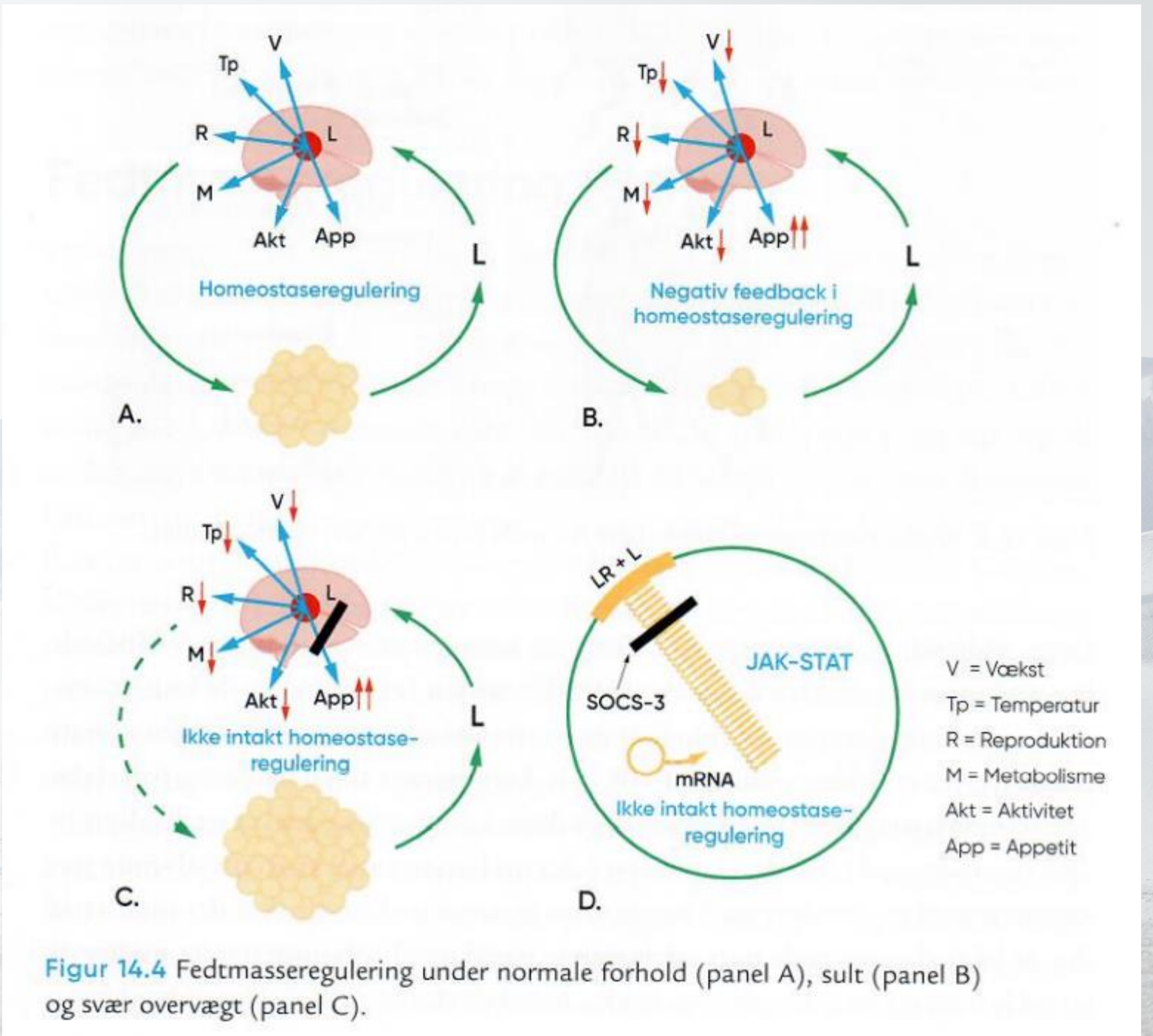




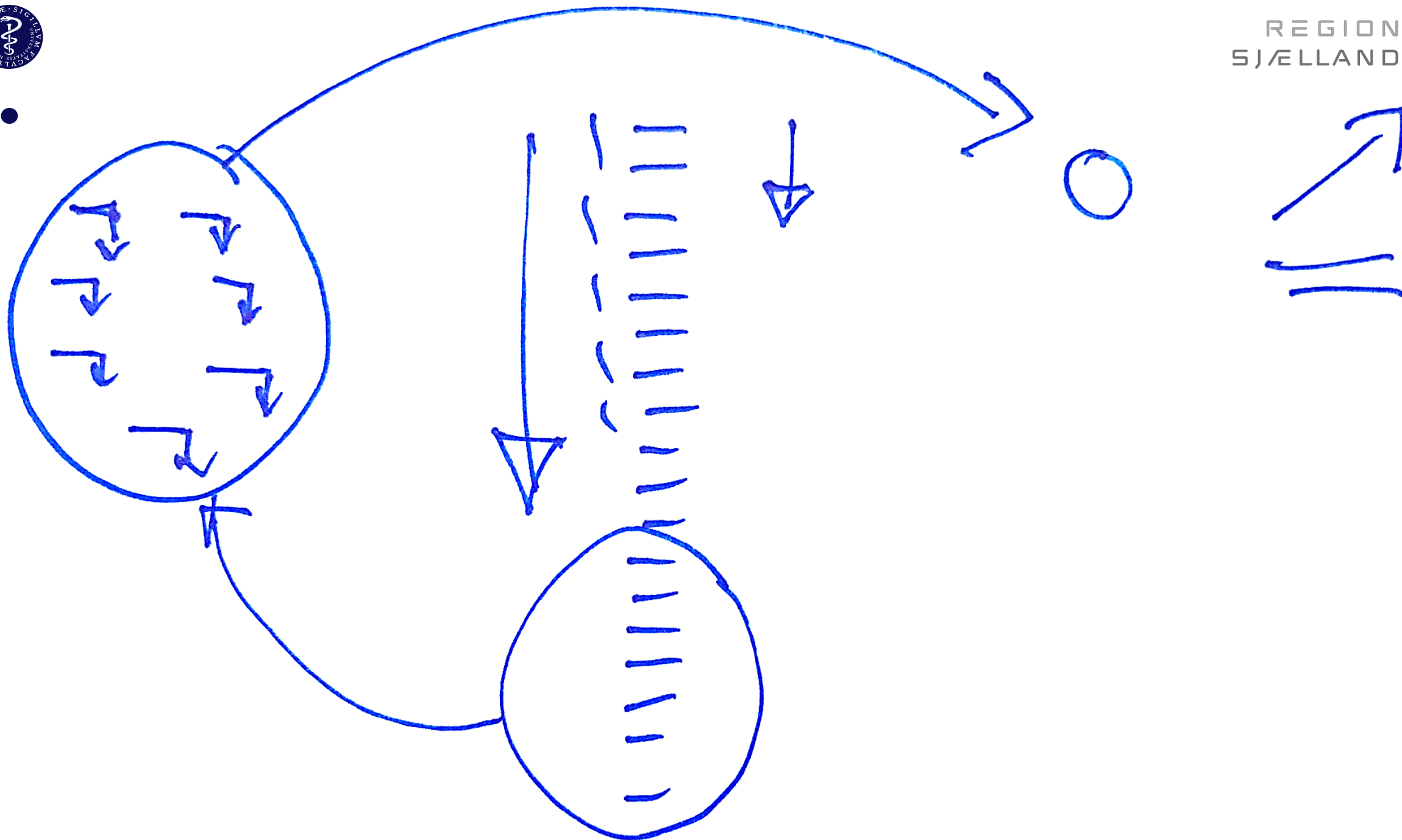


Two identified mechanisms that conveys disturbed fat mass regulation;

- 1. Diminished transport of leptin across the blood brain barrier i.e. diminished leptin transport capacity in relation to increased degrees of obesity.
- 2. After leptin – leptin receptor coupling, the subsequent JAK- STAT signalling pathway within the hypothalamic neurones is impaired by SOCS-3 in relation to increased degrees of obesity



Figur 14.4 Fedtmasseregulering under normale forhold (panel A), sult (panel B) og svær overvægt (panel C).





Neuroendocrinological adaptation against weight loss provide

Translation which explains weight regain

Self-identification in most patients

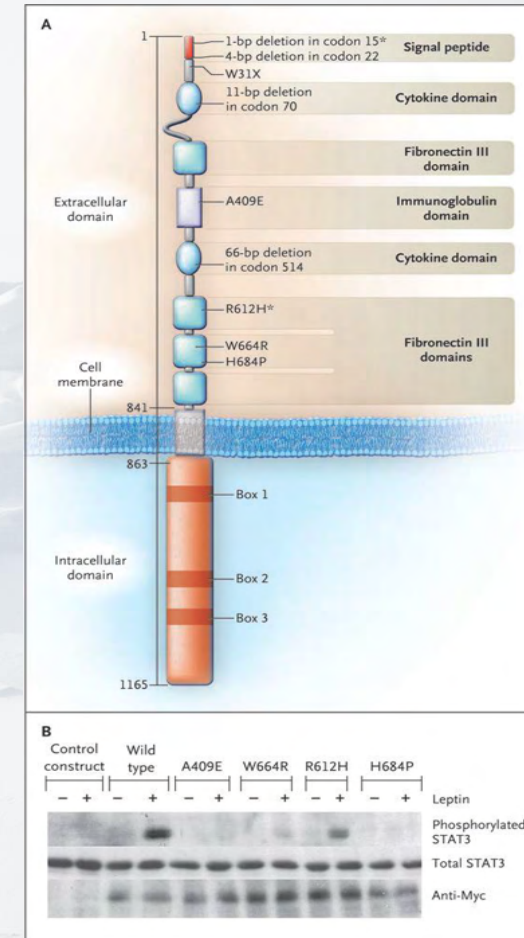
We don't know what the challenge is individually

Be humble and serious with your patient



Constantly hungry to a degree where he feels he is starving to death

-Totally leptin resistant-



Rev 2	12/15/06
Author:	Farooqi
Fig #	1
Title	Deficiency of the Leptin Recept
ME	
DE	Pharmacist
Artist	Williams

AUTHOR PLEASE NOTE:
Figure has been redrawn and type has been reset, please check carefully



Negative energy balance?

- *Induces* comprehensive neuroendocrinological adaptations
- Energy balance is not just a passive balance, but instead an *active asymmetric* biological function to ensure and secure sufficient energy to demands in the future
- Fat and energy regulation is able of being "*energy efficient*"
- *Be careful* about expectations/prejudice since you really dont know what is going on in the individual patient



Translational impact of fat mass regulation

As many as possible treatment plan points from the start!

Integrated energy balance regulation; I.e. not just focus on nutrition and activity, but also specifically inactivity, picky eating, sugar dependency, disturbed eating, child upbringing and more

Not just a diet, actually in principle food intake ad libitum!

Caloric restriction through growth and development!

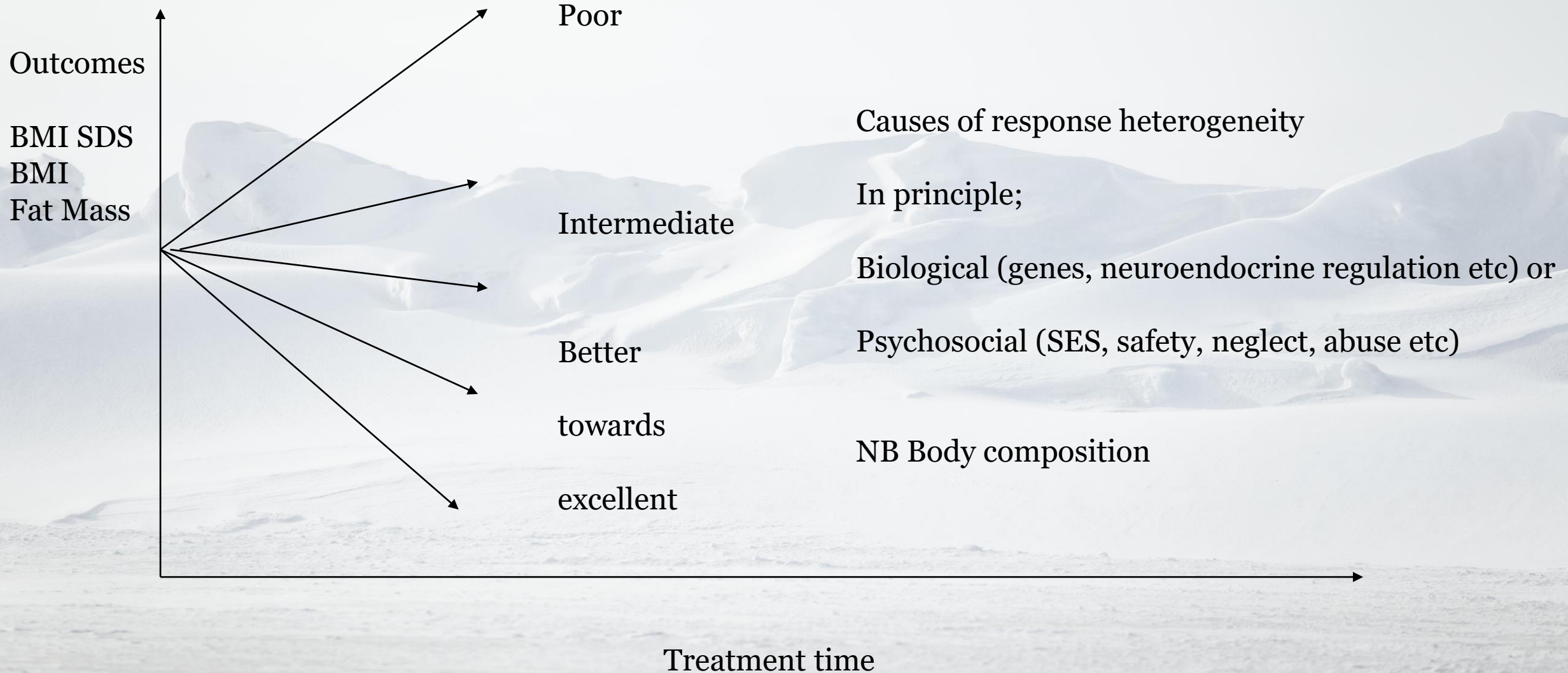
Avoid undereating! Regarded as counterproductive

Motivation!

Understanding of underreporting!

Fat mass regulation

- expected treatment heterogeneity i.e. treatment responses





- According to the Convention on the Rights of the Child (CRC) by the UNICEF;
- this reality is unacceptable because all children should be able to receive medical care when it is needed: 'States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services'





European Association for the Study of Obesity



**EASO Collaborating Centres for Obesity Management (COMs)
Paediatric Section**

Centre: The Children's Obesity Clinic, Copenhagen University Hospital
Holbæk, Denmark

Contact: Jens-Christian Holm

We would like to take this opportunity to thank you for submitting an application for your centre to become an EASO accredited Collaborating Paediatric Centre for Obesity Management.

Under the EASO COM scheme, paediatric obesity management centres (including university and public clinics) are accredited against a set of carefully developed criteria and in accordance with accepted European and academic guidelines, with applying centres assessed by the EASO Childhood Obesity Task Force (COTF). The COTF has completed its assessment of your centre and we are pleased to confirm that your application was successful – your centre has thus been granted EASO COM status for the three year period **1st May 2019 to 30th April 2022**.

Your centre will therefore be recognised by EASO as a leading paediatric obesity management centre in Europe throughout that period. The EASO COM network brings together accredited centres from across Europe and as a member of this network, your centre will have the opportunity to contribute to a number of important EASO projects. One of the main goals of the COM network is to develop consensus guidelines on a number of management issues, with consensus achieved via the exchange of expertise during specially convened 'Paediatric COM Summit Meetings'.

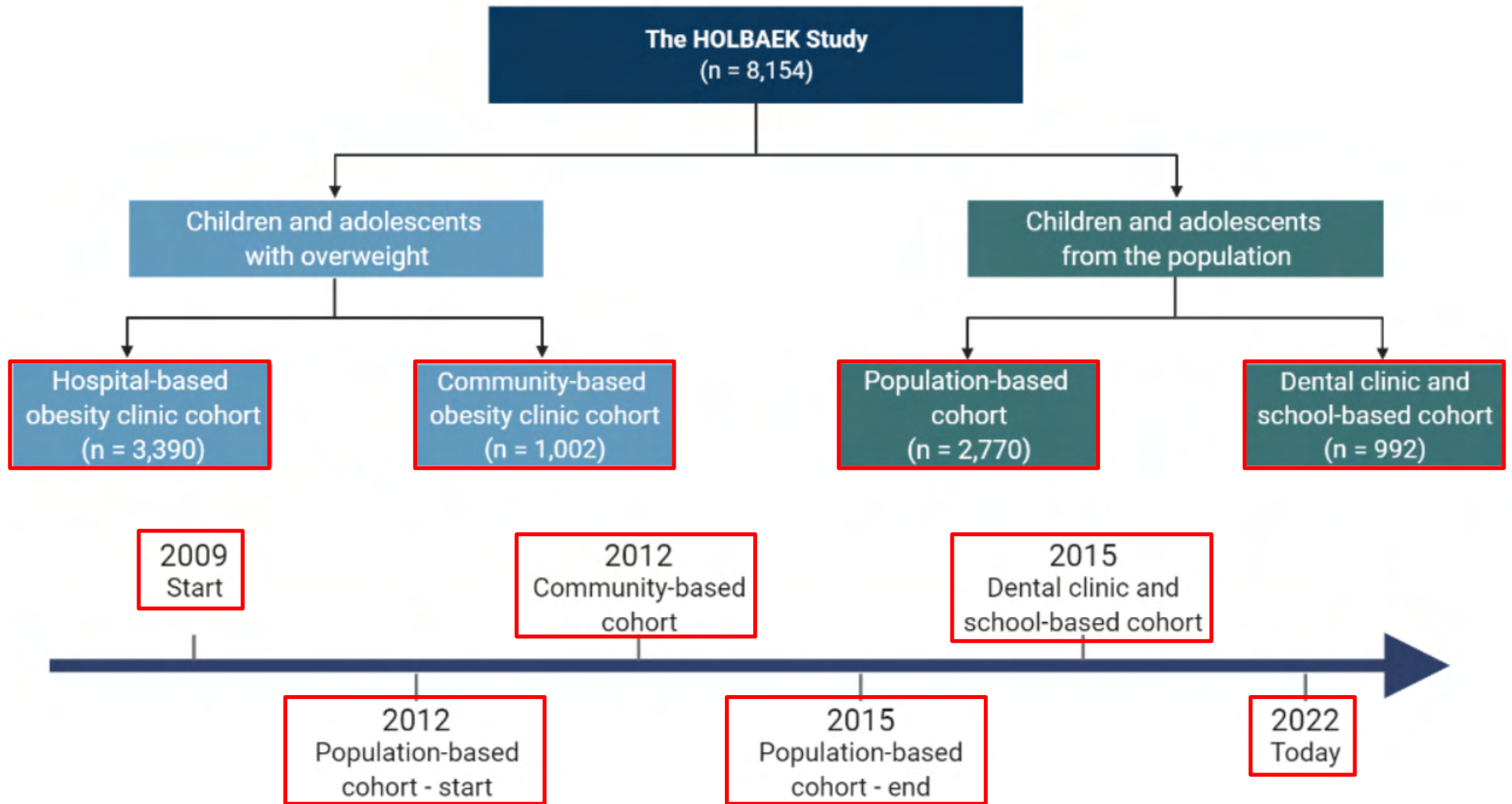
We will send further information in due course and look forward to working with you to develop the EASO Paediatric COM network and its important actions in the coming years.

With kind regards
Yours sincerely

Professor Nathalie Farpour-
Lambert
President, EASO

Mr Euan Woodward
Executive Director, EASO

On behalf of the EASO COTF and Executive Committee.

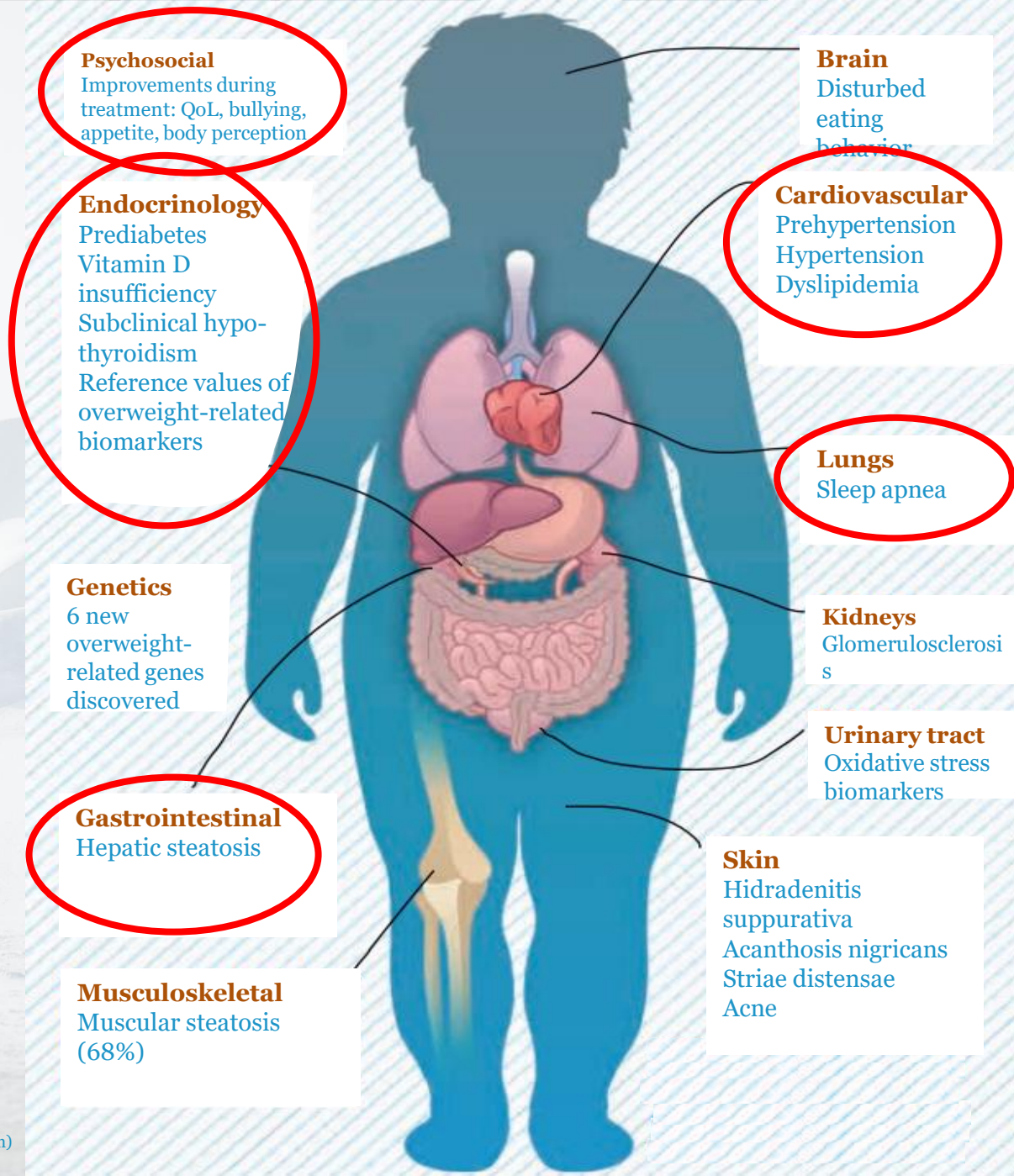


Complications to overweight

- 75% with low self-esteem, self-confidence or quality of life
- 82% with disturbed eating
- 50% with hypertension or prehypertension
- 28% with dyslipidemia
- 60% with vitamin-D insufficiency
- 14% with prediabetes
- 45% with sleep apnea
- 31% with hepatic steatosis

- Fogh, J Paediatr Child Health. 2020; 56(4):542-549
- Mollerup, J Hum Hypertens. 2017;31(10):640-646
- Nielsen, BMC Pediatr. 2017 Apr 28;17(1):116
- Plesner, J Pediatr Endocrinol Metab. 2018;26;31(1):53-61
- Kloppenborg, Pediatr Diabetes. 2018 May;19(3):356-365
- Andersen, Eur Arch Otorhinolaryngol. 2019 Mar;276(3):871-878
- Fonvig, PLoS One. 2015 Aug 7;10(8):e0135018

(Courtesy of Dr Holm)



The HOLBAEK model

4-5 hours of healthcare professional time per patient per year

Reduces the degree of obesity in 74-76% (up to 90%) of children and youths

Fogh, M., J Paediatr Child Health 2020; Mollerup, P., PLoS One 2017; Most, SW., BMC Pediatr. 2015; Nielsen TRH., PLoS One 2018;

Reduces the degree of dyslipidemia

Nielsen, TRH., Child Obes. 2012

Reduces the degree of hypertension

Hvidt, KN., J Hypertens. 2014

Reduces the degree of hepatic steatosis

Fonvig, CE., BMC Pediatr. 2015

Reduces the degree of parental obesity

Trier, C., PLoS One. 2016

Reduces appetite and bullying

Fonvig, CE., Qual Life Res. 2017

Implementable in primary and secondary sectors

Holm, J-C., Int J Pediatr Obes. 2011; Mollerup, P., PLoS One 2017

Increases quality of life and selfesteem

Mollerup, P., Qual Life Res. 2017

Independent on genetic risk scores (15 genes)

Hollensted, M., Obes. 2018

eHealth solution (weight reduction in 72-85%)

Langkjaer, IOJ., Mhealth. 2022

Weight reduction in 80%-85% adults in Norway

Unpublished

Independent on degree of obesity and SES at baseline

J-C., Int J Pediatr Obes. 2011

Independent on familial predisposition

Nielsen, LA., PLoS ONE 2015

Independent on sugary intakes

Trier, C., Pediatr Obes. 2016

Independent on impaired glucose metabolism

Kloppenborg, JT., Pediatr Diabetes 2018

Independent on disturbed eating

Fogh, M., J Paediatr Child Health 2020



Longitudinal evaluation of an mHealth overweight and obesity management tool

Ida Olivia Juhl Langkjær^{1^}, Cilius Esmann Fonvig^{2,3^}, Louise Aas Holm^{2^}, Andreas Friis Pihl^{4,5^}, Jens-Christian Holm^{1,2,3^}

¹University of Copenhagen, Faculty of Health and Medical Sciences, Copenhagen, Denmark; ²Faculty of Health and Medical Sciences, Novo Nordisk Foundation Center for Basic Metabolic Research, University of Copenhagen, Copenhagen, Denmark; ³Dr Holm App Aps., Holbæk, Denmark; ⁴Research Unit of General Practice, University of Southern Denmark, Odense, Denmark; ⁵Roche Diagnostics Denmark, Hvidovre, Denmark

Contributions: (I) Conception and design: CE Fonvig, JC Holm; (II) Administrative support: None; (III) Provision of study materials or patients: CE Fonvig, JC Holm; (IV) Collection and assembly of data: CE Fonvig; (V) Data analysis and interpretation: All authors; (VI) Manuscript writing: All authors; (VII) Final approval of manuscript: All authors.

Correspondence to: Jens-Christian Holm. Kalundborgvej 114, 4300 Holbæk, Denmark. Email: jch@drholm.com.

Results

www.DrHolmApp.dk

www.DrHolmApp.com

www.DrHolmApp.net

www.DrHolmApp.info

Original Article

Page 1 of 10

Longitudinal evaluation of an mHealth overweight and obesity management tool

JMIR MHEALTH AND UHEALTH

Islam et al

Ida Olivia Juhl Langkjær^{1,^},
Jens-Christian Holm^{1,2,3,^}

Original Paper

Use of Mobile Phone App Interventions to Promote Weight Loss: Meta-Analysis

Md Mohaimenul Islam^{1,2,3}, MSc; Tahmina Nasrin Poly^{1,2,3}, MSc; Bruno Andres Walther⁴, PhD; Yu-Chuan (Jack) Li^{1,2,3,5}, PhD

	DrHolmApp.dk (aug. 2021)	
Participants N	940	
Gender	♀ ~92%	
BMI difference	−0.63 (95% CI: −0.70 to −0.57, P<0.001)	
Change in physical activity	1.5 d/uge, P<0.001	

Results

www.DrHolmApp.dk

www.DrHolmApp.com

www.DrHolmApp.net

www.DrHolmApp.info

- Exactly as results seen in children and adolescents

Table 2 Characteristics of the 940 WADHA users

Variables	Baseline	Follow-up	P-values
Age, years, means (SD)	49.1 (11.1)	49.4 (11.1)	<0.001
Baseline BMI, kg/m ² , medians (IQR)	33.9 (29.6–38.9)	33.3 (29.0–37.9)	<0.001
Obesity class III (≥40), n (%)	185 (19.7)	157 (16.7)	
Obesity class II (35–39.9), n (%)	219 (23.3)	208 (22.1)	
Obesity class I (30–34.9), n (%)	271 (28.8)	269 (28.6)	
Overweight (25–29.9), n (%)	243 (25.9)	268 (28.5)	
Normal weight (18.5–24.9), n (%)	22 (2.3)	38 (4.0)	
Underweight (BMI <18.5), n (%)	0 (0.0)	0 (0.0)	
Visual Analogue Scale, medians (IQR)			
Mood	6.7 (4.4–7.9)	7.1 (5.4–8.4)	<0.001
Quality of life	6.9 (5.4–8.0)	7.3 (5.9–8.3)	<0.001
Appetite	6.7 (5.2–8.2)	6.2 (3.5–7.4)	<0.001
Bullying	0.1 (0.0–1.1)	0.0 (0.0–0.8)	<0.001
Wish for weight loss	10.0 (9.8–10.0)	10.0 (8.6–10.0)	<0.001
Body image satisfaction	1.5 (0.4–3.1)	2.3 (0.8–4.3)	<0.001
Treatment duration days, medians (IQR)		52.0 (25.0–84.0)	
Number of consultations, medians (IQR)		3.0 (2.0–4.0)	

WADHA, Web Application DrHolmApp; SD, standard deviation; BMI, body mass index; IQR, interquartile range.

Results

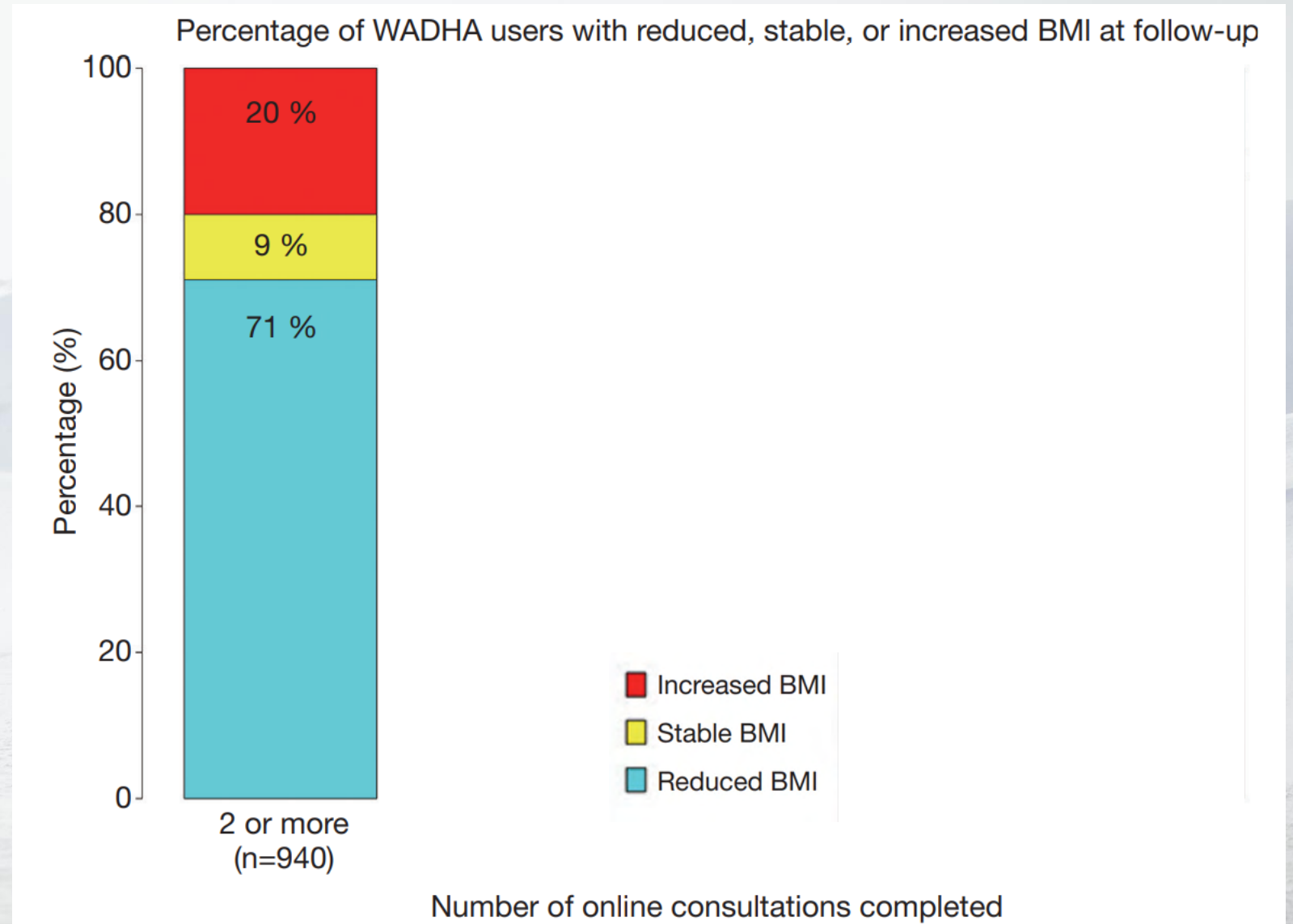
www.DrHolmApp.dk

www.DrHolmApp.com

www.DrHolmApp.net

www.DrHolmApp.info

- Private use
- Smartphone
- Tablet
- PC/laptop
- No contacts to hcps



Danish clinical guidelines for examination and treatment of overweight and obese children and adolescents in a pediatric setting

Anders Johansen, Jens-Christian Holm, Seija Pearson, Mimi Kjærsgaard, Lone Marie Larsen, Birgitte Højgaard, Dina Cortes

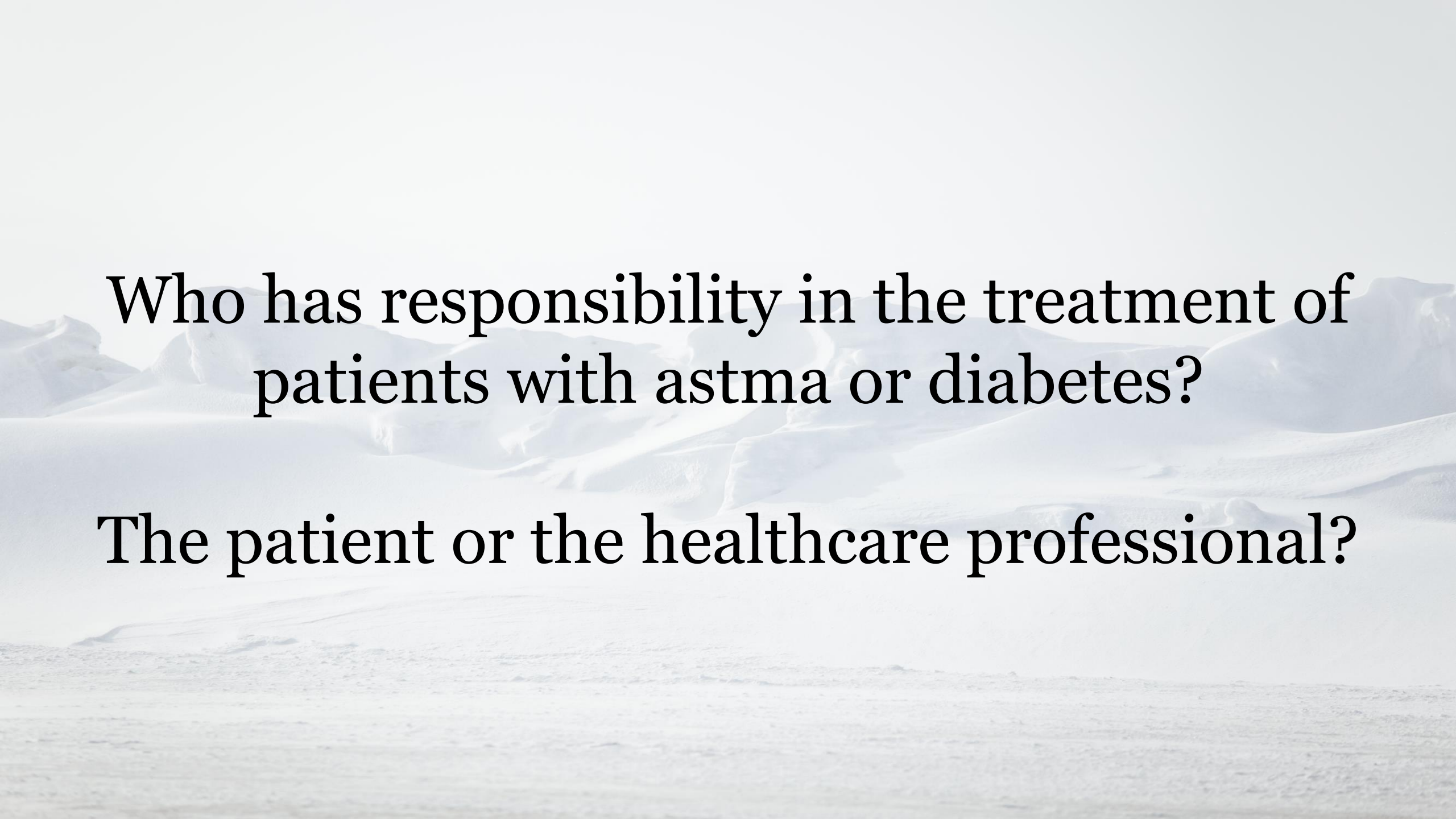
This guideline by the Obesity Committee within The Danish Paediatric Society has also been approved by the Committees for Endocrinology, Gastroenterology, Cardiology, Neonatology and Nephro-urology within The Danish Paediatric Society, Danish Paediatricians Organization, The Danish Society for Diabetes in Childhood and The Danish Association for the Study of Obesity.

The Danish College of General Practitioners supports the referral criteria for pediatric evaluation. November 28, 2014.

Correspondence: Anders Johansen, Department of Growth and Reproduction, Copenhagen University Hospital Rigshospitalet, Blegdamsvej 9, 2100 Copenhagen, Denmark

E-mail: Anders.johansen.01@regionh.dk

ly among the youngest boys (11). Furthermore, recent data shows an approximately 10% prevalence of overweight and obesity among preschool children (12). In the Funen birth cohort from 2001, the prevalence of obesity in children was 1.9% of the children aged 2.5-3.5 years; 2.5% of those aged 3.5-4.5 years; and 2.5% in the group aged 4.5-5.5 years (12). In Copenhagen in 2007, the prevalence of obesity in 5-8 year old girls and boys was 3.7% and 2.6% respectively, whilst in 14-16 year old girls and boys, it was 4.7% and 4.2% respectively (13). In the 2010 "Schoolchildren Study" comprising a random sample of schools in Denmark 2-3% of the children aged 11, 13 and 15 years were obese based on a BMI calculated from the children's self-reported height and weight (14).



Who has responsibility in the treatment of
patients with asthma or diabetes?

The patient or the healthcare professional?

Questions and answers

- 160 questions in 15-20 minutes
- Qualities, frequencies, and amounts
- Pattern recognition!
- Flow and rhythm induce acceptance and trust
- Identify most obstacles initially
- Answers are not/or less constructed
- 15-20 minutes or 1 second to establish treatment plan

Personal treatment plan for Dorte (12th of July 2022)

1. Be less picky.
2. **Breakfast:** not coarse bread, cheese with more than 13% fat, chocolate, spreadable chocolate, jam, fig spread, honey, müesli, yoghurt, juice or cocoa.
3. **Breakfast:** You can freely choose between oats, rolled oats and oatmeal porridge with a maximum of one teaspoon of raisins/sugar, puffed rye or oat grains (not sweetened), plain yogurt with a maximum of 0.5 % fat content, greens, rye bread with lean toppings/cold cuts with a maximum of 9 % fat and cheese with a maximum of 13 % fat.
4. **Pre-noon meal (between breakfast and lunch):** not coarse bread, chocolate, spreadable chocolate, jam, fig spread, honey, müesli, or yoghurt.
5. **Pre-noon meal:** If you're not hungry between breakfast and lunch, skip the meal. It is not necessary to eat between breakfast and lunch. If you are hungry, you can choose from ½-2 slices of rye bread (possibly roasted) with toppings/cold cuts with a maximum of 9 % fat content and cheese with a maximum of 13 % fat content, greens, oats, rolled oats, oatmeal porridge, puffed rye or oat grains (not sweetened), and plain yogurt with a maximum of 0.5 % fat content.
6. Eat lunch every day.
7. **Lunch:** not cheese with more than 13% fat, toppings/cold cuts with more than 9% fat, mayonnaise-based salads (e.g. tuna-, italian-, russian-, chicken-), ketchup, mayonnaise, remoulade, white rice, white pasta or meat with more than 7% fat.
8. For **lunch**, choose freely between greens, rye bread with lean toppings/cold cuts with a maximum of 9 % fat and cheese with a maximum of 13 % fat.
9. Eat an afternoon meal every day (between lunch and dinner).

10. **Afternoon meal:** not müesli or yoghurt.

11. **Afternoon meal:** just like breakfast, you can freely choose between oats, rolled oats and oatmeal porridge with a maximum of one teaspoon of raisins/sugar, puffed rye or oat grains (not sweetened), plain yogurt with a maximum of 0.5 % fat content, greens, rye bread with lean toppings/cold cuts with a maximum of 9 % fat and cheese with a maximum of 13 % fat.

12. **Dinner:** not white bread, coarse bread, cheese with more than 13% fat, toppings/cold cuts with more than 9% fat, mayonnaise-based salads (e.g. tuna-, italian-, russian-, chicken-), ketchup, mayonnaise, remoulade, cream, white rice, white pasta or meat with more than 7% fat.

13. **Dinner:** eat a mixed selection of greens. Choose freely between potatoes, whole-grain pasta, brown rice and rye bread. Choose freely between lean meats without visible fat, fish (both lean and fat) and legumes. Minced meat must contain no more than 7% fat. A maximum of 2 tablespoons of dressing or sauce per serving. Use as little fat as possible and a maximum of 2 teaspoons per person for cooking warm food.

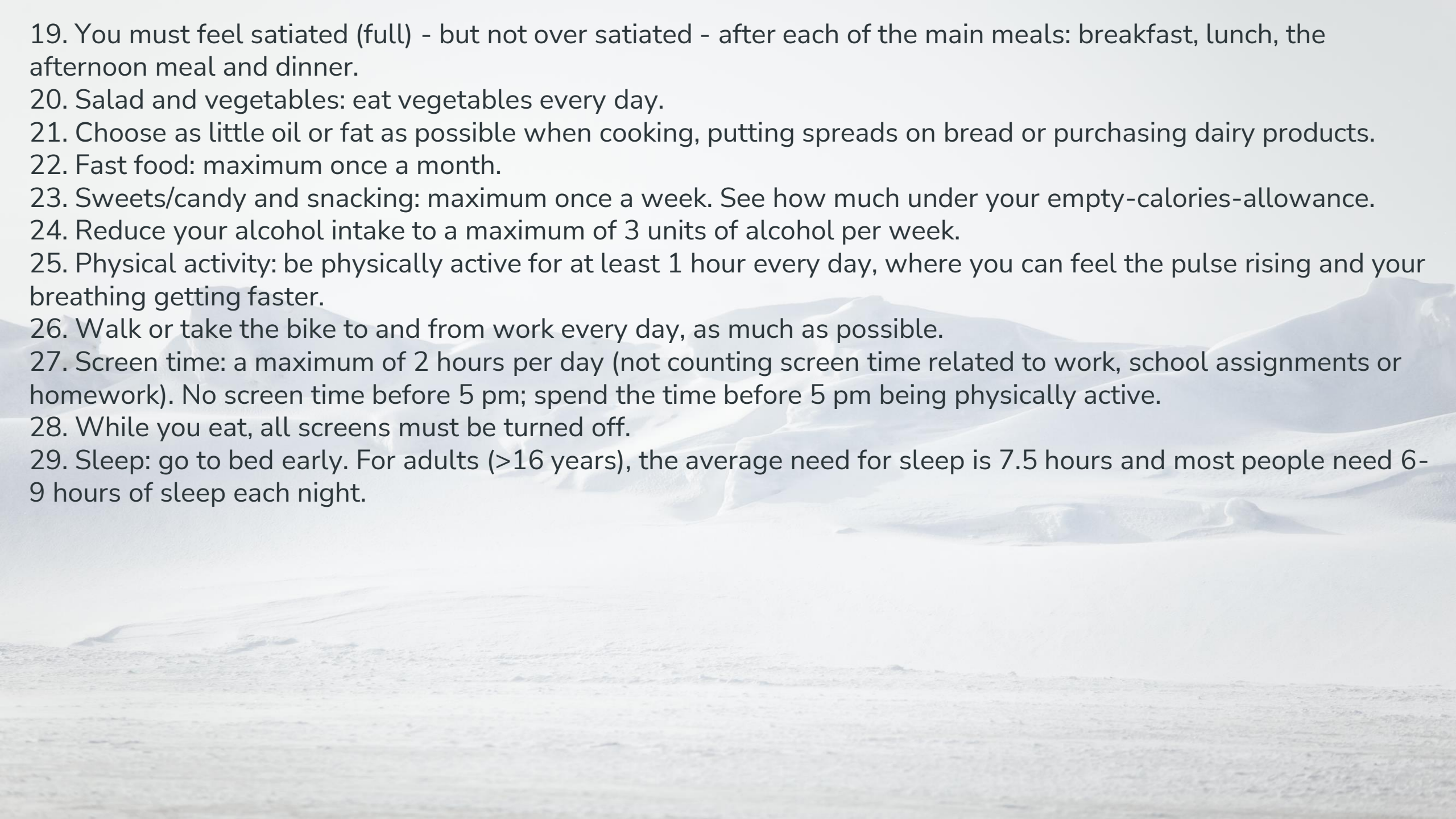
14. **Dinner** must be portioned (arranged on a plate) in the kitchen.

15. **Dinner** must be portioned according to the T-plate model.

16. **Dinner:** if a 2nd portion (2nd serving) is needed, it may be served no sooner than 20 minutes after the 1st portion is finished.

17. **Late-night meal:** Do not eat between dinner and breakfast. But if you are hungry, you can choose from ½-2 slices of rye bread (possibly roasted) with toppings/cold cuts with a maximum of 9 % fat content and cheese with a maximum of 13 % fat content, greens, oats, rolled oats, oatmeal porridge, puffed rye or oat grains (not sweetened), and plain yogurt with a maximum of 0.5 % fat content.

18. **Late-night meal:** not soft drinks between dinner and breakfast.

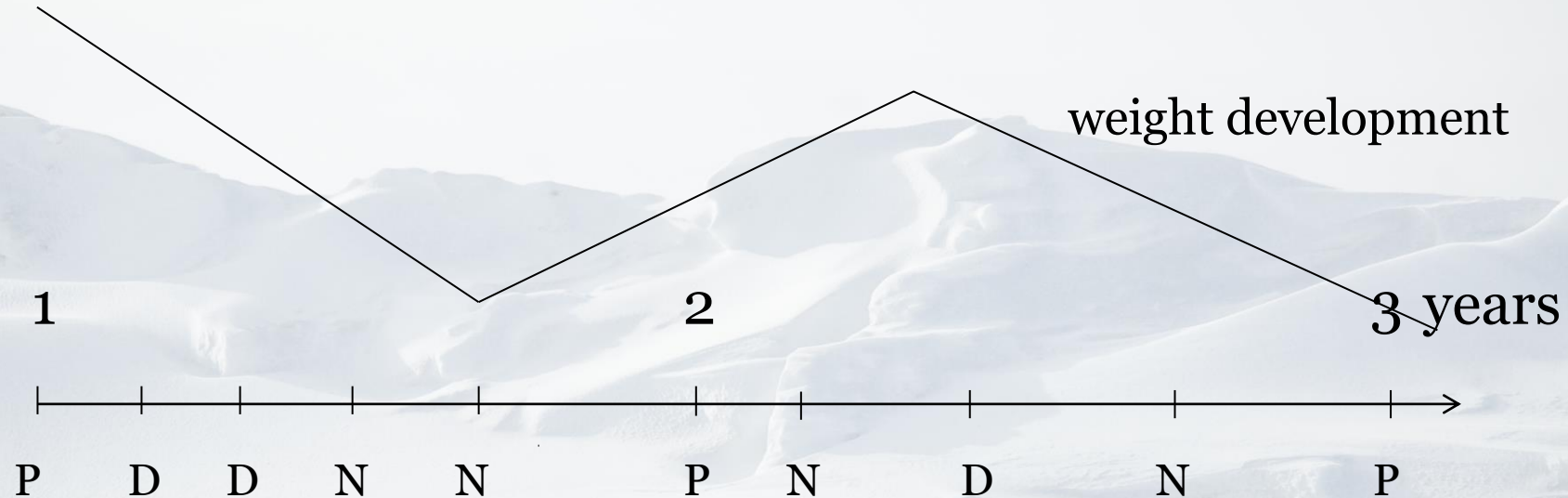
- 
19. You must feel satiated (full) - but not over satiated - after each of the main meals: breakfast, lunch, the afternoon meal and dinner.
 20. Salad and vegetables: eat vegetables every day.
 21. Choose as little oil or fat as possible when cooking, putting spreads on bread or purchasing dairy products.
 22. Fast food: maximum once a month.
 23. Sweets/candy and snacking: maximum once a week. See how much under your empty-calories-allowance.
 24. Reduce your alcohol intake to a maximum of 3 units of alcohol per week.
 25. Physical activity: be physically active for at least 1 hour every day, where you can feel the pulse rising and your breathing getting faster.
 26. Walk or take the bike to and from work every day, as much as possible.
 27. Screen time: a maximum of 2 hours per day (not counting screen time related to work, school assignments or homework). No screen time before 5 pm; spend the time before 5 pm being physically active.
 28. While you eat, all screens must be turned off.
 29. Sleep: go to bed early. For adults (>16 years), the average need for sleep is 7.5 hours and most people need 6-9 hours of sleep each night.

Incorporated strategies

- Normalise appetite and meal patterns over days, weeks, months etc
- Meal exercise included
- Reductions in SSB, snacking, fastfood etc
- Reduction in sedentary activity
- Increase in all kinds of physical activities
- Improve sleep patterns
- Many treatment points achieved with changed shopping choices

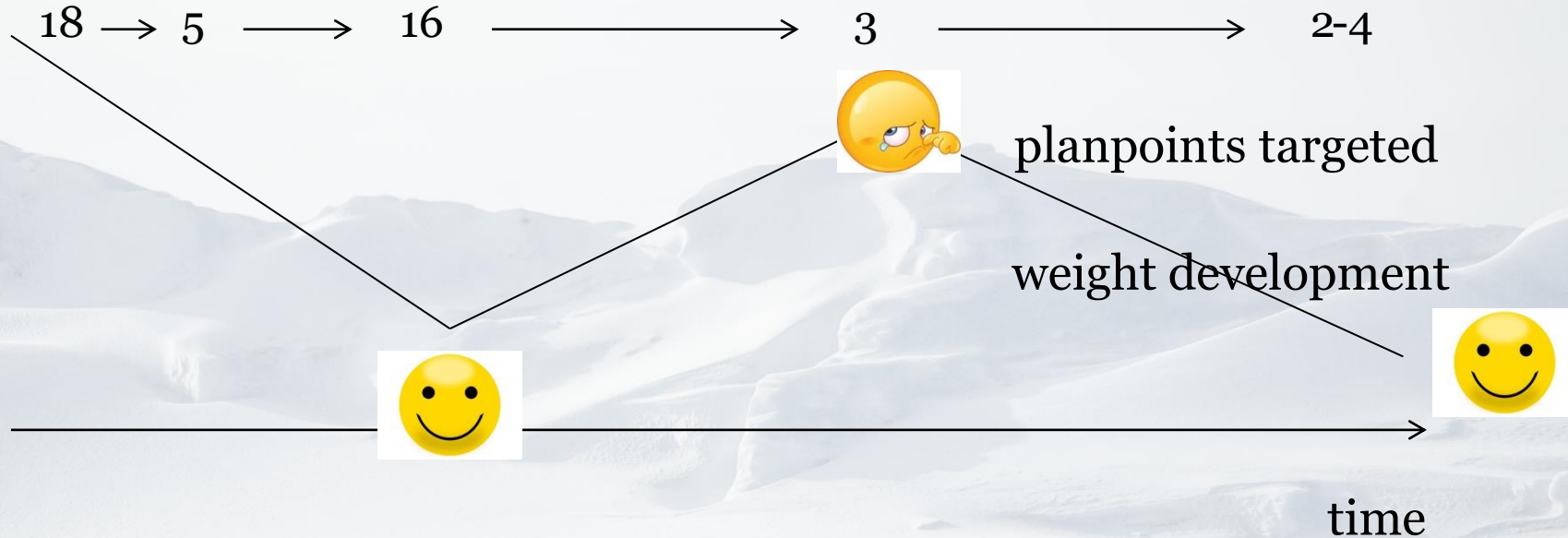


Treatment course



- 5.5 hours of hcp time per patient/year in secondary sector and 4.5 in the primary sector

Treatment dynamics

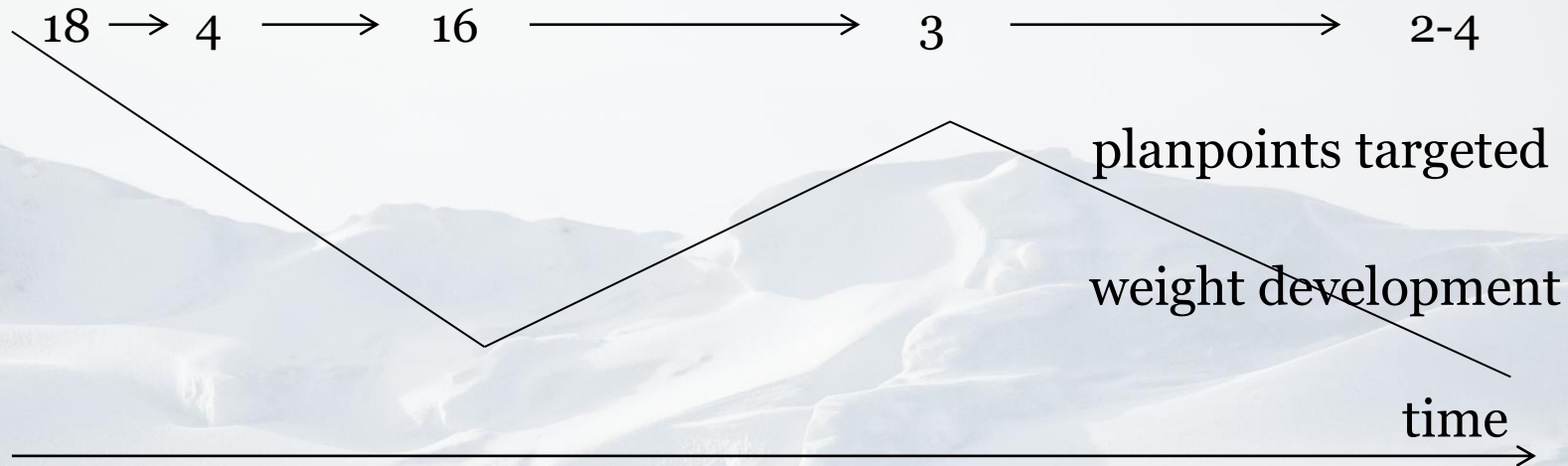


Identify those issues that troubles the patient and family quickly and focus target on those difficult issues in the forthcoming consultations

Patient makes treatment plan to ones own choices based on nessecity/suffering



Motivating techniques



induce shame, guilt and self blame

Holm JC. Behandlerbladet Diabetes. Behandleren kan gøre sig skyldig i mislykket vægttab. 2017



Authenticity and self-identification

- Neutral communication introduce adaptation against weight loss as an external cause of obesity, thus reduce guilt and shame, allow taboos
- Treatment obstacles are easily understood and causes no blame, focus on external factors
- All treatment points are essential in weight loss
- Introduce empowerment and self-awareness
- Compromises will burden the patient/child`s weight development
- Process development over time to integrate and establish a lifestyle as a new normal
- Control the environment



Direct and indirect effects

- Direct effects securing daily family based habits providing efficient sleep, nutrition, activity, development, education, and safety according to the **UNICEF criteria** of a healthy life during childhood
- Indirect effects secure well-being and thriving which induce family involving process development to guard the child, raising and parenting
- Parents aren't to blame
- Parents are the solution
- All parents want to guard their child
- Health care professionals act and take responsibility like in other chronic diseases in childhood
- All patients are highly motivated

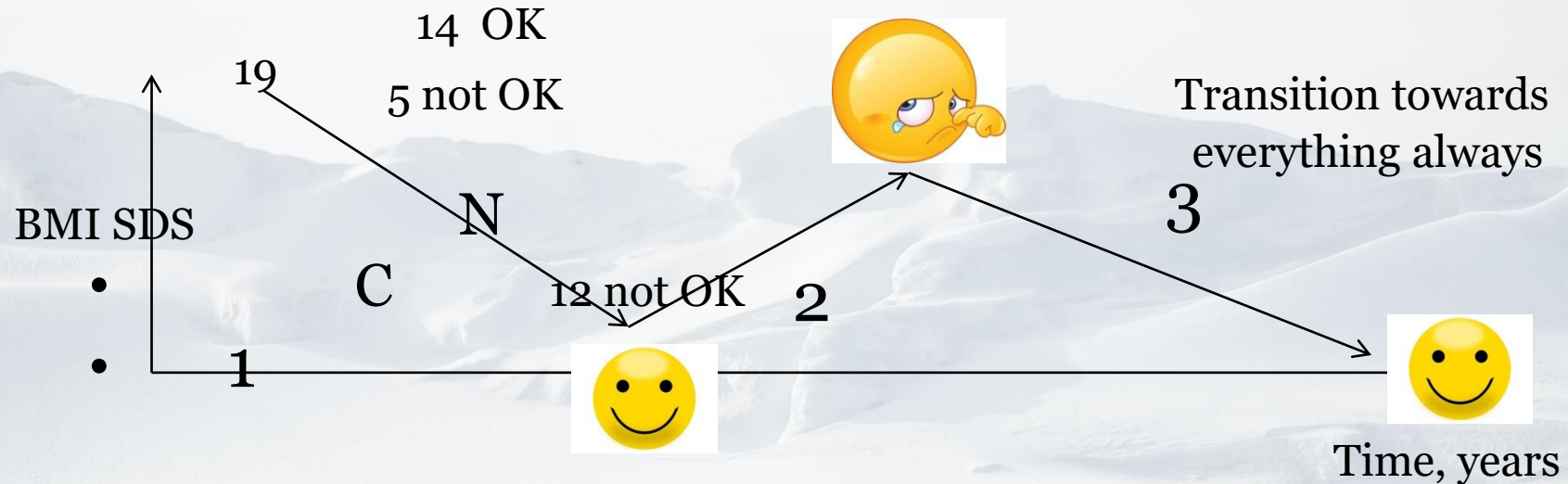


Double trouble

- *Challenges*; low social class, other ethnicity, deprived development, puberty, low IQ
- *Beliefs/Perceptions (HCPs / patients)*;
both parents should accompany the child, patient shall learn from own success, not measuring weight, a lot of psychosocial strain, expect less result with low SES, IQ
- *Double trouble*

The dynamics of weight loss

- Expected treatment outcome, process development



- Phase 1; weight loss by treatment plan
- Phase 2; compliance/ adaptation against weight loss
- Phase 3; realizing your reality and treatment need
- Induce process development within the family



Power and resistance respect autonomy

Resistance

- *Sarcasm*
 - *Irony*
 - *Excuses*
 - *Explanations*
 - *Intellectualisation*
-
- *Distraction*
 - *Confusion*
 - *Chaos*

Authority

- Set up borders/boundaries
 - Change
 - In character, authentic messaging
-
- HCP responsibility
 - HCP resignation
 - HCP excellence

SUFFERING

MOST UNKNOWN TO HCP

RESISTANCE

NATURAL, POWER RELATIONSHIPS

MODULATION

TRANSFORMATION OF MIND-SET

PERSPECTIVE

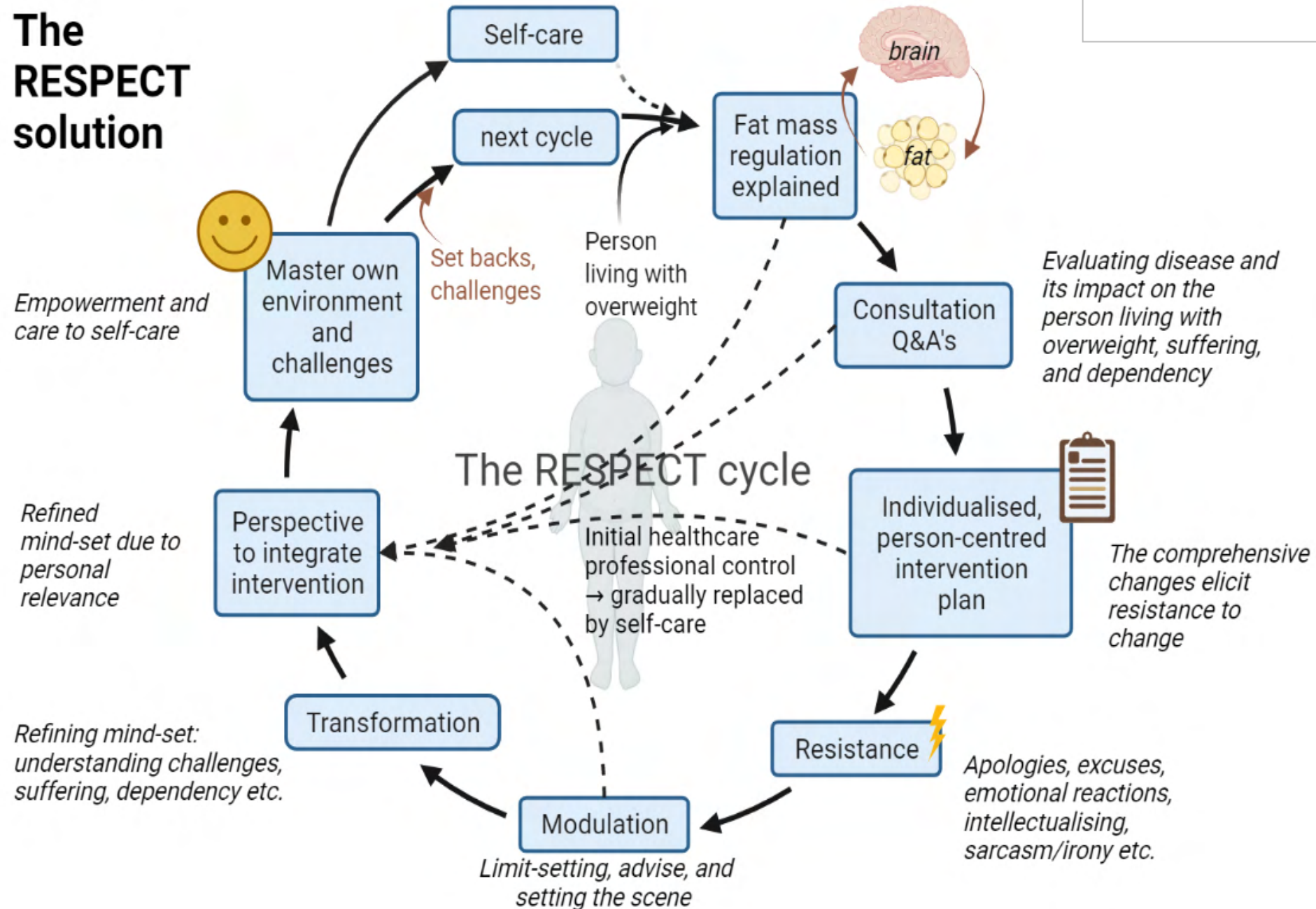
UNDERSTAND YOUR BODY, DISEASE AND REQUIREMENTS

INTERNALISE TREATMENT PLAN

DUE TO MEANING AND RELEVANCE

Figure 2.

The RESPECT solution



Communication and Pedagogy

- Presence and the left impression
- Neutral tone and language
- Flow and rhythm
- Perceptions and challenges

Breaking Down the Barriers

SMALL STEPS? OR as many as possible treatment plan points from the start!

an integrated energy balance regulation; I.e. not just focus on nutrition and activity, but also specifically inactivity, picky eating, sugar dependency, disturbed eating, child upbringing and more

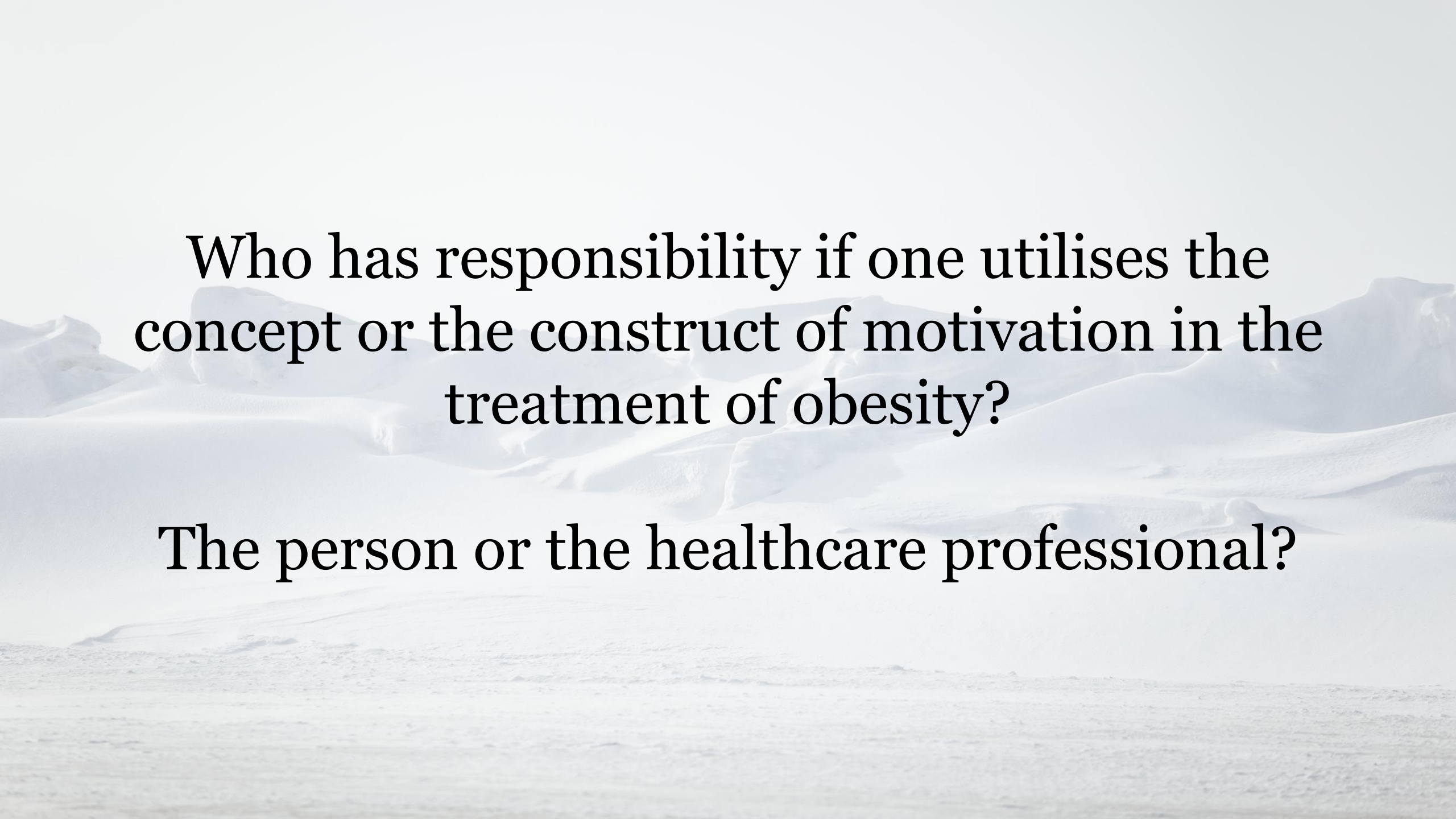
CALORIC RESTRICTION? OR Not just a diet, actually in principle food intake ad libitum!

During growth and development!

MOTIVATION! With inherent internalised blame and shame! Or a professional neutral approach?

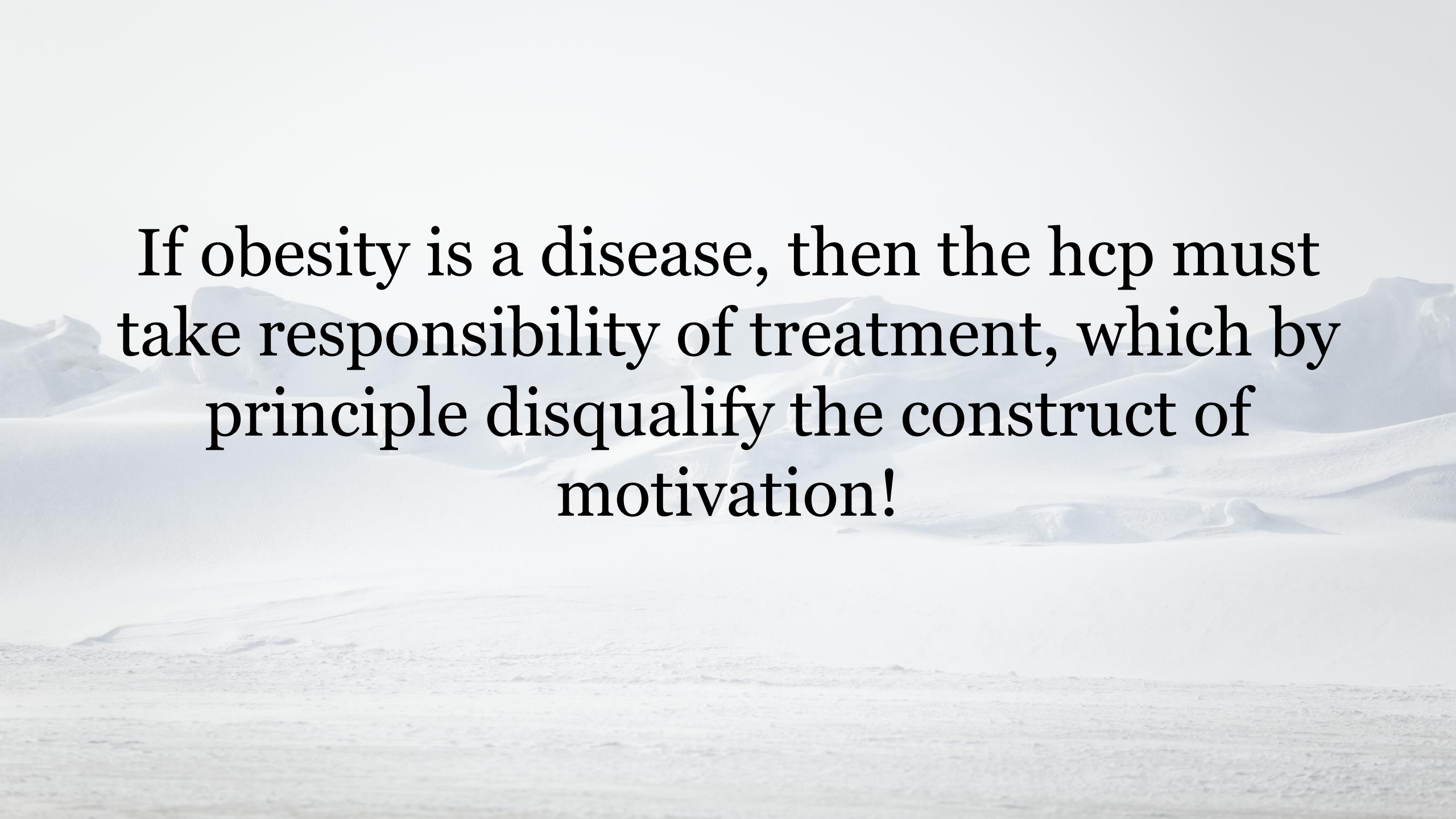
UNDERREPORTING OFTEN CONVEYING DISTRUST! Or understanding FMR adapt by increase energy intake i.e. instead utilise ad libitum intake

Avoid undereating! Regarded as counterproductive due to FMR adaptations



Who has responsibility if one utilises the concept or the construct of motivation in the treatment of obesity?

The person or the healthcare professional?



If obesity is a disease, then the hcp must
take responsibility of treatment, which by
principle disqualify the construct of
motivation!

Tendencies

- Stigmatisation! Discrimination!
- Not measuring height and weight!
- Eating disturbances
- Bio hacking
- Weight neutral approach
- Intuitive eating
- Food industry
- Secure optimal growth and development?

Kolding municipality

- Qualitative research concluded that children felt they were wrong
- On how many? Representative sample?
- Why stop measuring height and weight? Why not focus on the conversation and messaging?
- Who carry the responsibility of monitoring all the potential paediatric diseases impacting growth and development?
- Health authorities! WHO.

Consequences of not measuring

- Knowledge of growth and development in relation to hundreds of paediatric diseases with potential impact on growth, development and thriving (physical, mental and social)!
- To evaluate growth, development, growth velocity, sitting height, body proportions, familiar predisposition etc is in principle a specialist task!
- Neglect, child abuse, sexual abuse, anoreksia and bulimia!
- 100 years tradition of disease prophylaxis and health promotion!
- General care and compassion!
- Overweight and obesity, development, relapse?!



Many thanks for the attention

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