

SPECIAL TOPIC: OBESITY

KEY FACTS

- Approximately 13 percent of children (ages 6–11) and 14 percent of adolescents (ages 12–19) are overweight (National Center for Health Statistics, Centers for Disease Control and Prevention, 2001); an additional 14 percent of children and adolescents are at risk for being overweight (Troiano et al., 1995, as cited in Ehrman, 2001).
- In the past two decades, the percentage of U.S. children and adolescents who are overweight has nearly doubled (National Center for Health Statistics, Centers for Disease Control and Prevention, 2001).



Obesity is a complex process involving genetics, metabolism, and physiology as well as environmental and psychosocial factors.¹ Inappropriate eating behaviors and low levels of physical activity have contributed to the continuing rise in the prevalence of obesity among children and adolescents. Some children and adolescents overeat in response to emotional distress. Obesity can sometimes be the only visible sign of psychosocial distress (McCarty and Mellin, 1996). In addition to medical concerns, there are significant psychosocial consequences of childhood obesity that include discrimination, rejection, difficulty interacting with peers, low self-esteem, and depression (Gidding et al., 1996, and Dietz, 1998, as cited in Story et al., 2000; Hammer and Robinson, 1999).

INTERVENTIONS

Prevention

Primary care health professionals should be aware of the demographic and personal risk factors for child and adolescent obesity and should be knowledgeable about prevention and screening. Risk factors for child and adolescent obesity include (1) having a family history of being overweight, (2) coming from a family with a low income, (3) having a chronic illness or disability

¹Obesity is defined as the presence of excess adipose (fatty) tissue in the body. The term “overweight” may connote a milder degree of excess fat than the term “obesity,” but there are no clearly defined criteria to distinguish between the two. Thus, the two are used interchangeably here.

that limits mobility, and (4) being a member of certain racial/ethnic minorities (preadolescent and adolescent African American females, Hispanic populations, and American Indian/Alaska native populations) (Christoffel and Ariza, 1998; Troiano and Flegal, 1998, as cited in Story et al., 2000).

Because obesity is difficult to treat, primary care health professionals should do what they can to prevent it. Although genetics may influence whether an individual becomes overweight, environmental influences (e.g., eating behaviors, physical inactivity) may determine the manifestation and extent of the obesity. The most important strategies for preventing obesity are

- Maintaining healthy eating behaviors
- Engaging in regular physical activity
- Limiting sedentary activity (e.g., watching television and videotapes, playing computer games)

The primary care health professional's aim in preventing child and adolescent obesity is to teach and model healthy attitudes toward food and physical activity without emphasizing body weight.

Assessment and Treatment

The primary goals of an obesity treatment program include promoting healthy eating behaviors, regular physical activity, and psychological well-being. Children and adolescents who receive anticipatory guidance or treatment for obesity can benefit from the care of a team of health professionals (e.g., primary care health professionals, dietitian, mental health professionals) who can help families achieve the goals of a weight-management program. Experience in cognitive-behavioral approaches to intervention are helpful. The approach should

involve family members, with the goal being to help all family members achieve healthy behaviors rather than to single out the overweight child or adolescent.

1. Assess the child's or adolescent's and family's readiness to change. A weight-management program for children or adolescents and families who are not ready to change may be both ineffective and harmful because it can affect the child's or adolescent's self-esteem and impair further weight-loss efforts. Ask family members about how concerned they are about the child's or adolescent's weight, whether they believe weight management is possible, and what practices need to be changed. Assess family readiness with questions such as "How concerned are you about this problem?" and "Have you thought about or tried to lose weight? If so, what did you try, and when did you try it?"

Families who are not ready to change may express a lack of concern about the child's or adolescent's obesity, may believe that obesity is inevitable and cannot be changed, or may lack interest in modifying eating practices or physical activity behaviors. Ask children, adolescents, and families what effect being overweight has had on their lives. Ask if the child, adolescent, or family has experienced any negative consequences of obesity (e.g., increased cost of feeding the family, shortness of breath, teasing). Offer clear advice about the positive outcomes of maintaining healthy eating behaviors and engaging in adequate physical activity. Point out ways in which adopting a healthy lifestyle would address the child's or adolescent's and the family's immediate concerns. Recognize that the child or adolescent and the family may not share the same goals. Primary care health professionals

- should continue to foster a positive relationship with the family so that treatment may be possible in the future.
2. As families express a readiness to change, start slowly. Ask families to suggest one or two changes; then help them determine how to monitor the changes.
 3. Praise families of children and adolescents who have not gained additional weight, because weight stabilization is an important first step toward maintaining a healthy weight.
 4. Help families institute permanent changes (e.g., eat lower-fat foods, participate together in regular physical activity such as biking or hiking) and avoid short-term diets or physical activity programs aimed at rapid weight loss. Family-based programs such as SHAPEDOWN (Mellin, 2000) can help all family members develop a healthy family lifestyle and communicate effectively with each other. A dietitian can work with the family to review their current lifestyle and eating behaviors and to suggest changes that may be beneficial.
 5. In deciding whether a treatment strategy should include weight maintenance or weight loss, the primary care health professional should consider the child's or adolescent's age, body mass index (BMI) percentile, and any medical complications of obesity. Obese children younger than age 2 should be referred to a pediatric obesity specialist. For overweight children ages 2–7, weight maintenance is the recommended treatment strategy if BMI is between the 85th and 95th percentiles, or if BMI is at the 95th percentile or above and there are no medical complications of obesity. Weight loss should be considered if BMI is at or above the 95th percentile and medical complications of obesity exist. For overweight children ages 8 and above, and for all adolescents, weight maintenance is the recommended treatment strategy if BMI is between the 85th and 95th percentiles and there are no medical complications of obesity. Weight loss is recommended if BMI is between the 85th and 95th percentiles and medical complications exist, or if BMI is at or above the 95th percentile (Barlow and Dietz, 1998). Weight loss, if warranted, should be limited to approximately 1 pound per month (Barlow and Dietz, 1998).
 6. Evaluate children or adolescents for eating disorders if they feel unable to control their consumption of large amounts of food or if they report vomiting or using laxatives to avoid weight gain. (See *Eating Disorders*, p. 233.)
 7. Work with families to help support their child's or adolescent's weight-management goals. Encourage families to praise their child's or adolescent's successes. Parents can plan activities and special times together to reward desired behavior, but they should not use food as a reward. Support families in encouraging regular, enjoyable physical activities and in limiting the amount of time spent watching television and videotapes and playing computer games.
 8. Assist the child, adolescent, and family in dealing with teasing or hurtful social situations resulting from overweight.
 9. Because children and adolescents who are overweight are at risk for depression and other psychosocial problems, monitor the child or adolescent for signs or symptoms of depression or other psychosocial problems. (See *Tool for Health Professionals: Pediatric Symptom Checklist*, *Mental Health Tool Kit*, p. 16.)

10. Help children and adolescents value aspects of themselves other than physical appearance. Ask them to identify things they like about themselves. Encourage parents to compliment their child or adolescent on positive features and to support their child or adolescent in pursuing areas of strength.

For further information, see *Bright Futures in Practice: Nutrition* (Story et al., 2000).

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