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An Examination of the Family's Role in Childhood Obesity

Mandy Perryman
Lynchburg College

Steve Nielsen
Lynchburg College

Jeanne Booth
Lynchburg College

Perryman, Mandy L., is an Assistant Professor at Lynchburg College in Lynchburg, Virginia. She teaches graduate courses and provides clinical supervision in Counselor Education. Her research interests include counseling ethics and childhood obesity.

Nielsen, Steven K., is an Associate Professor of Counselor Education at Lynchburg College in Virginia. He is a licensed psychologist who maintains a private practice specializing in addictive and compulsive disorders.

Booth, Jeanne D., is the Counselor Education Program Coordinator at Lynchburg College. She is a certified parent education facilitator who does extensive work with families through Lynchburg College's Center for Family Studies.

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The number of children and adolescents struggling with significant weight problems and obesity is growing at an alarming rate. In the past thirty years, the number of obese children and adolescents in the United States has more than tripled (Ogden , Flegal, Carroll, & Johnson, 2002). This trend does not appear to be limited to this country, as nearly 22 million children around the world are classified as either overweight or obese (Deckelbaum & Williams, 2001). This dramatic increase has resulted in serious medical consequences with 45% of all newly diagnosed type-2 diabetes cases being children or adolescents and ever-increasing numbers of children being diagnosed with hypertension, cardiovascular problems, and sleep apnea due to overweight and obesity (Singhal, Schwenk, & Kumar, 2007). Research has also shown that these children are at a high risk for becoming obese adults (Deckelbaum & Williams, 2001, Laessle, Uhl, & Lindel, 2001; see also Baughcum, Chamberlin, Deeks, Powers, & Whitaker, 2000) and overweight girls are more likely to quit school, live in poverty and suffer unemployment as adults (Mellin , Neumark-Sztainer, Story, Ireland, & Resnnick, 2002). Despite ongoing efforts among health professionals to address this epidemic, the number of children who are obese continues to rise with no indication of improvement (Wadden, Brownell, & Foster, 2002).

While some researchers adhere to only one theory, most assert obesity is multidimensional and involves physical aspects, such as genetics and metabolism, as well as psychological schemas and environmental conditions (Wilkins, Kendrick, Stitt & Hammarlund, 1998). Childhood obesity may be best conceptualized as a combination of family, social, and individual experiences that interact and impact one another.

Family Environment

The family environment is where children first experience the social world: the place and time where they develop a sense of self and explore their prospects for the future. Subsequently, these early years are a critical period for the developing child, and the messages that the family provides surely shape and direct that child. Some developmental theories argue that obesity begins in infancy where food is used to reduce stress, which ultimately becomes a learned coping behavior used in childhood. For children overwhelmed by chaotic family dynamics and lacking resilience, food consumption becomes a means of emotional survival, which results in disturbed eating patterns throughout a child’s life.

Practitioners embracing a family systems model explore possibilities of why the family came to need and then maintain the overweight member. Minuchin and Nichols (1993) stated that the obese child was psychosomatic for the purpose of eliciting attention and protection from the family. The family members would then be trapped into an inflexible way of interacting with one another and have difficulty resolving conflict (Minuchin & Nichols, 1993). In this model, the family is as responsible as the individual for obesity because the family is where basic development occurs and understanding of society

begins.

Family dynamics may be made considerably more complex by the presence of an obese child and are likely more intricate than is apparent from outside of the family. Families with an obese child may be perceived as dysfunctional or emotionally detached. Parents may be exceptionally stressed with time and financial factors specifically related to having an obese child, such as numerous doctors' appointments and requisite medications (Harper, 2006). How the family copes with the emotional realities and possible attendant psychological disorders of the obese child can also alter how the family functions (Harper, 2006). Obese children may even be assigned the role of the family scapegoat and receive a disproportionate amount of undeserved blame.

The comments that parents make related to weight may further exacerbate the problems of the obese child. When one parent is overweight and that condition is focused on and repeatedly addressed by the other parent, it creates an environment that can negatively affect the child (Jacobi, Agras & Hammer, 2001). The child may identify strongly with the parent who is being criticized and feel attacked as well. The child may also believe that he or she is also at risk of being confronted if he or she does not conform to the verbalized norm. Parents who concede to stereotypical societal standards of appearance may promote dieting for themselves and their children, both of which constitute risk factors for body dissatisfaction in adolescence (Paxton, Eisenberg, & Neumark-Sztainer, 2006). Furthermore, overweight and obese children were nearly 300% more likely to consider suicide as an option in homes where family members teased their children about weight, regardless if they are also teased by peers (Eisenberg, Neumark-Sztainer & Story, 2003).

Children struggling with obesity and weight problems frequently come from homes where one or both parents are struggling with significant weight problems. Research has demonstrated a relationship between the mother's Body Mass Index, the father's history of weight problems, and the secretive eating of their 5-year-olds (Stice, Agras & Hammer, 1999). In research with obese mothers, though nearly all of the mothers acknowledged their own obesity, only 20% correctly recognized that their children were obese, and of the mothers that did consider their children overweight, only about 67% expressed concern about it (Baughcum, et. al., 2000). Less educated obese mothers had the most difficulty identifying their children as being overweight and were less aware of the health risks associated with excess weight (Baughcum, et. al., 2000). In a recent study, mothers of obese preschoolers did not gauge their child's size by growth charts. Instead, they believed that if their child was taunted for his or her size at school then he or she was overweight; however, as long as the child's size did not impact his or her activity, then the mother was not concerned about the child's weight (Jain, Sherman, Chamberlin, Carter, Powers, & Whitaker, 2001). These mothers also reported having difficulty adhering to and continuing a healthy food plan for themselves and their children (Jain, et. al., 2001).

Children and adolescents struggling with excess body weight are often captives of environmental factors beyond their control that support an unhealthy lifestyle and foster inappropriate messages about food consumption and body image. Sociocultural factors such as ethnic identity may promote overeating. In an ethnographic study of low-income Latino families, Kaufman and Karpati (2007) found that being overweight was not viewed as a negative body characteristic, shopping within their community (where unhealthy foods were plentiful) was seen as an obligation, and gratifying children with food was considered a characteristic of responsible fatherhood and good parenting.

Children and adolescents suffer problems related to stigma, ridicule, and depression as they attempt to negotiate their peer environment which intensify their eating behaviors. Janicke, Marciel, and Ingerski (2007) examined the impact of peer environments on obese children and how that further influenced the parental response. Their research demonstrated that overweight children are more likely to experience a lower quality of life characterized by peer victimization, depressive symptoms, and parental distress. Similarly, girls in early adolescence who are teased about their bodies and have friends who are dieting experience body dissatisfaction (Paxton, Eisenberg, & Neumark-Sztainer, 2006).

Family Intervention

Most of the literature on childhood and adolescent obesity intervention emphasizes the critical need for family-based treatment (Epsein, Valoski, Wing, & McCurley, 1994; Myers, Raynor, & Epstein, 1998) and stress the importance of establishing a strong bond among family members. Family connectedness (Mellin et. al., 2002) has been found to be a salient theme in well-adjusted children who are overweight. Family connectedness is comprised of open communication between parents and their children, children perceiving their parents love and relate to them, and family participation in recreational activities (Mellin et al., 2002). Overweight adolescent girls who scored high on family connectedness ate breakfast, did better in school and were less anxious. Overweight boys rated similarly, with high scores on healthy behaviors and fewer psychological difficulties (Mellin, et. al., 2002). There was also a moderate connection between high family connectedness and less excessive dieting among overweight children (Mellin, et. al., 2002).

Parental attitudes and expectations also play an important role in the success of establishing and maintaining an effective perspective on weight loss and health development. The parents of overweight children who expected higher school performance and a successful educational future for their children had children who participated in more health-related behaviors, engaged in less extreme dieting and exhibited fewer emotional problems. However, very high or very low ratings on parental expectations had the reverse effect (Mellin, et. al., 2002).

Family-based treatments designed to address weight problems and obesity follow several

different protocols. Behavior modification programs with a family focus have been shown to be effective in terms of the amount of weight loss and maintenance (Wadden, et. al., 2002). Behavioral interventions are predicated on the principle that the overeating is a learned behavior and can, subsequently, be modified. Research has indicated that "pressuring" the child is particularly ineffective and can initiate overeating, especially in obese girls (Fisher & Birch, 1999a; Fisher & Birch, 1999b; and Johnson & Birch, 1994) and that children respond more favorably to positive reinforcement strategies which emphasize healthy eating that results in "feeling and looking good" (Bourcier, 2003, p. 269).

Family-based interventions that promote the parent as the regulator of food and exercise have some advantages. They contain a regimented routine with clear directions and could be instituted into schools and health care settings without much expense or hassle (Golan, Weizman, Apter, & Fainaru, 1998). This approach requires involvement of the family as a whole and particular initiative on the part of the parent. While intensive family behavior treatment may not be feasible for some obese children and adolescents, further education for parents in the reduction of sedentary behaviors and the importance of balanced nutrition may be utilized. One recent study found that creating a positive communal eating experience, valued by the family, was associated with decreased depressive symptoms in overweight adolescents (Fulkerson, Strauss, Neumark-Sztainer, Story & Boutelle, 2007).

It is particularly important to note that family-based models of all variations have historically provided effective assistance for children struggling with obesity. Epstein, Paluch, Roemmich and Beecher (2007) examined family-based treatments for obese children over the past 25 years and determined that while the design and implementation of family-based treatments vary, familial involvement and positive support remain a viable form of intervention.

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