Wake Forest™ Baptist Health
Brenner Children's Hospital

Families as agents of change:

Engaging the whole family in weight management

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Disclosures

- I just returned from Italy and ate A LOT of food
- No funding or conflicts of interest to disclose

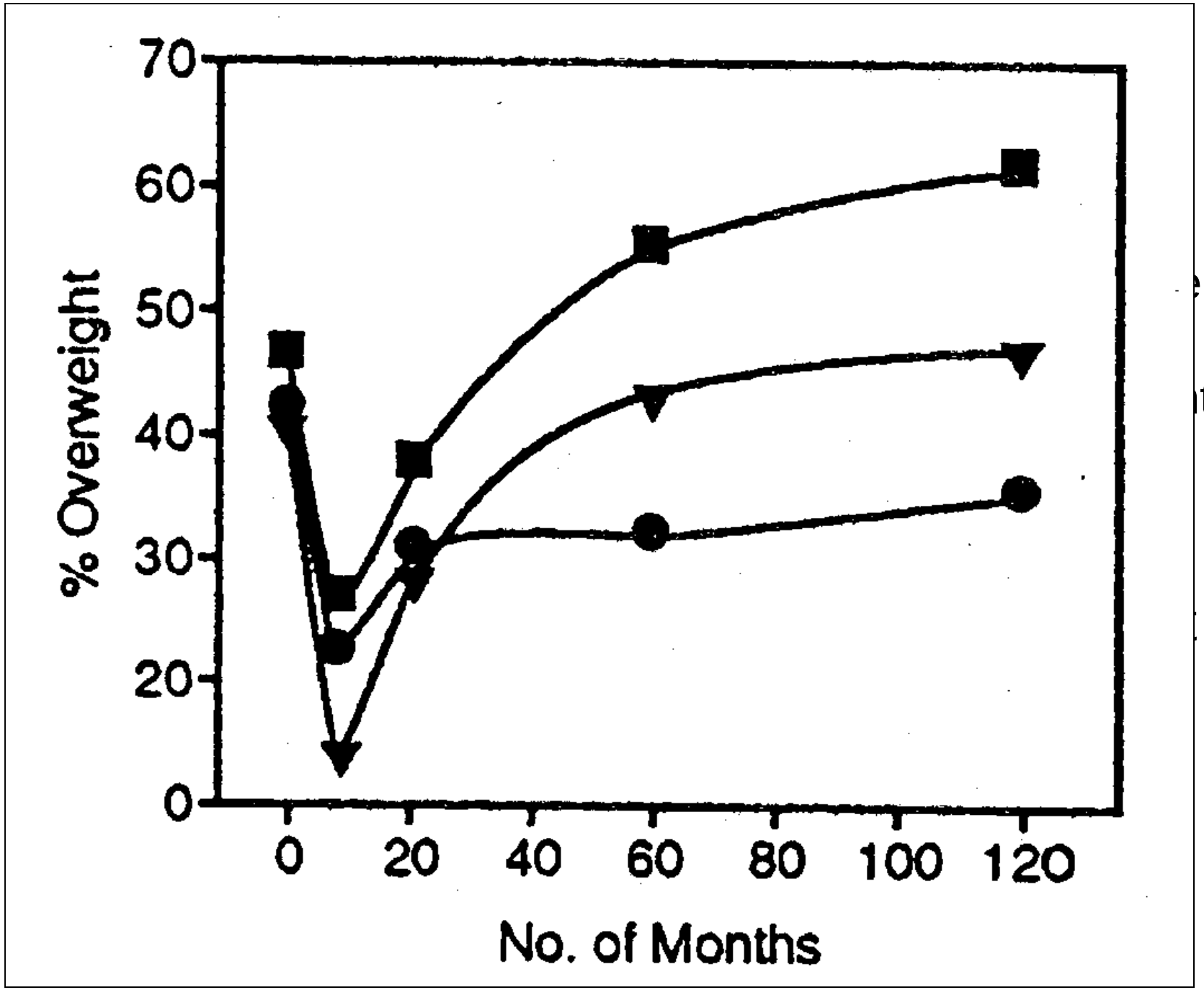
Objectives

- Learn practical approaches to engaging whole families in behavioral weight management
- Understand parents as agents of change in the family
- Discuss age and developmental considerations in pediatric weight management

Pediatric Obesity Treatment*

- Staged treatment: primary care → tertiary care
- Patient-centered communication
- Behavior change
- Frequent and on-going treatment
- ***Family-based treatment***

*Barlow, Pediatrics 2007;120:s164-192


70
60
50
40
30
20
0
% Overweight
0
20
40
60
80
100
120
No. of Months

Who participates in family-based treatment

- **Epstein**: Parent & Child are the focus of weight loss
  - Parent weight change was not linked to child's
- **Brownell**: Adolescent and Parent in "parallel" treatment
  - Nature of parent and child involvement important
- **Golan**: Parents as exclusive agents of change
  - Children ages 7-14 years
- **Clinical Programs**: Parents attend treatment
  - Who should attend? How are others involved or engaged?

What We (Don't) Know about Families…

Fathers, siblings, others?

- Most research: Mothers

Generalizable?

- Most research: Middle class, educated, white

Do families change?

- Most research: Stable & intact families, motivated

Do we really know HOW to include parents & families?

Dyads vs. Families:
Practical Considerations

- Weight management clinics
  - Medical settings: geared towards parent/caregiver and child
  - Daytime hours: difficult for school and work absences
  - Clinics: typically one parent/caregiver and child. Which caregiver comes can vary

- Community-based programs and groups
  - Evening and weekends: when do families have “downtime”?
  - Who attends? Roles in the family
  - Designed for multi-generations? Different age children

Family-Based Obesity Treatment

- Family-focus
  - Family habits, not just the child's
  - Child involvement: varies by age and motivation
- Family-centered
  - "Providing care that is respectful of and responsive to a family's preferences, needs, and values"
  - "Ensure these values guide all clinical decisions."
  - Every family is different
- Family-friendly
  - Recognize hectic schedules and lives of families
  - Schedule, comfort, siblings, language, communication

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What Families
Want US to see


WHAT WE NEED TO SEE.

“We mock what we don’t understand.”

-Austin Millbarge

(played by Ottowa native Dan Aykroyd)

Family Systems Theory

Murray Bowen (1950's): Comprehensive view of "family"

Core Concepts:

- Individuals cannot be understood in isolation
- Individuals are interconnected and interdependent
- Emotional units sharing common goals
- Geared towards homeostasis: want things reliable and predictable
  - Family roles, family rules
- System, with subsystems, of related, overlapping parts
  - Action of one → action of the system

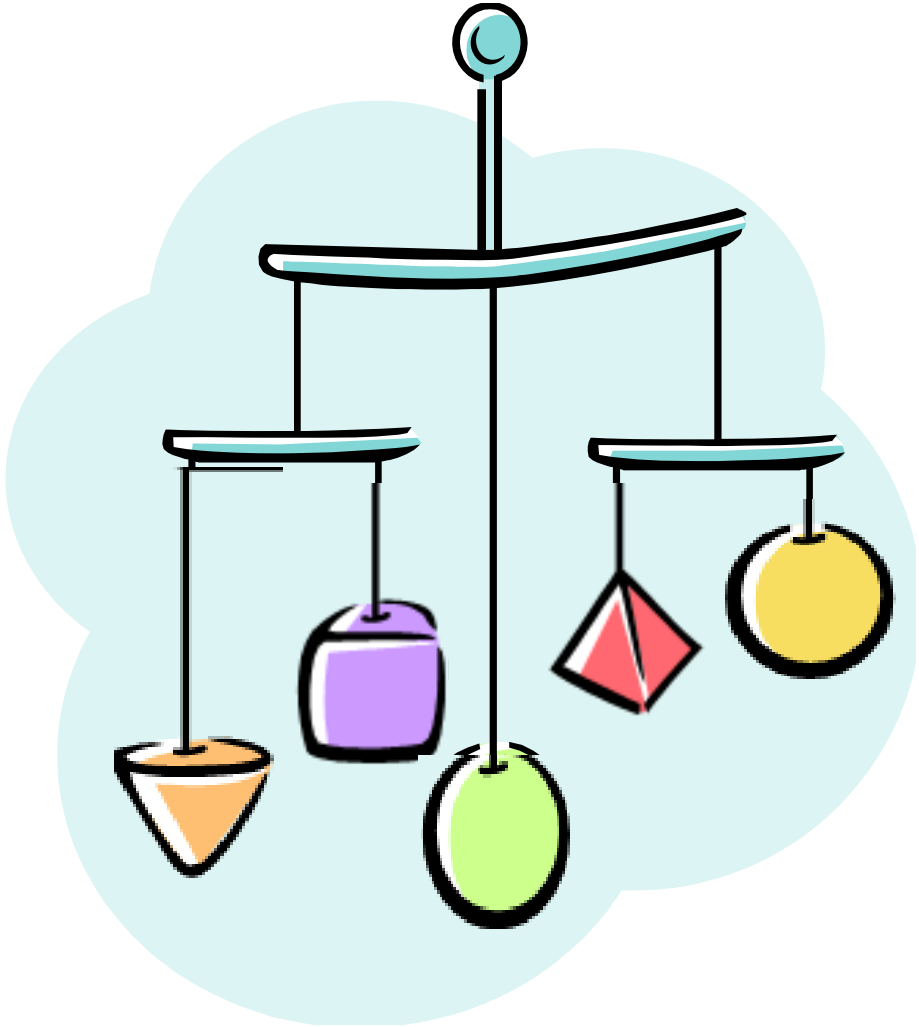
Requires a Dual Focus

- Focus on each Individual
- Focus on the complex, collective unit

BUT… change is natural and inevitable

- Normative (predictable life cycle changes)
- Non-normative (crisis; stresses)

Family Systems Theory



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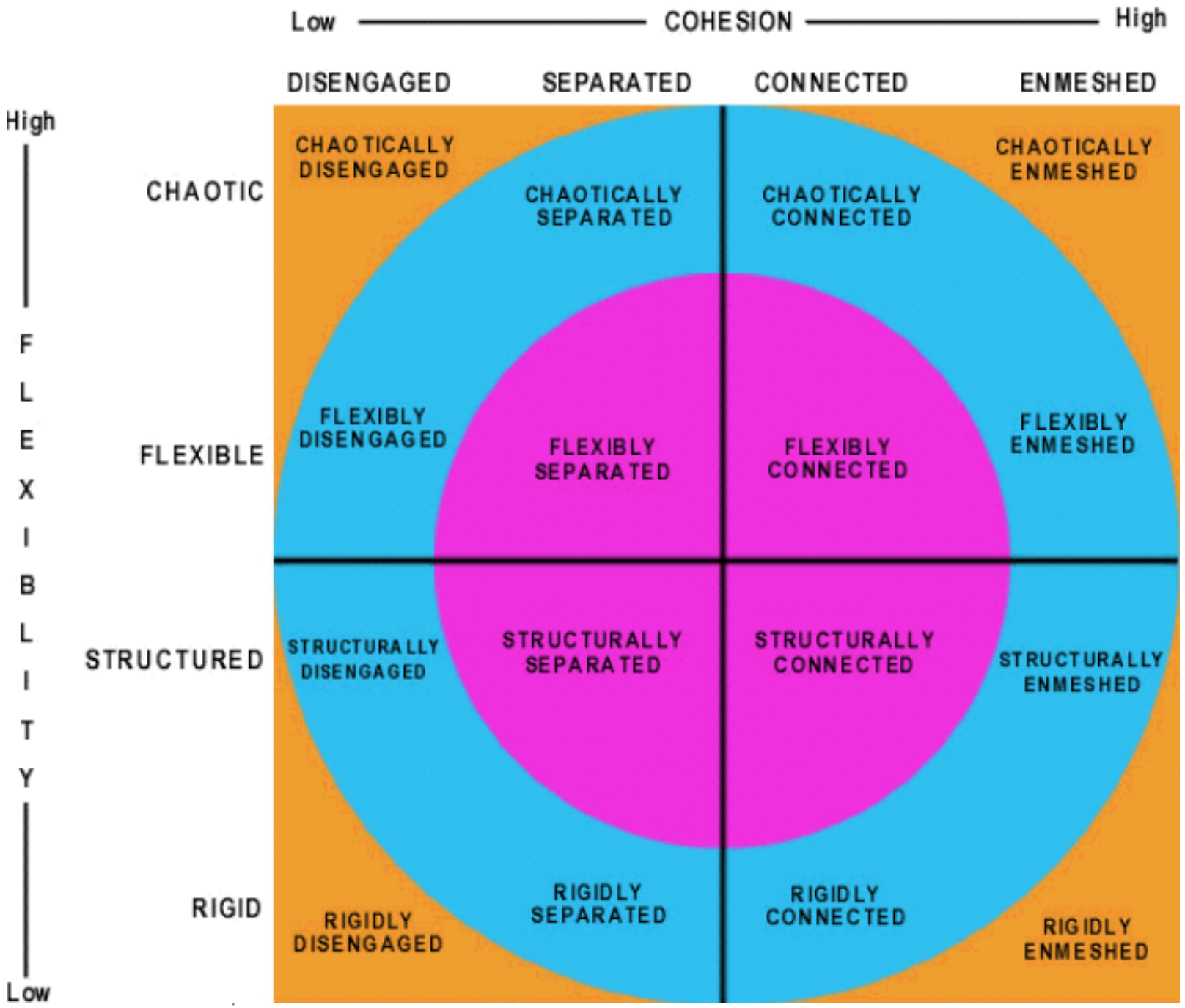
Circumplex Model
of Marital and Family Systems

- **David H. Olson (1979)**
  - Balanced family systems will be more functional compared to unbalanced family systems

- **3 Main Family Dimensions**
  1. **Family cohesion**
  2. **Adaptability (flexibility)**
  3. **Communication:** Facilitates cohesion and flexibility


Low
COHESION
High
DISENGAGED
SEPARATED
CONNECTED
ENMESHED
High
FLEXIBILITY
Low
CHAOTIC
FLEXIBLE
STRUCTURED
RIGID
CHAOTICALLY DISENGAGED
CHAOTICALLY SEPARATED
CHAOTICALLY CONNECTED
CHAOTICALLY ENMESHED
FLEXIBLY DISENGAGED
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RIGIDLY CONNECTED
RIGIDLY ENMESHED

The Family and Weight

- Who else has problems with weight
  - Genogram
  - Parent attempts at weight loss
  - How is weight discussed in the home
  - Arguments and disagreements
- Family schedules
  - Work and school schedules
  - Who is at dinner?
  - Who cooks? Who shops for food?
  - Leisure activities

Family Interventions

- Family Systems Theory… applied [1]
  - Triangulation
  - Differentiation of self
  - Nuclear family emotional system
  - Family projection process
  - Multigenerational transmission process
  - Emotional cutoff
  - Sibling position
  - Societal emotional process
- Family-focused Pediatrics [2]
  - Family meetings
  - Family communication and agreement

[1] Kaplan SG, ICAN, 2014
2 Coleman WL, Family-Focused Pediatrics, 2nd Ed, 2011

FST and Pediatric Obesity Treatment

- **Pay attention to family relationships**
  - Marital relationship, parent-child, siblings, etc…
- **Focus on each individual AND the collective unit**
  - Target the health of everyone, regardless of their weight
- **Understand their complex rules, goals, and interactions**
  - Get to know them and earn their trust!
  - Tailor approach to match the uniqueness of each family
- **Implement change SLOWLY for longer periods of time**
  - *Lasting* change takes time, it's hard, & it won't be perfect
  - Identify and assist families in over coming barriers

Practical approaches

GOAL: Engage entire family in change process

- **See it, hear it, read it**
  - See it: visual representation- videos, pictures, displays
  - Hear it: verbally explained by person familiar with program
  - Read it: written materials, brochures
- **Program orientation**
  - Best if in-person, but on-line or videos work well
  - Don’t overload with information- keep it simple
- **Space: less clinic, more family**
  - Bariatric furniture
  - Couches, counseling space
  - Make use of downtime: ChopChop magazines, customized educational materials

Practical approaches: PRACTICE

- Put “test” or “practice” family through process
- One of each
  - Family already in program
  - Non-medical friend or colleague and child (no weight problem)
  - Professional: customer service or patient experience representative, quality improvement professional
- Things we had learned
  - Comfort and language: families not used to discussing
  - Parents felt judged by certain questions
  - Parents uneasy answering certain questions in front of children
  - Siblings: made situation worse for child that had weight issue
  - Clinic flow: time with family together, and time apart

Dyad to Whole Family

How to virtually engage family

- Weight and health of family
  - Assess potential support or resistance in family
  - Invite others to participate
  - Navigate systems issues
- Plan to disseminate
  - Teach the teacher: know parents will have to spread message to family
  - Handouts, videos, Fridgemos (refrigerator memos)
  - Preparing for debate: recognize parent A will have to sometimes defend changes to parent B- support them
- Facilitate communication
  - Offer to talk to other parent
- Teleconferencing

Invitational Theory

- Developed by Purkey, Novak, and Siegel
- Counter-approach to weight-bias
- Five Principles
    1. People are able, valuable, and responsible, and should be treated accordingly.
    2. Educating should be a collaborative, cooperative activity.
    3. The process is the product in the making.
    4. People possess untapped potential in all areas of worthwhile human endeavor.
    5. Potential best realized by places, policies, programs, and processes designed to invite development, by people who are intentionally inviting.
- Apply to every step of clinic process

Do Entire Families Make a Difference?

- Little to no research
    - Some data on positive association between parent and child weight loss
- Unpublished data: the more “second parent” attends, the more success the child has (M. Irby)
- Support for weight loss known to be key predictor of success
- Builds stronger families?*

*Skelton, Clinical Obesity 2016

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Parent-only interventions in the treatment of childhood obesity: a systematic review of randomized controlled trials

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ABSTRACT

Background An effective and cost-effective treatment is required for the treatment of childhood obesity. Comparing parent-only interventions with interventions including the child may help determine this.

Methods A systematic review of published and ongoing studies until 2013, using electronic database and manual searches. Inclusion criteria: randomized controlled trials, overweight/obese children aged 5–12 years, parent-only intervention compared with an intervention that included the child, 6 months or more follow-up. Outcomes included measures of overweight.

Results Ten papers from 6 completed studies, and 2 protocols for ongoing studies, were identified. Parent-only groups are either more effective than or similarly effective as child-only or parent–child interventions, in the change in degree of overweight. Most studies were at unclear risk of bias for randomization, allocation concealment and blinding of outcome assessors. Two trials were at high risk of bias for incomplete outcome data. Four studies showed higher dropout from parent-only interventions. One study examined programme costs and found parent-only interventions to be cheaper.

Conclusions Parent-only interventions appear to be as effective as parent–child interventions in the treatment of childhood overweight/obesity, and may be less expensive. Reasons for higher attrition rates in parent-only interventions need further investigation.

Keywords children, obesity

Introduction

The high prevalence of childhood obesity is a significant

spends 5–6% of its budget on overweight and obesity-related problems,[8] equating to ~£5.1 billion per year. Interventions aimed at both preventing and treating obesity have been put

The Role of Parents

- Parents are important: How and why?
  - Change home environment
  - Change interaction between parent and child
  - Role modeling of healthy behaviors
  - Parents act as “behaviorists”, supporting behavior change outside of clinical setting
  - Educators
  - Source of support for child’s behavior change
  - Leaders of the family

Parenting Styles*

	High expectations for self-control	Low expectations for self-control
High Sensitivity	**Authoritative** Respectful of child's opinions, but maintains clear boundaries Obesity: 3.9%	**Permissive** Indulgent Without discipline Obesity: 9.8%
Low Sensitivity	**Authoritarian** Strict disciplinarian **Obesity: 17%****	**Neglectful** Emotionally uninvolved and does not set rules Obesity: 9.9%

*Baumrind, Dev Psychol Monogr 1971
Maccoby, Martin Handbook of Child Psychol 1983

**Rhee K, Pediatrics 2006

Parenting: a leverage point

- "Modification of parental variables known to be associated with obesity-promoting behaviors… may show promise…" [1]
- Parent intervention alone prevents obesity[2]
  - Many parent-only interventions shown beneficial
  - Many parenting interventions shown successful[3]
- Not easy
  - Intensive
  - Parents may not be receptive
  - Resources

[1] Skouteris H Ob Revies 2011
[2] Brotman LM Pediatrics 2012
[3] Gerards S, Int J Ped Ob 2011

Parenting Interventions

- Triple P: Positive Parenting Program
  - Matthew Sanders, University of Queensland
  - Adapted for obesity treatment (Gerards S, BMC Public Health 2012)
- Positive Discipline
  - Based on work of Alder and Dreikurs
  - Dr. Jane Nielsen
- Ellyn Satter's Division of Responsibility
  - Emphasis on:
    - *Competency in eating*
    - *Providing rather than depriving*
    - *Trust rather than control*
  - Useful approach in addressing younger children and feeding

Preparing families to change

- Parents were unsure of their role in treatment*
- Appropriate expectations important**
- **FIT 101:** Outline approach and roles early
  - Group class
    - Open discussion
    - Role playing
    - “Expert” videos
  - Parents and child’s role in treatment
  - Importance of parenting and family
  - Division of Responsibility
  - Nutritional approaches: no restriction
  - Activity approaches: fun, family-based

*Giannini, Am J Health Beh 2016
Skelton, Clinical Obesity 2016
**Skelton Academic Peds 2012

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Children's ability to participate

- Self Regulation
  - Modulating function to maintain homeostasis
- Executive Functions
  - Goal directed behavior, planning, memory, attention, inhibitory control
- Ability to self regulate develops overtime
  - Exerting effortful control to reach goals
- The Game of Simon Says
  - Children get better at it as they grow older

Cognitive Development of Children

- Piaget's Developmental Stages Theory
  - Sensorimotor: birth-2 years
  - Preoperational: 2-7 years
  - Concrete: 7-12 years
  - Formal operational: Adolescence

How to include the child and parent

- **2-7 years: Parents do the bulk of work**
  - PARENTS include child in decision making
  - Parents provide more structure in the home, model good behaviors
- **8-11 years: Limited inclusion of child**
  - Child can understand education, limited understanding of behaviors
  - Parental supervision and monitoring important, but should be done with warmth and autonomy granting
- **12-18 years: Full inclusion of child, but with limits**
  - Parents should provide support and resources, as children may not know responsibilities and consequences of certain behaviors
  - Respect the child's autonomy, but provide a framework in which the child can succeed

How to include parents

- **2- 7 years old: Parents-only**
  - Easier scheduling
  - Less missed school
  - Focus on parenting: the What and the How
- **8-11 years old: Parents with and without children**
  - Educational focus with children
  - Children in room, but responsibility to parents
  - Clinic- parents / Classes- children with parents
- **12-18 years old: *Parallel treatment***
  - Together and Separate
  - Parents only: encourage proper support of teen
  - Child only: goal setting, monitoring
  - Teen-only program*

*Skelton, Clinical Obesity 2016

Safety

- AAP Clinical Report: Preventing Obesity and Eating Disorders in Adolescents
  - Awareness that restrictive or harsh approaches to weight loss could result in disordered eating behavior
  - “Weight talk” by family members can be harmful
- Berge JM, JAMA Pediatrics 2013
  - Parent discussions about weight associated with increased risk of disordered eating behaviors
  - Focus on healthful eating are protective
- Brown CL, Obesity 2016
  - Healthy weight loss behaviors: motivators are “better at sports”
  - Unhealthy weight loss behaviors: motivated by teasing, friends

SAFELY putting into practice

- Weigh patient in comfortable format
  - Away from parents
  - Keep in kilograms
  - Don’t avoid discussing weight, but model a focus on health and habits/behaviors
- Outcomes aside from weight
  - Habit change: institute means of tracking behaviors
  - Reach out to colleagues to prevent opposite messages
- Language
  - Terms to avoid: fat, obese, “belly”
  - Preferred terms: extra weight, BMI, unhealthy weight

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Family Care P
7/26/16

Healthy Habit	Goal
Enjoying family time together	☐ Write on our calendar family ☐ Saturday, Sunday or Friday A ☐ Ideas: Kickball, fishing, swim hiking, UNO
Packing lunches	☐ Think of lunch ideas
Practicing Motor Skills	☐ Going down stairs—one foo other ☐ Skipping—Practicing connec ☐ Running—walking/running

Clinic Visits:

Meet your team (Survey and Our Family Goals)	6/29/16
Visit #1	7/26/16
Visit #2	8/18/16 at 1pm
Visit #3 (Check in)	
Visit #4	
Visit #5 (Plan for labs for MD visit)	
Visit #6 (Survey and Family Goals Check in)	
Check in with Pediatrician	December 2016

Classes:

FIT 101	5/23/16	

Habits Established:

-
-
-

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Our Family Goals – Check In

We would like to…

Eat together:	Already doing	Would like to work on
Eat meals together, wherever that is	☐	☐
Eat at the table together	☐	☐
Create a routine for mealtime (set table, serve ourselves, eat together)	☐	☐

Eat at home:		
Plan meals ahead of time	☐	☐
Plan for more meals at home	☐	☐
Create a grocery list ahead of time	☐	☐

Make eating important:		
Make 3 meals a day a part of family routine	☐	☐
Enjoy meals at set times	☐	☐
Make snack time a priority (1-2x/day)	☐	☐

Enjoy feeding and eating:		
Learn about helping picky eaters	☐	☐
Provide one meal that everyone can eat	☐	☐
Parents don't have to be the food police	☐	☐
Positive mealtimes: focus on family, not food	☐	☐

Get more sleep:		
Sleep matters: Get enough zzzs.	☐	☐
Establish bedtime routine	☐	☐
Establish morning routine	☐	☐

Enjoy family time together:		
Enjoy play time together	☐	☐
Offer fun activities (crafts, hobbies, cards, board games, entertainment)	☐	☐
Schedule family time	☐	☐
Find active ways to be together	☐	☐

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Family Interventions

- Family-focused Pediatrics [1]
  - Family meetings
  - Family communication and agreement
- Problematic child behavior
  - Pediatric Symptom Checklist
  - BASC
- Practice
  - Parenting: role playing
  - Nutrition: parent role modeling, cooking classes, get take out and practice a family meal
  - Activity: family-based games, family rules about electronics
- Include child in decision making
- *Family time, together*[2]

1 Coleman WL, Family-Focused Pediatrics, 2011
2 Skelton JA, Clinical Obesity 2016

Final Tips on Engaging Families

- Group and Individual programming
- Family Time Together: paramount to success
  - Children desire more positive, engaged time with parents
  - Opportunities for families to “practice”
  - Structure nutrition and activity programs around increasing family time together
- Support: Remove the blame and shame
- Embrace the Complexity
  - Family function
  - Family communication

“It is much more important to know what sort of patient has a disease than what sort of disease a patient has.”

-Sir William Osler

Thank You!
Questions?