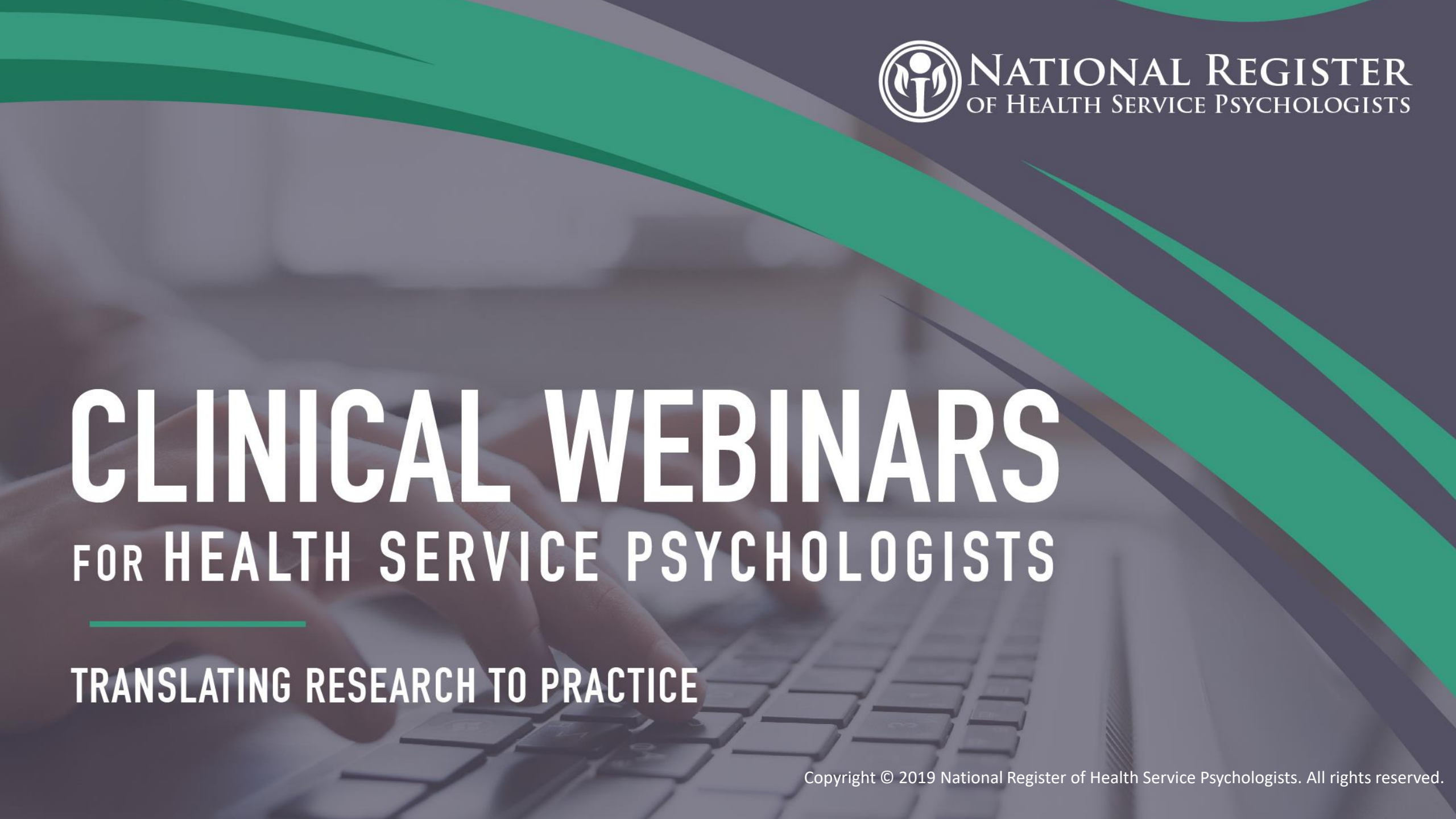

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

CLINICAL WEBINARS

FOR HEALTH SERVICE PSYCHOLOGISTS

TRANSLATING RESEARCH TO PRACTICE

Weighing in on Adolescent Obesity: Food for Thought

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Assistant Professor of Pediatrics

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University of Oklahoma Health Sciences Center

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Paulette D. Pitt, PhD

Paulette D. Pitt, PhD, is an Assistant Clinical Professor at the University of Oklahoma Health Sciences Center, Department of Pediatrics, Section of Adolescent Medicine. She has spent her academic and professional career working with children and adolescents in various capacities. Currently, her work includes helping adolescents diagnosed with disordered eating as well as serving as Chair of the Eating Disorders Committee for the Society of Adolescent Health and Medicine.

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Disclosures/Conflicts of Interest

I, Paulette D. Pitt, Ph.D., having no conflicts of interests or disclosures.

Learning Objectives

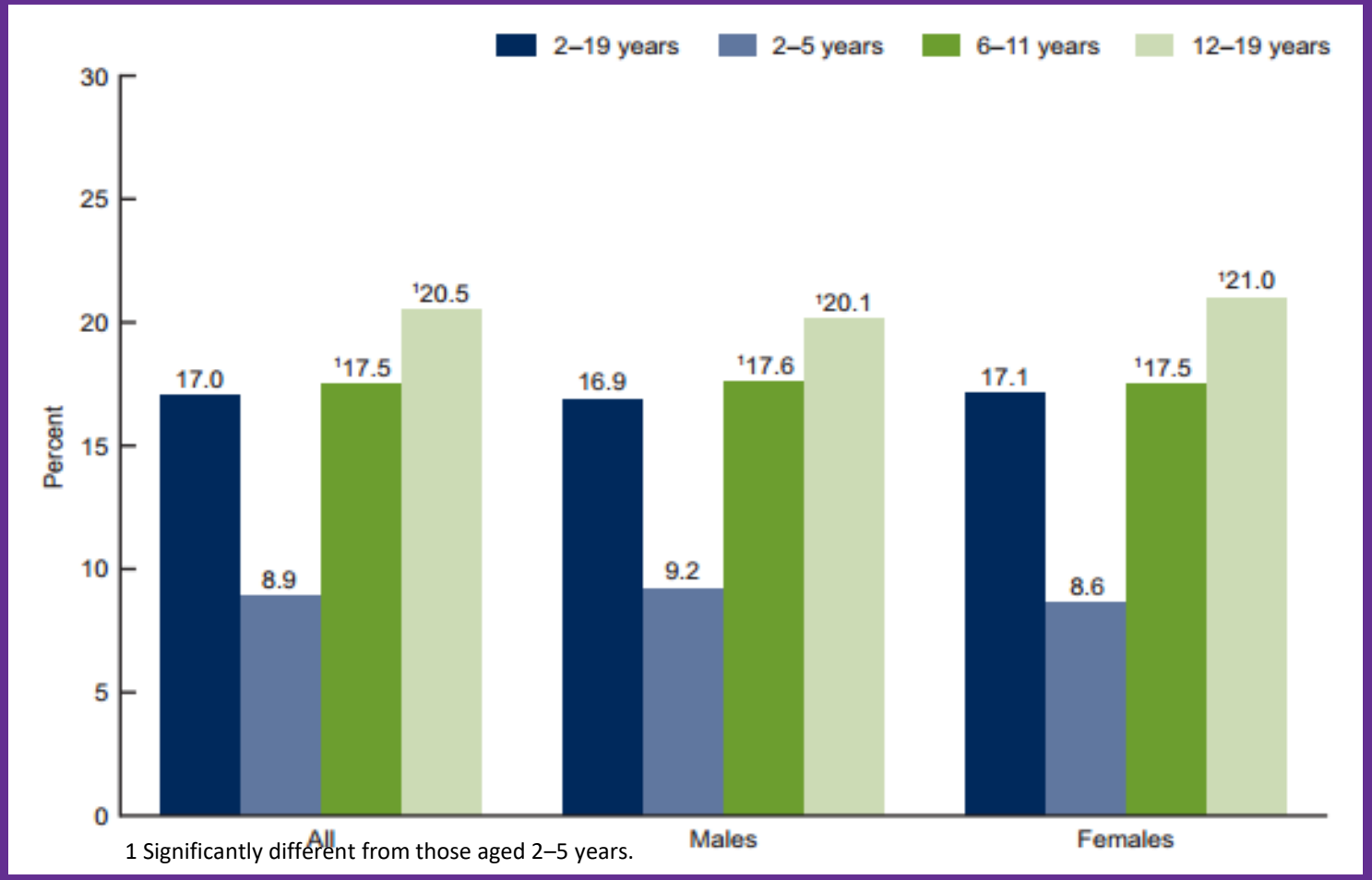
- Learners will be able to correctly:
  - Discuss the trajectory and proposed causes of obesity prevalence among adolescents.
  - Apply interventions supported by empirical outcomes.
  - Analyze new ways of conceptualizing obesity intervention.

Weight Categories

Category	Description
Underweight	BMI <5th percentile for age
Normal weight	BMI ≥5th to <85th percentile for age
Overweight	BMI ≥85th to <95th percentile for age
Obese	BMI ≥95th percentile for age
Severely obese	BMI ≥120% of the 95th percentile, or BMI ≥35 (whichever is lower)
	BMI ≥140% of the 95th percentile, or BMI ≥40 (whichever is lower)

https://www.cdc.gov/obesity/adult/defining.html

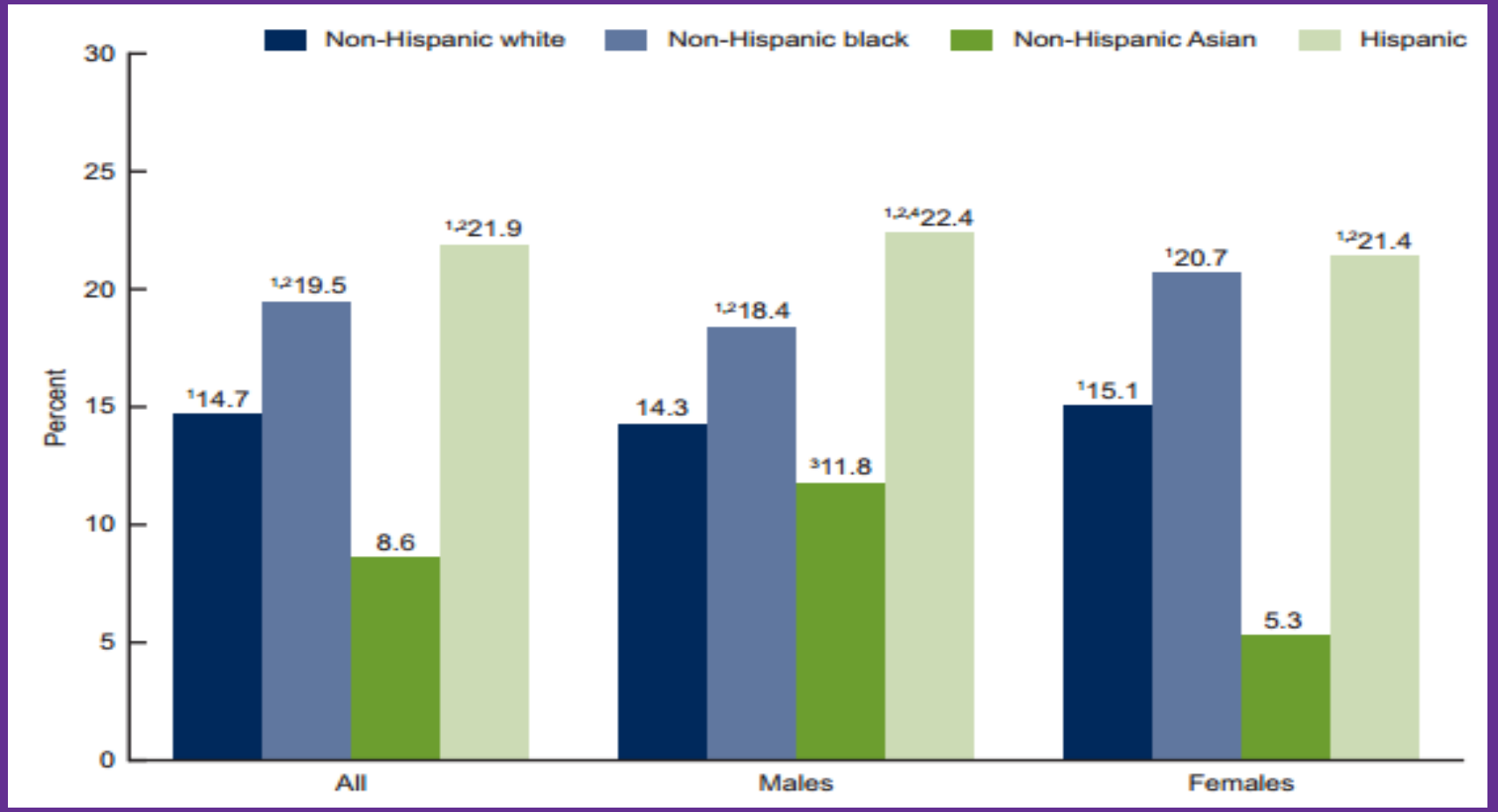
Prevalence of Obesity Among Youth Aged 2–19 Years, by Sex and Age: U.S., 2011–2014



1 Significantly different from those aged 2–5 years.

Source: CDC/NCHS, National Health and Nutrition Examination Survey, 2011-2014

Prevalence of Obesity Among Youth Aged 2–19 Years, by Sex and Race and Hispanic Origin: U.S., 2011–2014



1 Significantly different from non-Hispanic Asian persons.
2 Significantly different from non-Hispanic white persons.
3 Significantly different from females of the same race and Hispanic origin.
4 Significantly different from non-Hispanic black persons

Source: CDC/NCHS, National Health and Nutrition Examination Survey, 2011-2014

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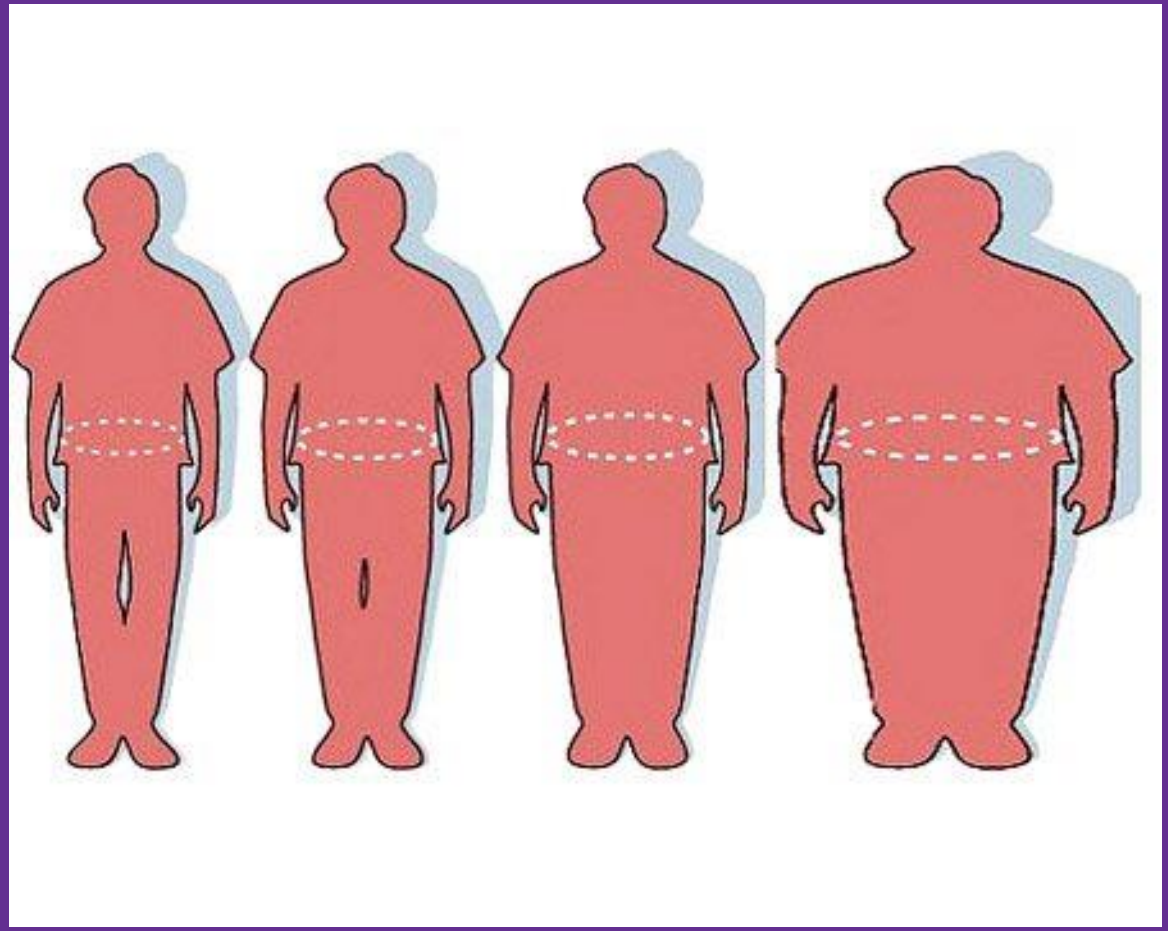
Persistence of Obesity into Adulthood

- Persistence is related to:
  - Age
  - Parental obesity
  - Severity of obesity



Contributors to Weight Gain

- Processed foods and sugar-sweetened beverages
- Low levels of physical activity
- Increased screen time
- Lack of sleep
- Medications
- Proposed Causes
  - Gut microbiome, toxins, viruses
  - Multiple specific genetic syndromes, endocrine disorders, hypothalamic lesions, metabolic programming

Medical Complications of Obesity

- Endocrine
- Cardiovascular
- Gastrointestinal
- Pulmonary & Orthopedic
- Neurologic & Dermatologic

Psychosocial Complications of Obesity

- Alienation
- Poor self-esteem
- Distorted body image
- Mental health comorbidities
- Discrimination
- Bullying

Comorbid Psychiatric Disorders

- Depression and obesity linked bidirectionally
  - Depressed adolescents have 70% higher risk of obesity
- Anxiety and obesity associated at modest level
- Personality Disorders linked to severity of obesity in females
- Adult ADHD - females
- Eating disorders and obesity associated closely
- Alcohol use risk factor among women

Rajan, TM & Menon, V. Psychiatric disorder and obesity: A review of association studies. J. Postgrad Med. 2017 63(3): 192-190.

Prevention Programs that Work

- Most prevention programs do not produce reliable outcomes
- Effective programs/Intervention effects:
  - Involved fewer hours of intervention
  - Most described as general health education
  - Strongest for adolescents
  - Better outcomes with females
  - Shorter duration

Stice, E., Shaw, H., and Marti C. N. (2006). A meta-analytic review of obesity prevention programs for children and adolescents: The skinny on interventions that work. Psychological Bulletin 132(5). P 667-691.

Obesity Prevention & Intervention

- Establish relationships
- Coordinate with other team members
- History
- Identify areas for change
- Assess attitudes toward change
- Provide/Elicit – provide positive feedback for the behaviors that are positive, discuss/elicit ideas to address behaviors not in the optimal range

Davis, M.M., Gance-Cleveland, B., Hassink S., Johnson, R., Paradis G, & Resnicow, K. (2007). Recommendations for prevention of childhood obesity. Pediatrics 120(4). P S229-253.

Initial Assessment - History

- Dietary history
  - 24 hour diet history
  - Skipped meals
  - Binge eating
- Activity level
  - Exercise and daily activity
  - Screen time
- Medical history
  - Medications
- Family history
  - Parental obesity
  - Family history of comorbid conditions
- Psychosocial history
  - Depression
  - Anxiety
  - Eating disorders
  - School issues
  - Smoking/substance use

Behavioral Targets

- What behaviors can change?
- What behavior is a good place to start?
- Agree on target behaviors

Davis, M.M., Gance-Cleveland, B., Hassink S., Johnson, R., Paradis G, & Resnicow, K. (2007). Recommendations for prevention of childhood obesity. Pediatrics 120(4). P S229-253.

Motivation and Confidence

- Willingness/Importance – 0 to 10 scale of importance for behavior and overall desire to lose weight
- Confidence – 0 to 10 scale of level of confidence that you can succeed
- Probes – Probe why each number/rating was chosen – what would it take to move you to higher numbers

Davis, M.M., Gance-Cleveland, B., Hassink S., Johnson, R., Paradis G, & Resnicow, K. (2007). Recommendations for prevention of childhood obesity. Pediatrics 120(4). P S229-253.

Summarize and Probe Possible Changes

- Summarize advantages and disadvantages of change
- Discuss possible next steps - how are you going about the change, and how can you move it along in a few days?
- Summarize the change plan
- Provide positive feedback

Davis, M.M., Gance-Cleveland, B., Hassink S., Johnson, R., Paradis G, & Resnicow, K. (2007). Recommendations for prevention of childhood obesity. Pediatrics 120(4). P S229-253.

Specific Behavior Changes

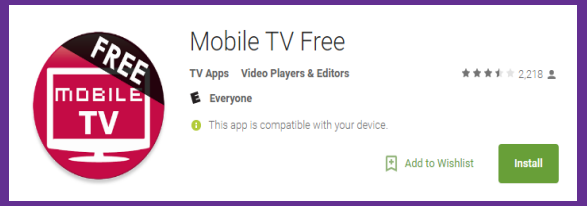
- Decrease sugar-sweetened beverages
  - Discuss alternatives
- Limit calorie-dense foods and increase foods of low caloric density
  - Promote fruit and vegetable consumption
  - Reduce portion size of high calorie foods
- Encourage families not to use food as reward or punishment

Specific Behavior Changes

- Family/friend meals
  - Also improves communication and modeling
- Discourage skipping meals
- Preplanned meals
- Reduce fast food consumption
- Be aware of food portions; choose smaller portion sizes
- Choose fewer processed snacks and side items (apple slices, water)

Specific Behavior Changes

- Limit television/screen time
  - Limits exposure to food advertising/snacking
  - Also limits exposure to violent and sexual images



- Promote leisure and lifestyle physical activity
  - 60 minutes of moderate to vigorous physical activity daily
  - Also may improve mood
  - Preplan activities
- Improve sleep patterns
  - Poor sleep is associated with obesity
  - Also improves academic achievement

Daniels, S.R., and Hassink, S.G. (2015). The role of the pediatrician in primary prevention of obesity. Pediatrics 136(1). E275-92

Specific Behavior Changes

- Change environment
  - Encourage parental involvement
- Monitor behaviors
  - Weight
  - Diet
  - Activity
- Promote self-management skills
- Provide more accountability

Mitchell, T. G., Amaro, C.M., and Steele, R.G. (2016). Pediatric weight management interventions in primary care settings: A meta-analysis. Health Psychology 15(3). P 704-713.

Behavioral Modification

- Behavioral incentives
  - Social support
  - Point systems
  - Relative value
- Environmental controls
- Integration of specialists

Wilfley, D.E., Balantekin, K.N., Hayes, J.F., Van Buren, D.J., Epstein, L.H. (2018). Behavioral interventions for obesity in children and adults: Evidence base, novel approaches, and translation into practice. American Psychologists 73(8). P 981-993.

When Counseling: Balancing Obesity versus EDs

- Do not describe/recommend “dieting”
  - Dieting among teens is associated with greater weight gain and increased rates of binge-eating among males and females
  - Dieting has been found to be a predictor of developing an ED
- Recommend family meals
- Discourage “weight talk” – this is linked to overweight and EDs
- Discourage “weight teasing” – it predicts the development of overweight status, binge-eating and weight-control behaviors
- Encourage healthy body image

Golden, N.H., Schneider, M., & Wood, C. (2016). Preventing obesity and eating disorders in adolescents. Pediatrics 138 (3).

Healthy Relationships with Food

- Problematic relationships with food arise during adolescence
- Little effort toward prevention
- Proactively educate
  - Trajectory and deviations
  - Balance restoring total functioning
  - Signs of eating disorders
- Total diet approach
- Reduce reliance on processed foods
- Improving nutritional messaging

Emerging Thoughts

- Be in it for the long-haul
- Be conscious of macro-level variables
- Reconsider targeted settings
- Reconceptualize responsibility
- Measurement has meaning
- Behavior is dynamic
- Consider alternatives
- Empirical support

Beets, M.W., Brazendale, K., Weaver, R.G., & Armstrong, B. (2019). Rethinking Behavioral Approaches to Compliment Biological Advances to Understand the Etiology, Prevention, and Treatment of Childhood Obesity. Childhood Obesity. 15(6).

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Q&A

Dr. Sammons will read select questions that were submitted via the Q&A feature throughout the presentation.

Due to time constraints, we will not be able to address every question asked.

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