Running Head: CHILDHOOD OBESITY: FAMILIAL INFLUENCES & EFFECTS

Childhood Obesity: Familial Influences & Effects

Janet Vick

University of Georgia

SOWK 7232

Childhood Obesity: Familial Influences & Effects

The percentage of children and adolescents who are overweight and obese is now at its highest. Approximately 25% of children and adolescents are considered overweight, a figure which has double in the last 30 years (American Obesity Association, 2000). For boys, ages 6-11, obesity has tripled in nearly 25 years and increased more than two and a half times for girls. Obesity is also associated with many adverse side effects including asthma, diabetes, hypertension, sleep apnea, psychosocial effects and stigma and increased risk of morbidity and mortality (American Obesity Association, 2000). Because obesity is associated with chronic disease and adverse health outcomes, the growing incidence of obesity in the population has become a serious public health concern. Studies from a variety of disciplines including pediatric nutrition and epidemiology demonstrate that childhood obesity is not caused by one thing; rather, obesity has a multifactorial origin (Gable, S. & Lutz, S., 2000).   Some of these factors include: genetic predisposition, family demographics, parenting beliefs and practices, child television viewing and computer use, physical activity, "food as reward", increasing hectic family lifestyles and large portion, high fat foods in abundant supply.

Psychosocial Implications of Obesity

The most immediate consequences of being overweight during childhood and adolescence are psychosocial (Dietz, 1998). The social implications of obesity are a major problem area that is often neglected. "The obese, do less well academically, have poorer job prospects and lower self esteem. The latter often caused by repeated failures at weight loss. Obese children are often taller than their non-overweight peers, and are apt to be viewed more mature. This is an inappropriate expectation that may result in adverse effects on their socialization (Dietz, 1998). Overweight children and adolescents report negative assumptions

made about them by others, including being inactive or lazy, being strong or tougher than others, not having feelings and being unclean (American Obesity Association, 2000).

<center>Family Dynamics Coupled with Risk Factors</center>

Of the above risk factors of obesity, the majority of these factors directly originate with parent and family processes. The ecosystems model recognizes that there are relationships between and among individuals, families, psychosocial groups, institutions and society (Caple & Salicido, 1995). These interactions between or among these systems have a significant impact on human behavior and functioning. Ecological theory posits that some of the potential risk factors that directly touch obese children are associated with aspects of the family's dynamics (Gable, S. & Lutz, S., 2000).

For example, research indicates that food choices are related to demographic characteristics of the family. Single parent households and households in which both parents work full time have a tendency to favor the consumption of prepared foods, which tend to be high in sodium and fat (Crockett & Sims, 1995). Household income also indirectly influences children's eating habits and weight. Between 1977-1778 and 1987-1988, lower income households reduced their vegetable consumption by 22%, as compared to 12% in high-income households (Lutz, Blaylock, & Smallwood, 1993). These findings suggest that healthy foods are expensive and require more time to prepare. Dual-worker or single parent households may not have the time to prepare healthy meals and low-income families may not have reliable sources of income to regularly provide healthy foods. Thus, although food availability in the home sets the stage for food intake and eating habits, food availability itself is affected by parents' time and income.

Parents' beliefs about children's nutritional needs and their attitudes toward mealtimes can also make a difference in children's weight. A common response to a child's increasing weight is to restrict "bad" foods –those foods we usually associate with poor nutritional quality, such as chips, cookies and cake. Yet, when a child's intake is restricted, profound negative consequences ensue. Establishing food restrictions can disrupt a child's natural ability to regulate food choices (Gingras, 2000). By enforcing rigid guidelines, parents alter their child's responsiveness to internal signals of hunger and satiety. When parents impose eating practices with few opportunities for children to learn self control, children learn to depend on external signals, such as looking at a clock to determine hunger or overeating "comfort foods" as a way of coping with stress. Parents need to learn to trust their children to eat when they're hungry and to stop once they feel satisfied. It is a parents' responsibility however, to provide healthy food choices for children at appropriate times. Whether a child learns to appreciate the role of healthy foods in their own physical and emotional well-being and to recognize their bodies' signs of hunger and fullness is linked to the nutrition and mealtime environment created by parents (Gable, S. & Lutz, S., 2000).

The rapid advancement of our society has systematically eliminated the need for physical exertion. Children at younger and younger ages spend more time at home watching television, sitting in front of computer screens and playing video games, drastically reducing the amount of time they spend actively engaged in physical activities. Research examining dual income and single family households suggests that these parents are under more stress and spend less time at home than two parent, single income families (Bianchi, 1995). These children spend more time than their other agemates on household tasks, implying greater maturity demands and responsibilities. Translating those differences to a child's health and nutrition is not difficult.

For example, these children may more frequently prepare their own meals which consist of prepared food items, or spend more time unsupervised allowing them to engage in sedentary activities. In line with the household and parent characteristics described thus far, lack of activity involvement does not occur in isolation. Parents presumably contribute to and arrange their child's extracurricular activities and monitor the time they spend watching television or sit behind a computer screen. Studies have shown reducing children's television viewing yielded positive result for preventing childhood obesity (Robinson, 1999). The challenge is to promote other activities and adapt family resources and time to follow through on these activities.

<u>Parental Modeling</u>

Parental modeling is crucial to the eating behaviors of children as well as self-esteem and body image. When parents cringe as they step on the scale, children learn that the body of the person they love and admire is somehow unacceptable. This is a dangerous lesson. If parents cannot love themselves for who they are, how can children be expected to appreciate and respect their own bodies? Parents need to impart a sense of balance when it comes to food, weight and self-esteem. Proponents of a family perspective contend that individuals develop a normal or distorted body image in the context of family life (Haworth-Hoeppner, 2000). As a mediator of culture, the family operates as an influence on identity, contributing to the formation of self-esteem. Homes in which talk about weight is prominent, focus on dieting is central, and in some incidences, include derogatory remarks about overweight people, reflect cultural attitudes about weight that is prevalent in our society. These types of homes serve as defining mechanisms for the construction of collective identity; it creates a common outlook on the value of being thin. Part of being in the family means embracing this attitude, which determines the status of insider

v. outsider (e.g., thin v. fat). This discourse on weight can lead to dysfunctional consequences such as binge eating, food hiding and eating disorders.

With many overweight children, it isn't the extra pounds but parent reaction to the pounds that take the greatest emotional toll. As a result, parents face a balancing act of helping the child without giving the impression to the child that they are not loved unconditionally. A useful model to explain parental influence on a child's behavior is the expectancy-value model of Eccles and Harold (1991). In this model, socialization behaviors are thought to be influenced jointly by parental expectation for the child's success in a given area and the value parents place on this success. Parents who expect that their child can be successful and who value success in an area will be more likely to influence their children to pursue this behavior. Four different socialization variables especially influence physical activity behaviors in children (Welk, 1999): (a.) Parental Encouragement - Refers to obvious verbal and non verbal forms of encouragement for a child.   Parental efforts to build competence and a sense of mastery are likely to promote involvement. (b.) Parental Involvement – The parent provides direct assistance or involvement in the child's activity. This could include family walks, playing catch or practicing skills. Demonstrates to the child that the parent feels physical activity is important. (c.) Parental Facilitation - Effort is made by the parents to make it easier for children to become physically active. For example, providing access to facilities or programs or obtain equipment. (d.) Parent Role Modeling - Parent models an active lifestyle for their child. Modeling promotes self-efficacy and also informs the child of what is important or valued.

<center>Family Dynamics and Treatment</center>

Dr. Joseph Scherger, M.D., chair of the department of family medicine at University of California believes that understanding the family dynamics and expanding the scope of treatment

beyond the pediatric patient is critical. A complete family history should reveal sufficient clues to determine if the child's obesity results from a strong genetic component.   He also believes that it is very common, particularly in childhood obesity, for behavioral issues and interpersonal dynamics between the child and parents to have played a major role.   With this said, treating obesity in children becomes a team effort involving parents and family from the outset. Behavior change will not occur unless there is group buy-in. If they are not in the state of mind or the position to deal with the problem, or if they have other problems and issues that they're dealing with, it is futile, if not counterproductive, to try to address the obesity (Grinfield, 1998).

Conclusion

What clearly emerges from the literature is the association between environmental/behavioral factors and children's obesity. All adults who parent, educate and care for children need to understand the important role they play in socializing children's healthy eating habits. Parents need to be educated on good nutrition as well as provide healthy food choices, model healthy lifestyles and encourage physical activity. Most importantly, families need to evaluate their attitudes and beliefs on weight, body image and self-esteem and determine if what they are conveying to family members in regards to those issues are appropriate, and foster positive behavior change. Parents can impart a sense of balance for their children when comes to food, weight and self-esteem. Learning to let go of unrealistic and unhealthy ideals that society sets forth is the first step. Finally, changing eating and physical activity habits must be an entire family process in order for those habits to change. The focus needs to be on health, not appearance, and more activity, not less food or stringent diet.

References

American Obesity Association. (September, 1999). Obesity in youth. (Conference outcomes). Washington, DC: Author. Retrieved November 22, 2000, from the world wide web: http://www.obesity.com/Obesity_Youth.htm.

Bianchi, S. (1995). The changing demographic and socioeconomic characteristics of single parent families. Marriage and Family Review, 20, 71-97.

Caple F. S., & Salicido, R. M. (1995). Engaging effectively with culturally diverse families and children. Social Work in Education, 17 (3), 159-171.

Caterson, I.(1997). Obesity part of the metabolic syndrome. The Clinical Biochemist Reviews, 18 (1), 11-21.

Crockett, S., & Sims, S. (1995). Environmental influences on children's eating. Journal of Nutrition Education, 27, 249.

Dietz, W. (1998). Health consequences of obesity in youth. Childhood Pediatrics, 101 (3), 518-525.

Eccles, J. & Harold, R. D. (1991). Gender differences in sport involvement: Applying the Eccles' expectancy-value model. Journal of Applied Sport Psychology, 3, 7-35.

Epstein, L., Myers, M., Raynor, H., Saelens, B.(1998). Treatment of pediatric obesity. Pediatrics,101 (3), 554-570.

Gable, S., & Lutz, S. (2000). Household, parent, and child contributions to childhood obesity. Family Relations, 49 (3), 293-300.

Grinfield, M. (1998). Childhood obesity: Will all the attention matter? Medicine & Behavior. Retrieved November 22, 2000, from the World Wide Web: http://www.cmea.com/mb/mb980401a.html.

Haworth-Heoeppner, S. (2000). The critical shapes of body image: The role of culture and family in the production of eating disorders. Journal of Marriage and Family, 61 (1), 212-227.

Lutz, S., Blaylock, J., & Smallwood, D. (1993). Household characteristics affect food choices. Food Review, 16 (2), 12-17.

Robinson, T. (1999). Reducing children's television viewing to prevent obesity. Journal of the American Medical Association, 282, 1561-1567.

Welk, G. (1999). Promoting physical activity in children: Parental influences. Retrieved November 18, 2000, from ERIC Clearinghouse on Teaching and Teacher Education database (ED436480) on the World Wide Web: http://www.ed.gov/databases/ERIC_Digests.