COPE WEBINAR SERIES FOR HEALTH PROFESSIONALS

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Parenting Strategies to Combat Pediatric Obesity: Nuts and Bolts and Debunking Misconceptions

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Nursing Education Continuing Education Programming Research

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OBJECTIVES

1. Discuss common frustrations of childhood obesity treatment experienced by health professionals and parents
2. Provide a conceptual overview of, evidence for, and common misconceptions of the Family Based Treatment (FBT) model in child overweight treatment.
3. Learn specific behavior change strategies parents/families using FBT for child obesity management are challenged to make

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CE CREDITS

- This webinar awards 1 contact hour for nurses and 1 CPEU for dietitians
- Suggested CDR Learning Need Codes: 2000, 5110, 5220 and 6000
- Level 2
- CDR Performance Indicators: 8.1.2, 8.1.5, 8.3.1, 8.3.6

PARENTING STRATEGIES TO COMBAT PEDIATRIC OBESITY: NUTS AND BOLTS AND DEBUNKING MISCONCEPTIONS

Myles Faith Ph.D.
Professor and Chair
Department of School and Educational Psychology
Graduate School of Education
University at Buffalo-State University of New York

DISCLOSURE

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Parenting Strategies to Combat Childhood Obesity: Nuts and Bolts, and Debunking Misconceptions

Myles S. Faith, PhD
Professor and Chair
University at Buffalo – State University of New York

Overview

1. Challenges of treating childhood obesity for health professionals.
2. Family-based treatment (FBT) model.
3. Common Misconceptions.
4. Summary

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Health Professionals Lack Skills for Treating Pediatric Obesity

- 39% of Pediatricians report low proficiency in behavioral management strategies.
- 31% of RDs and 25% of Pediatricians report low proficiency in managing parenting techniques.
- 13% of Registered Dieticians and 18% of pediatricians report low proficiency in modifying sedentary behaviors.
- 46% of Registered Dieticians and 30% of pediatricians report low proficiency in assessing family conflict.

Source: Storey et al. (2002). Pediatrics. 110: 210-214.

YOUR biggest needs are:

Strategy	%
Improving my use of behavior management strategies	65%
Improving patient eating patterns	60%
Teaching effective parenting	50%
Teaching families how to address conflict	50%
Increasing patient physical activity	20%
Reducing sedentary behavior	15%
Assessing overweight and obesity	10%

Opportunities for FBT Counseling in Primary Care

- Long-term relationship with families.
- History re: growth charts, BMI assessment.
- Work with full family, including siblings.
- Advocacy for children in community; drive policy.

Perrin et al. (2007). Current Opinion Pediatrics. 19: 354-361

Stettler (2004). Obesity Reviews. 5 (Suppl 1). 1-3.

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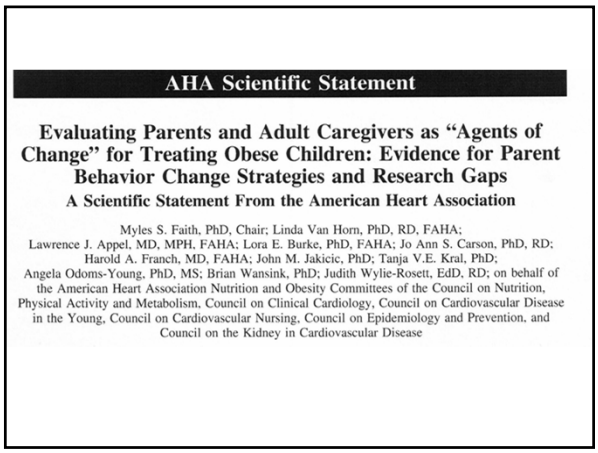

AHA Scientific Statement

Evaluating Parents and Adult Caregivers as "Agents of Change" for Treating Obese Children: Evidence for Parent Behavior Change Strategies and Research Gaps

A Scientific Statement From the American Heart Association

Myles S. Faith, PhD, Chair; Linda Van Horn, PhD, RD, FAHA; Lawrence J. Appel, MD, MPH, FAHA; Lora E. Burke, PhD, FAHA; Jo Ann S. Carson, PhD, RD; Harold A. Franch, MD, FAHA; John M. Jakicic, PhD; Tanja V.E. Kral, PhD; Angela Odoms-Young, PhD, MS; Brian Wansink, PhD; Judith Wylie-Rosett, EdD, RD; on behalf of the American Heart Association Nutrition and Obesity Committees of the Council on Nutrition, Physical Activity and Metabolism, Council on Clinical Cardiology, Council on Cardiovascular Disease in the Young, Council on Cardiovascular Nursing, Council on Epidemiology and Prevention, and Council on the Kidney in Cardiovascular Disease

Family Treatment Nuts & Bolts

- Select target behavior & self-monitor that behavior.
- Goal Setting
- Behavioral Challenge (go for the goal).
- Review and feedback on challenge.
- Goal adjustment(s) before next challenge.

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Selecting a Specific Target Behavior

- Fruits & vegetables ?
- "Red Light" foods ?
- Sugar beverages ?
- Soda ?
- Water ?
- Total calories ?
- Screen time ?
- Walking ?
- Pedometer step counts ?

"Starting the Conversation" toolkit by Alice Ammerman (UNC – Chapel Hill) to guide target behavior selection.

University at Buffalo | Graduate School of Education

Monitoring Forms: Flexibility and Personalizing

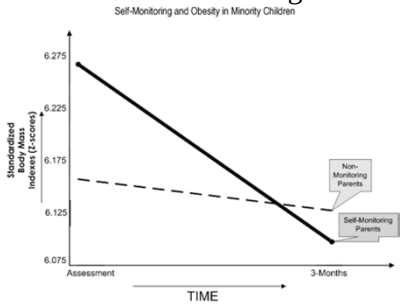
Initial Self-Monitoring *is* …

- A powerful tool for raising self-awareness
- A powerful first-step for behavior change
- Non-judgmental
- Valuable for knowing how often you do specific behaviors

Pedometer Step Counter

- Potential teachable moment in clinic to demonstrate, model?
- Fun and engaging.
- Opportunity for success
- "America on the Move" website

Greater Parental Monitoring is Associated with Greater Child Weight Loss



Germann et al.. (2007) J Pediatric Psych, 32;111-121

Family Treatment Nuts & Bolts

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Goals should be…

- Realistic, achievable.
- Foster success.
- Determined together with family/child.
- Be short-term (daily goals to start)
- Be specific and countable.

Goals Should *Not* …

- Promote failure or be unattainable
  ("I will drink no soda in the next week")
- Be set unreasonably high
  ("I will drink 12 glasses of water every day")
- Vague and uncountable
  ("I will eat more fruits and vegetables")

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Attempting Goal

- Parent/Caregiver encouragement of daily goals
- "Go for it"
- "Give it your all"
- "Try your best"
- "See how you do"
- "You can do it"

Family Treatment Nuts & Bolts

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Review of Goal Attainment

- Focus on progress.
- Reinforce progress.
- Opportunity for feedback.
- Think about barriers to success/problem-solve.
- Enhance motivation.
- Opportunity for positive parenting.

Goal Review: How did I do?

1. Did I reach my goal…
   Not at all? Some? Completely?

2. Reviewing why…
   What did I do differently to meet my goal?
   What challenges kept me from meeting my goal?

3. Should I change my goal…
   Same goal? Lower/Higher goal?

4. What's my new goal? _____

Dietary Modification Strategies

- Providing energy balance concept and recommended calorie ranges for children.
- Teaching "Traffic Light" System.
- Portion Control as strategy to limit calories.

"Portion Distortion" materials: http://hp2010.nhlbihin.net/portion/

Eating Healthy the Traffic Light Way!

	Drinks 'n Things	Cereals 'n Grains	Snacks 'n Sweets	Extras
Less Healthy Choice Not Everyday	Soda/Pop Lemonade Fruit Punch Ice Tea Whole or 2% milk Milkshakes	Muffins Sugar-coated cereal (>6 grams/serving) Toaster pastry Cornbread Stuffing French Toast/Pancakes	Chips Ice Cream Cake Cookies Pie Candy Jelly/Honey/Sugar	Fried Foods Salad Dressing Mayonnaise Butter/Margarine Baked Beans Flavored/Sweetened Yogurt Creamy Soups
OK Choice Watch Portions	1% or skim milk 100% juice (4 oz/day) Flavored Waters (check label-no caffeine) Fresh, canned fruit	Whole Wheat/White bread Bagels Hot cereal-unsweetened Cereals (less than 6 gms sugar/serving) Graham/Goldfish crackers Tortilla/Wrap	Non-creamy soups Stews Pizza (plain or veg) Baked, roasted or grilled meats, fish, poultry Casseroles made with low fat sauces Corn, potatoes	Light salad dressings Cheese Low fat yogurt (light) Pretzels Baked chips Rice cakes Popsicles (< 60 calories/svg) Low fat or fat-free pudding
Healthy Choice Eat Everyday	Water Flavored Seltzer Mustard Ketchup Herbs 'n Spices	All non-starchy vegetables Asparagus Beans Bean sprouts Beets Broccoli Brussels sprouts	Celery Cauliflower Cucumbers Eggplant Endive/Kale Lettuce Mushrooms Okra/Onions Peppers	Radishes Rutabaga Tossed Salad Sauerkraut Spinach Squash Tomatoes Vegetable Juices

Green and Yellow will make you smile; Save Red Light foods for "once in a while!"

NHLBI: "We Can" Program

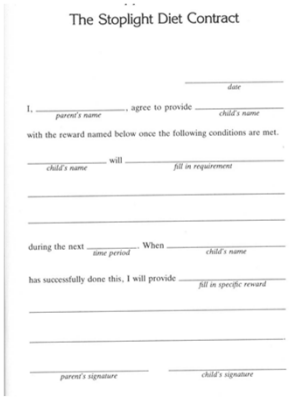
Food Group	GO (Almost Anytime Foods)	SLOW (Sometimes Foods)	WHOA (Once in a While Foods)
	Nutrient-Dense ←	→	Calorie-Dense
Vegetables	Almost all fresh, frozen, and canned vegetables without added fat and sauces	All vegetables with added fat and sauces; oven-baked French fries; avocado	Fried potatoes, like French fries or hash browns; other deep-fried vegetables
Fruits	All fresh, frozen, canned in juice	100 percent fruit juice; fruits canned in light syrup; dried fruits	Fruits canned in heavy syrup
Breads and Cereals	Whole-grain breads, including pita bread; tortillas and whole-grain pasta; brown rice; hot and cold unsweetened whole-grain breakfast cereals	White refined flour bread, rice, and pasta. French toast; taco shells; cornbread; biscuits; granola; waffles and pancakes	Croissants; muffins; doughnuts; sweet rolls; crackers made with *trans* fats; sweetened breakfast cereals
Milk and Milk Products	Fat-free or 1 percent low-fat milk; fat-free or low-fat yogurt; part-skim, reduced fat, and fat-free cheese; low-fat or fat-free cottage cheese	2 percent low-fat milk; processed cheese spread	Whole milk; full-fat American, cheddar, Colby, Swiss, cream cheese; whole-milk yogurt
Meats, Poultry, Fish, Eggs, Beans, and Nuts	Trimmed beef and pork; extra lean ground beef; chicken and turkey without skin; tuna canned in water; baked, broiled, steamed, grilled fish and shellfish; beans, split peas, lentils, tofu; egg whites and egg substitutes	Lean ground beef, broiled hamburgers; ham, Canadian bacon; chicken and turkey with skin; low-fat hot dogs; tuna canned in oil; peanut butter; nuts; whole eggs cooked without added fat	Untrimmed beef and pork; regular ground beef; fried hamburgers; ribs; bacon; fried chicken, chicken nuggets; hot dogs, lunch meats, pepperoni, sausage; fried fish and shellfish; whole eggs cooked with fat

http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/downloads/go-slow-whoa.pdf

Praise and Positive Reinforcement

Incentives for Children

- Give hugs and kisses
- Praise and encouragement
- Compliment your child in front of others
- Use the computer
- One-on-one time with a parent
- Brother's Day/Sister's Day
- Spend a special day with a parent
- Surprises
- Back rubs
- Thank-you notes in the lunch box
- Thank-you notes through the mail
- Have lunch at school with parent
- Books, reading a story
- Posters
- Science kits
- Work on models, building kits
- Gardening
- Play board games, or puzzles
- Magic tricks
- Painting or drawing supplies
- Using a calculator
- Playing outside, playing catch
- Sporting events
- Baseball cards
- Go for a walk or a family bike ride
- Go for a drive in the car
- Go on a mystery ride
- New clothes
- Use the VCR/rent a movie
- Use the telephone
- Make low-fat microwavable popcorn
- Stay up late on weekends
- Take Special Trips
- Have a picnic outdoors
- Spend time at a friend's house
- Have a friend come to the house
- Have a slumber party
- Make a blanket tent
- Sing songs or play music
- Go to a relative's house
- Fly a kite
- Go swimming, fishing, skating, or bowling
- Play miniature golf
- Go to the movies
- Go to the zoo, park, museum, or library
- Prepare a meal together
- Bubble baths
- Brushing hair
- Help with chores
- Help Mom or Dad with projects
- Stickers/sticker books/happy faces
- Stars/points on a chart
- Money/ allowance
- Open a savings account
- Others: _____



The Stoplight Diet Contract

_____ *date*

I, _____ *parent's name*, agree to provide _____ *child's name*

with the reward named below once the following conditions are met.

_____ *child's name* will _____ *fill in requirement*

_____

_____

during the next _____ *time period*. When _____ *child's name*

has successfully done this, I will provide _____ *fill in specific reward*

_____

_____

_____ *parent's signature* _____ *child's signature*

Epstein & Squires (1978). Stoplight Diet

FBT Strategic Grid

	Child Only	Parent Only (As Change Agent)	Child + Child Together	Child + Other?
Info. Provision (eg, NHLBI's WeCan!)				
Goal setting				
Monitoring				
Feedback / Review				
Reinforcement				

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Misconceptions About Effective FBT Model

1. FBT cannot be implemented or effective in primary care settings.
2. Targeting >1 behavior change necessarily yields better outcomes.
3. Greater parental involvement is always or necessary better.
4. Greater parental 'control' is always or necessarily better.

Misconception #1
About Effective Pediatric Obesity Treatment

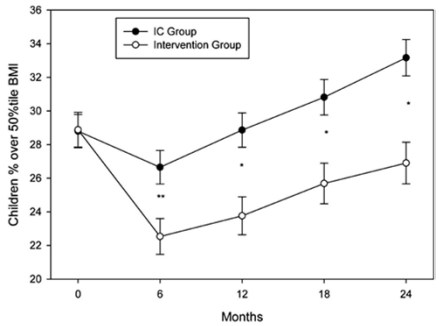
FBT cannot be implemented or be effective in primary care settings.

Primary Care Treatment of Obesity

- RTC conducted in 4 large urban/suburban settings.
- Targeted 2-5 year old overweight and obese children, identified by EMR.
- Ten 60-min sessions, with diet information, physical activity recommendations, 8 phone calls with a coach.
- "Intervention" = parent behavior modification training (monitoring; role modeling; positive parenting; etc)

Quattrin et al. Pediatrics 2014;134:290-297

Primary Care Treatment of Obesity
2 – 5 Year Old Youth

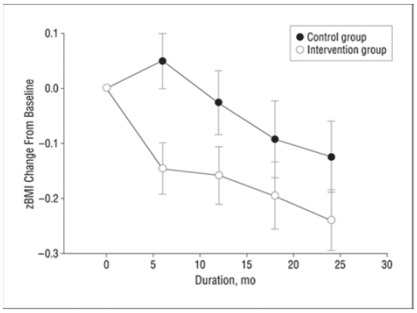


Quattrin et al. Pediatrics 2014;134:290-297

Misconception #2
About Effective Pediatric Obesity Treatment

Targeting more than 1 behavior change necessarily yields better outcomes.

Screen-time Reduction for Treatment of Obesity 4 – 7 Year Old Youth



Epstein et al. (2008). Arch Ped Adol Med, 162, 239-245.

Targeting Sugar Sweetened Beverages for Childhood Obesity Tx/Prevention

- Ebbeling et al. (2012). A randomized trial of sugar-sweetened beverages and adolescent body weight. New England J Med. 367: 1407-1416.
- Stettler et al. (2014). Prevention of excess weight gain in paediatric primary care: beverages only or multiple lifestyle factors. The Smart Step Study, cluster randomized clinical trial. Pediatric Obesity. (In Press).

Misconception #3: About Effective Pediatric Obesity Treatment

Greater parental 'involvement' in treatment is always or necessarily better.

Parental Involvement and Childhood Obesity Treatment Response

- Meta-analytic review.
- Compare studies with low, medium, or high level of parental participation.
- "High"= Family involved in all aspects of tx.
  "Medium" = Family is involved, but child is solely responsible for significant aspects of tx.
  "Low" = Parents have minimal involvement.

Haddock et al. (1994). Annals Behavioral Med, 16, 235-244.

Participation Level	N	Cohen's d (Standardized mean difference for tx vs. control)
High	6	.48
Medium	6	.70
Low	12	.51

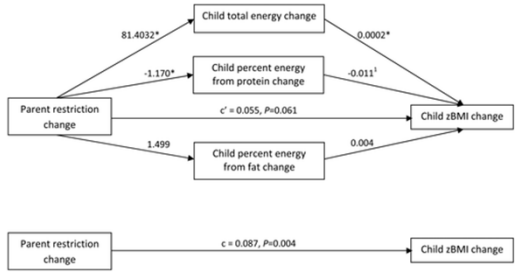
"Since providing training to parents may increase the cost of childhood weight loss programs, this finding suggests reducing parental participation to minimum necessary levels".

Misconception #4
About Effective Pediatric Obesity Treatment

More parental 'control' is always or necessarily better for child outcomes.

- Restrictive feeding associated with increased child BMI gain (Faith et al., Pediatrics, 2004, 114: e429-436; Shloim et al., 2015, Frontiers in Psych, 6, 1849)
- Pressuring children to eat food is associated with poorer eating regulation and questionably effective for promoting healthy eating (Blissett, Appetite, 2011, 57, 826-831).
- Compliant eating among girls is associated with obesity onset over 10 years (Faith et al., 2012, Childhood Obesity, 2013, 9, 427-436).
- Restrictive feeding predicts poorer child treatment response to family-based obesity treatment (Holland et al., Obesity 2014, 25, E119-E126)

Modifications in parent feeding practices and child diet during family-based behavioral treatment improve child zBMI



Wifley et al (2014). Modifications in parent feeding practices and child diet during family-based behavioral treatment improve child zBMI. Obesity.

Summary and Looking Forward

- Nurses, pediatricians, and other primary care staff are critical forces in addressing childhood obesity.
- Many opportunities exist for translating behavioral counseling strategies to primary care; research in infancy.
- Consider starting with just a few simple goals to build success (rather than change 'all at once').
- Promote specific goals and self-monitoring.
- Keep it positive!

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QUESTIONS & ANSWERS

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