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Food Security in Focus

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Respectful, Evidence-Based Care for Children with Elevated BMI

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Respectful, Evidence-Based Care for Children with Elevated BMI

Event Materials

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This material is based upon work supported by the National Institute of Food and Agriculture, U.S. Department of Agriculture, and the Office of Military Family Readiness Policy, U.S. Department of Defense under Award Number 2019-48770-30366.

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MILITARY FAMILY READINESS ACADEMY

Military Families and Food Security
A CALL TO ACTION

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Food Security in Focus

Among our nation's active-duty members and their families, almost 24% are food insecure.

Food Security in Focus!

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Today's Presenters

Ashleigh Spitza, MS, RD, CD, CDCES
Clinical Dietitian
Children's Wisconsin

Racquel Ward, LPC
Licensed Professional Counselor
Behavioral Health Consultant
Children's Wisconsin

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Poll: What is your profession?

- Registered Dietitian Nutritionist
- Social Worker
- Licensed Professional Counselor
- Other

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Poll: What is your primary work setting?

- Community/Public Health
- Healthcare
- Individual/Private Practice
- Government
- Education

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Objectives:

- Describe weight bias and understand how this and other structural inequalities impact pediatric health and healthcare.
- Understand the interconnected impacts of mental health and physical health.
- Identify key tenants of weight-inclusive vs. weight-normative care approaches and what current research states about each.
- Integrate evidence-based practices into caring for pediatric patients with higher-weight from a whole child perspective.

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Introduction/Level Setting

Image credit: Children's Wisconsin

AAP Guidelines – No more 'watch and wait' regarding child obesity, intensive lifestyle intervention starting at age 2

NEDA, AED, CEDO responses - focusing on weight/ weight loss and BMI instead of health does not take into account the risk of disordered eating and could further perpetuate weight stigma

Our assumption: everyone wants healthy, thriving children who grow into healthy adults (mentally, emotionally, physically)

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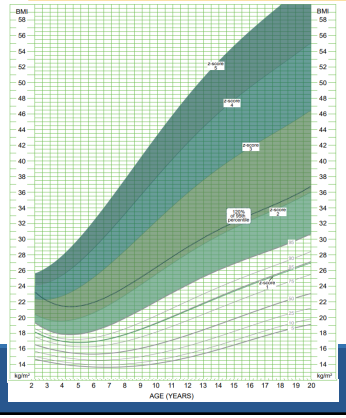
Classification of Child Weight Status (CDC)



Based on BMI percentile data

Weight Status Category	Percentile Range (Z score)
Normal or Healthy Weight	5th percentile to <85th percentile (Z score >-1.5 to +1)
Overweight	85th to less than the 95th percentile (Z score >+1)
Obese	95th percentile and above (Z score >+2)

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Centers for Disease Control and Prevention (2016). Overweight and Obesity. Centers for Disease Control and Prevention. Accessed 11/29/16 from https://www.cdc.gov/obesity/childhood/defining.html

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Terminology and assumptions

Based on body mass index (BMI) percentiles we have terms such as "normal weight/healthy weight," "overweight," and "obese"

- Term "normal weight" assumes one weight/range all kids should be or fall within, ignoring natural human diversity
- Term "healthy weight" assumes there is one weight or weight range where children will be healthy
- Terms such as "obesity" and "morbid obesity" in practice pathologize body size and perpetuate stigma
- Origins of "obese" is from Latin obesus, "having eaten until fat;" incorrectly describes cause of fatness

Photo: Shutterstock, used with permission

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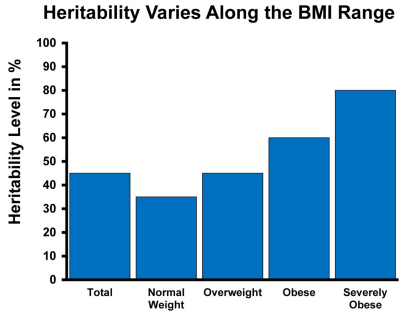
Weight Acceleration

BMI is not the whole picture; body size is strongly genetically determined (Bouchard, 2021)

- Consistent at 85th% or 95th%ile or slow shift up/down vs. sustained increase in growth velocity
- Abrupt crossing of multiple growth percentiles is *unlikely* normal
- Rapid weight gain in childhood is *associated* with poor health outcomes (Arisaka et al., 2020)
- Disrupted feeding dynamics, stress, negative life events, food insecurity, attachment concerns can all interfere with natural growth trajectory (Satter, 1996)



ImageL Genetics of Obesity: What We Have Learned Over Decades of Research; Obesity, Volume: 29, Issue: 5, Pages: 802-820, First published: 26 April 2021, DOI: (10.1002/oby.23116)

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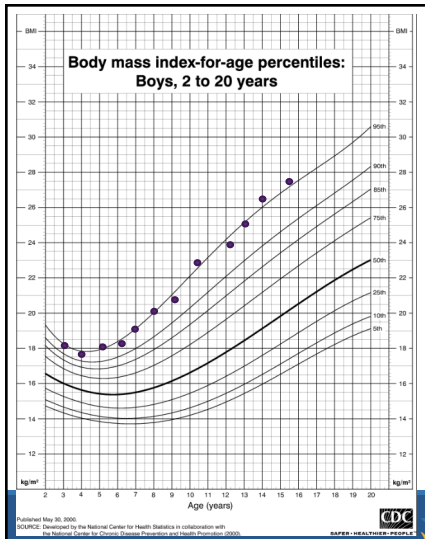

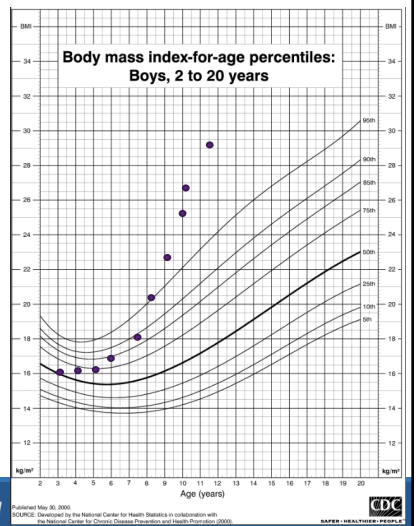

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Weight bias and stigma

Weight bias: the action of treating fat people differently, often unfairly, pervasive in healthcare; "inclination to form unreasonable judgments based on an individual's weight" (Washington, 2011)
- Can be implicit and explicit

Weight stigma: social "mark" carried by those who do not comply with prevailing social norms of adequate body weight and shape

Weight discrimination: overt forms of weight-based prejudice and unfair treatment (biased behaviors) toward individuals with overweight or obesity.

Internalized weight bias: when stigmatized individuals engage in self-blame and self-directed weight stigma, including acceptance of stereotypes
- Associated with healthcare avoidance, disordered eating and binge eating

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Weight bias and stigma

Weight bias is pervasive, harmful, and based on incorrect assumptions *(Rubino et al., 2020; Lawrence et al., 2021).*

- Weight bias in healthcare impacts quality of care provided *(Phelan et al., 2015)*
- It starts in childhood and consequences are long-lasting *(Haaq et al, 2021)*
- Experiences of or expectations for poor treatment may lead to avoidance of care *(Phelan et al., 2015)*

Photo: Shutterstock, used with permission

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Weight bias and stigma

Increasing evidence that weight bias leads to poor health outcomes *(Alimoradi, et al., 2020)*

- Weight-based discrimination associated with 60% increase in mortality rate
- Greater than other forms of discrimination (race, sex, age)

Photo: Shutterstock, used with permission

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Weight bias and stigma

Weight stigma drives adverse psychological and physiological outcomes by:

- Poorer healthcare delivery and avoidance *(Phelan et al., 2015)*
- Direct effect of chronic stress *(Tomiyama, 2019)*
- Allostatic load (AL) – highest in Black and Hispanic children *(Brown et al., 2021)*

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Consequences of weight stigma:

Eating disorders are more common in adolescents with obesity but go much longer before being diagnosed *(Jebeile et al., 2021)*

Dieting: restriction of food intake with goal of weight loss, can lead to increased weight gain *(Fildes et al., 2015)* and disordered eating *(Jebeile et al., 2021)*

Weight talk: comments made by family members about their own weight or the weight of their child; increases risk of obesity and disordered eating *(Berge et al., 2015; Kluck, 2010)*

Weight teasing: weight is number one reason girls are bullied, second most for boys *(Puhl et al., 2015);* at school or at home, predictor of higher weight, binge eating, dieting, ED and poor body image *(Puhl et al., 2017)*

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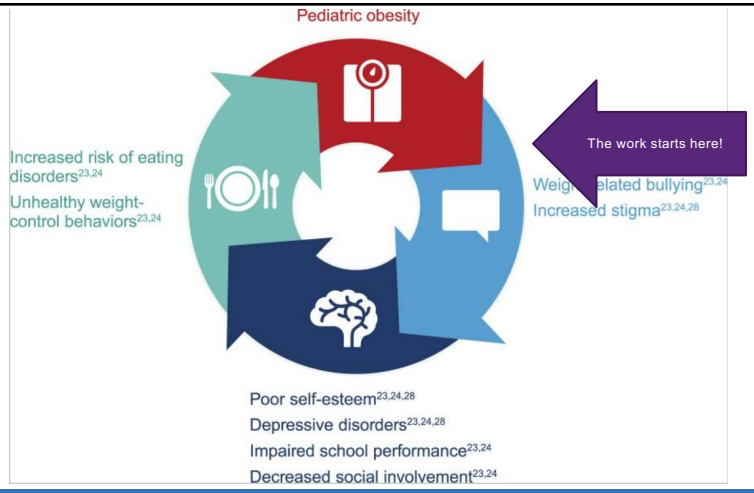

Figure 1: Negative feedback loop in pediatric obesity from Haqq, A. M., Kebbe, M., Tan, Q., Manco, M., & Salas, X. R. (2021). Complexity and Stigma of Pediatric Obesity. Childhood obesity (Print), 17(4), 229–240. https://doi.org/10.1089/chi.2021.0003

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Childhood weight within the lens of health disparities

"The deleterious effect of weight bias falls disproportionately on the minority and socioeconomically disadvantaged groups most affected by obesity, structural barriers to health, racism, and other forms of discrimination." *(Townsend et al., 2020)*

- BIPOC individuals experience bias from healthcare professionals (HCPs)
- Child weight and HCP weight bias can influence assessment of pediatric pain *(Boyle et al., 2019)*
- Many structural and societal factors, along with the toxic stress associated with racism and adverse childhood experiences (ACEs) increase the risk of childhood obesity

National Institute on Minority Health and Health Disparities (2017). NIMHD Research Framework. Retrieved from https://nimhd.nih.gov/researchFramework. Accessed on June 23, 2023

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Social Determinants of Health (SDOH)

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health

(Healthy People 2023)

(Royal, 2022)

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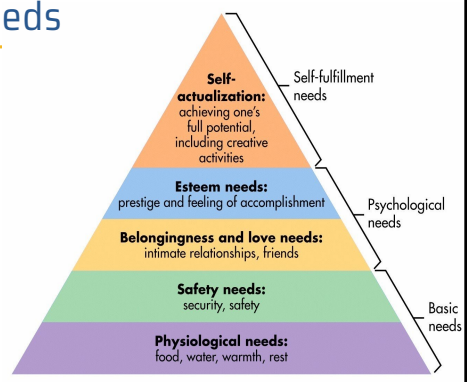
Maslow's Hierarchy of Needs

Maslow's hierarchy of needs is a motivational theory in psychology comprising a five-tier model of human needs, often depicted as hierarchical levels within a pyramid

Needs lower down in the hierarchy must be satisfied before individuals can attend to higher needs



Mcleod, 2023

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Food Insecurity and Mental Health

- Stress goes beyond the immediate relief of food box or meal
- Uncertainty of where the next meal is coming from
- Not getting the right nutrients
- Weight of relying on others for help can be taxing
- Lack of sleep or focus due to hunger pains
- Unable to talk about food insecurity due to stigmas, shame, embarrassment, and guilt attached to being food insecure
- Ongoing mental health concerns and stress can lead to physical and medical concerns

Hernandez, 2023

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Food Insecurity and Child Mental Health

- 257% Increase of Anxiety due to food insecurity
- 253% Increase of Depression due to food insecurity
- 32% Increase in suicidal ideations due to moderate food insecurity
- 77% Increase in suicidal ideations due to severe food insecurity

- Increased developmental risk
- Bullying or not getting along with others
- Body image and self-esteem concerns
- Relationship with food
- School performance
- Sleep concerns
- Behavior concerns
- Mental health concerns (depression, anxiety, PTSD)
- Suicidal ideations
- Lower physical activity
- Adverse Childhood Experiences (ACEs)

Jackson & Chilton, 2019 & Sunshine Behavioral Health, 2022

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Adverse Childhood Experiences (ACEs)

Prevent Child Abuse Illinois, n.d.

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Food Insecurity and ACEs

- Findings from the 2016 National Survey of Children's Health found that one out of every 25 children in food-secure homes were exposed to three or more ACEs
- In food-insecure homes that rose to one in every four children

Jackson & Chilton , 2019

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Food Insecurity and Adult Mental Health

- Mothers with school aged children who face severe hunger are:
  - 56.2% likely to have PTSD
  - 531% likely to have depression

- Sleep concerns
- Lower physical activity
- Mental health concerns (depression, anxiety, PTSD)
- Suicidal ideations
- Lower cognitive functioning
- Complex stress
- Substance use
- Parenting practices
- Maintained employment
- Maintenance of healthy relationships
- Stigma

Sunshine Behavioral Health, 2022

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QUESTIONS?

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Poll: What percent of female adolescents with obesity have disordered eating/eating disorder

A: 8%

B: 12%

C: 20%

D: 32%

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Poll: What percent of female adolescents with obesity have disordered eating/eating disorder

A: 8%

B: 12%

C: 20%

D: 32%

- Compared with 8.4% of "normal-weight" female teens
- Adolescents with BMI >95th%ile 3.5 times more likely to undertake unsafe measures of weight loss (Jebeile, 2021)

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Evidence-based care

Interventions can be provided in two ways *(Tylka et al., 2014)*

Weight-normative care

- Focuses on weight loss and weight management to prevent and treat a myriad of health problems, often perpetuates weight stigma
- Whether or not it is relevant to the presenting concern, patients seeking medical evaluations or treatment are evaluated first based on their weight
- Recommending weight loss is considered a harmless intervention

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Evidence-based care

Interventions can be provided in two ways *(Tylka et al., 2014)*

Weight-inclusive care

- Approach wherein weight is not a focal point for medical treatment or intervention, aims to diminish weight stigma
- Health habits are adopted for the sake of health and well-being
- People of all sizes who have the same symptoms/diagnoses etc. are given the same interventions
- Believes prescribing weight loss can be detrimental

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Weight normative care

Multidisciplinary, long-term, intensive specialty-clinic pediatric weight interventions are marginally effective (O'Connor et al., 2017)

- Average BMI Z score -0.34 with >26 contact hours after 12 months; less-intensive intervention is not "effective"
- e.g. 6 year old with BMI Z +2.81(>99th%ile), 12 lb wt loss → BMI Z +2.47 (>99th%ile)

Weight loss program success in adults varies depending on the definition of 'weight loss maintenance' for participants, from less than 3% to 28% (Sumithran & Proietto, 2013) and often leads to weight cycling (Field et al., 2004) associated with negative health outcomes (Nillson, 2008)

Emphasizing weight loss as the target of care is associated with worse health outcomes than those that target health markers (Tylka et al., 2014) and dieting frequency is associated with higher BMI (Pietilainen et al., 2012; Neumark-Sztainer et al., 2006)

In pediatrics, weight labeling may be obesogenic (Hunger et al., 2014; Robinson et al., 2016)

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Weight normative care - Weight Inclusive care

Diet: fo… other…
- L… c…

Exerci… of interv… out child …rt …gle

Is it possible to provide non-stigmatizing weight-focused care?

If not, then the impacts of weight stigma and bias are potential side-effects of this care model.

BMI Z score is primary or sole measure of "successful" intervention

Reducing food consumption independent of hunger cues disrupts homeostasis, leading to excess hunger hormones and overeating *(Outland, 2012)*

Pressuring and restriction of higher-weight children has the opposite of intended effect: accelerated weight gain *(Faith & Kerns, 2005; Faith et al., 2004)*

Health markers, quality of life and/or growth trajectory are measures of successful intervention

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Weight inclusive care

Why not promote weight loss as the result of healthy habits?

- Fear of comments about body size or weight can result in shame and medical avoidance *(Puhl et al., 2021)*
- Approaches focused on weight loss as a measure of success may to internalized negative beliefs about their appearance and lack of agency for their own health
- The benefits of a Health at Every Size intervention on eating behavior and psychological well-being more broadly outweigh the potential risks of weight-focused care *(Raffoul & Williams, 2021)*

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Weight inclusive care

- ✓ Focuses on health while lessening potential for harm e.g. development of eating disorders *(Austin et al., 2005).*
- ✓ Recognizes weight is not a behavior – it is challenging to attribute health improvements to weight change vs. behavior change
- ✓ Emphasizes non-restrictive eating, body acceptance, and health
- ✓ De-emphasizes weight and focus on addressing barriers to health-promoting behaviors
- ✓ Requires change on multiple levels: clinician, practice environment, systemic

Weight-inclusive interventions can improve biomarkers and do improve psychological health without weight loss *(Bacon & Aphramor, 2011)*

Attrition rates significantly lower in interventions reviewed *(Clifford et al. 2015; Schaefer & Magnuson, 2015)*

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Integrating evidence-based practices from a whole child perspective

Addressing SDOH is primary
- Enough and consistent food before "healthy" food
- Mental health before health behaviors

Binge-eating correlates with elevated BMI and less-healthful food choices; it is often seen in instances of: not having enough to eat, whether due to food insecurity of calorie-restricted dieting *(Bryant et al., 2008)*

Satter EM. Hierarchy of food needs. J Nutr Educ Behav. 2007;39 (suppl):S187-188.

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Integrating evidence-based practices from a whole child perspective

Frame conversations around health, not weight.

- Start by asking about health behaviors "What's going well? What has been a challenge?" rather than framing it around growth chart/BMI
- Have these discussions with all children, not just those with elevated BMI

Challenge yourself, "Do I really need to discuss weight? Or am I having an equal impact without the harm by talking about health habits?"

- Ask permission before discussing weight or health behaviors
- Use a neutral tone when delivering information about weight if necessary
- When discussing weight, acknowledge body size is largely outside of one's control, genetics plays the biggest role by far

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Integrating evidence-based practices from a whole child perspective

Provide family-based education and counseling

- Parent modeling of behavior is important – encourage parent to take ownership and leadership, "leading the charge," change integrated into family system
- Bring everyone together around a goal rather than isolating the child or teen

Address weight talk and weight teasing

- I noticed you said ____ - language is important in how kids think about themselves. "What I'm hearing is you want your child to be…" successful, healthy, not have any heart conditions

Motivational interviewing

- Open-ended questions, listen for change talk and reflect it back

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Integrating evidence-based practices from a whole child perspective

Pressuring and restricting of children backfires.

Examples of pressuring

- Verbally encouraging child to eat more fruits and vegetables
- Making child go outside to play
- Telling a child to eat less

Examples of restriction

- Limiting child on second servings or portion sizes
  - Weight control vs. food budget
- Telling child to "stop playing video games" rather than having set schedule for screens
- Hiding treats or never buying them

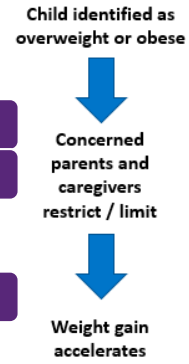

Image adapted from Skelton, 2022

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Ellyn Satter's Division of Responsibility: non-restrictive "weight management"

Dietitian specializing in weight loss in early career

- Defeated by weight cycling, patient feelings of failure
- Noted increased EDs from dieting "failures"
- Later attended graduate school for family therapy

Developed approach to feeding children using parenting styles, feeding dynamics, and child development.

- ***Feeding dynamics (FdSatter)***
- ***Eating competence (EcSatter)***
- ***Trust Model (vs. deficit model)***

www.ellynsatterinstitute.org

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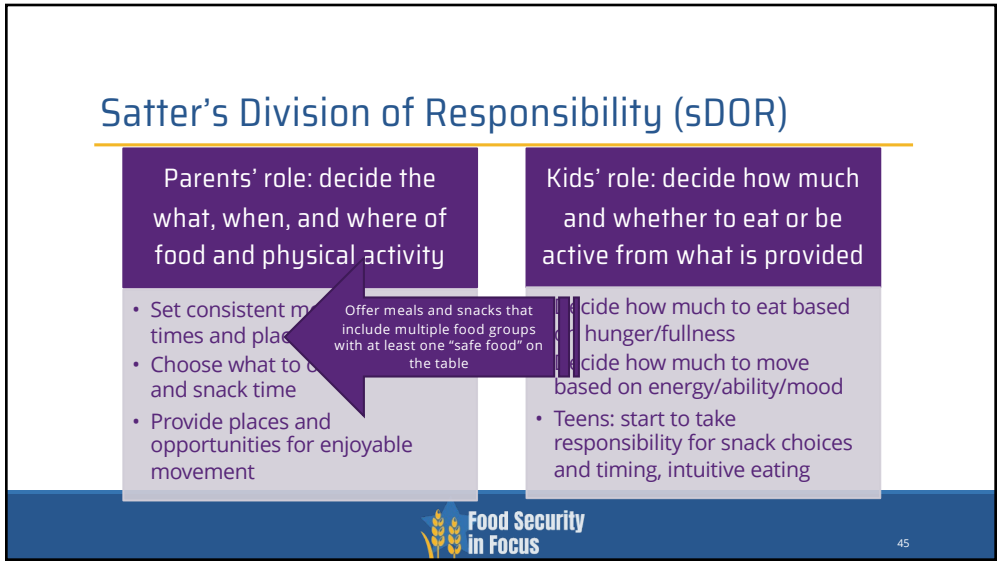
Satter's Division of Responsibility (sDOR)
Parents' role: decide the what, when, and where of food and physical activity
Kids' role: decide how much and whether to eat or be active from what is provided
Offer meals and snacks that include multiple food groups with at least one "safe food" on the table
Set consistent m
times and plac
Choose what to
and snack time
Provide places and opportunities for enjoyable movement
cide how much to eat based
hunger/fullness
cide how much to move based on energy/ability/mood
Teens: start to take responsibility for snack choices and timing, intuitive eating
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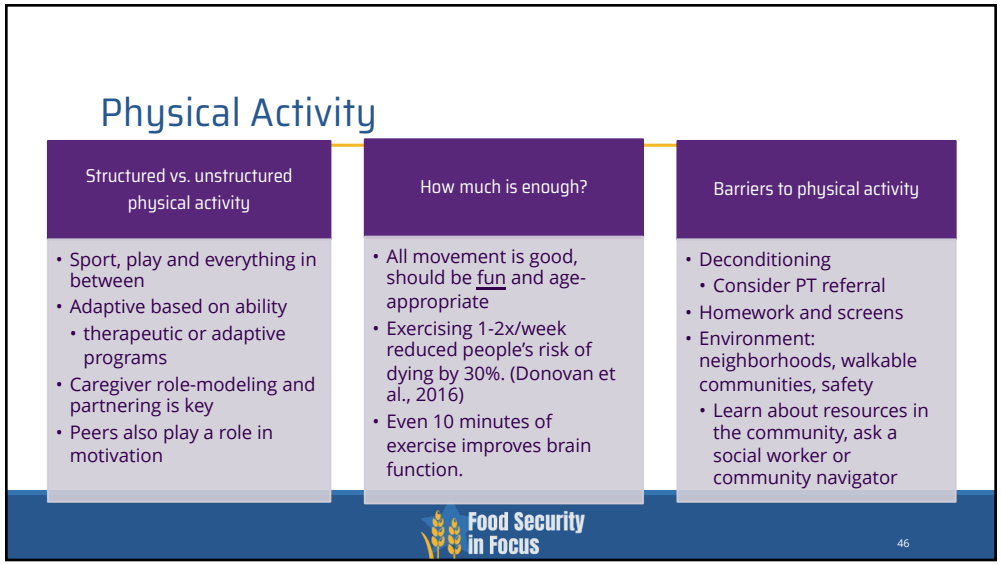
Physical Activity
Structured vs. unstructured physical activity
How much is enough?
Barriers to physical activity
Sport, play and everything in between
Adaptive based on ability
therapeutic or adaptive programs
Caregiver role-modeling and partnering is key
Peers also play a role in motivation
All movement is good, should be fun and age-appropriate
Exercising 1-2x/week reduced people's risk of dying by 30%. (Donovan et al., 2016)
Even 10 minutes of exercise improves brain function.
Deconditioning
Consider PT referral
Homework and screens
Environment: neighborhoods, walkable communities, safety
Learn about resources in the community, ask a social worker or community navigator
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The "Overweight" Child
Guide parents to:

Avoid
- Try to get child to eat less
- Restrict certain amounts/types of food
- Control portion size
- Push low calorie or "healthy" food
- Give "the look"
- Ask "should you really be eating that?"
- Pressure or hover
- Participate in diets, weight talk, teasing
- Force exercise

- Eat family meals as able (in car is option)
- Include regular time for connection through movement

Slide info credit: ©Nutrition4ALLBodies, LLC
Ellyn Satter Institute

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QUESTIONS?

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Poll: What percent of children with obesity also have depression?

A: 5%

B: 10%

C: 20%

D: 30%

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Poll: What percent of children with obesity also have depression?

A: 5%

B: 10%

C: 20%

D: 30%

Almost one out of ten children with obesity were found with depression. Compared with "normal" weight children, children with obesity were 32% more likely to have depression (Kanellopoulou et al., 2022)

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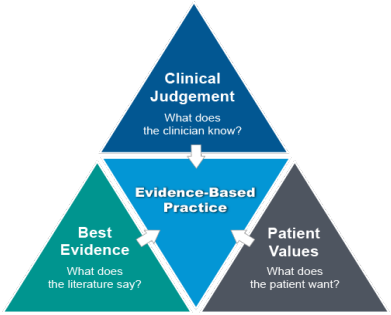
Evidence Based Practices for Depression

- Cognitive Therapy
- Behavioral Activation (BA) Therapy
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Family Therapy
- Interpersonal Therapy (IPT)
- Mindfulness Based Therapy
- Psychodynamic Therapy
- Emotion Focused Therapy (EFT)
- Play Therapy
- Social Emotional Learning (SEL)



Medical News Today, n.d.

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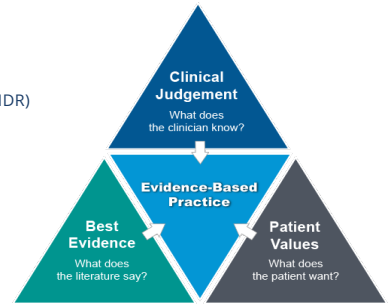
Evidence Based Practices for Anxiety

- Cognitive Behavior Therapy (CBT)
- Exposure Therapy
- Acceptance and Commitment Therapy (ACT)
- Dialectical Behavioral Therapy (DBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Interpersonal Therapy (IPT)
- Psychodynamic Therapy
- Art & Music Therapies
- Animal Assisted Therapy
- Family Therapy
- Mindfulness Based Therapy
- Play Therapy
- Social Emotional Learning (SEL)



MA & MD, n.d.
Medical News Today, n.d.

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Social Ecological Model Levels of Help

In order to thrive and survive, help goes beyond what the individual can do.

It takes the work and help of the community, organizations, and government.

Brown, n,d.

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Individual Interventions

- **Knowledge**
- **Attitudes**
- **Access**
- **Capacity**
- **Behaviors (participation, execution)**

- Knowledge of community resources
- Grow own fruits and vegetables
- Local food pantries
- Farmers markets
- Nutrition and mental health workshops/education
- Community meal programs
- Backpack programs
- Peer mentoring
- Physical activities/classes
- Supplemental Assistance Program (SNAP), (Women's, Infants and Children Program (WIC)
- Groups (therapeutic, informational, prevention)
- Professional providers (doctor, counselor, social work, case managers, etc.)

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Organizational Interventions

- Church
- School and childcare centers
- Community centers
- Library
- Backpack food programs
- Meal programs
- Farmers Market
- Food pantry
- Primary care facilities
- Employment

Why Hunger works to remote community-based solutions that can improve food security, economic justice, and self-reliance

Child and Adult Care Food Program in Emergency Shelters helps individuals and families in the event of an emergency, including immediate worries related to food insecurity

The Meals on Wheels Association of America has connections with local mental health resources in the area

Feeding America food network that consists of more than 200 regional food banks

Mental Health Services

(Sunshine Behavioral Health, 2022)

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Public Policy Interventions

Funding

Federal Laws create changes and provide oversight across the states

States make decisions about their mental health systems

- SNAP
- WIC
- Food Prescriptions Programs
- Older Americans Act
- Americans with Disabilities Act (ADA)
- Rehabilitation Act
- Mental Health Parity and Addiction Equity Act (MPHAEA)
- Affordable Care Act (ACA)
- Mental Health Block Grants (MHBG)

(Mental Health America, n.d.)

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Putting it all together

- Ask permission to talk about health habits before jumping in.
  - Ask if it is a good time in their life to discuss these things. Honor their autonomy.
- Encourage small changes, one step at a time. Allow families to choose where they want to begin.
- Acknowledge weight stigma, the role of genetics in body size and encourage health habits for the sake of well-being, addressing barriers first.
- Prioritize routine, connected meals and Division of Responsibility with food and movement rather than pressuring children to eat less by portion control or counting calories.
- Help families to find fun ways to play and move together in support of health rather than weight loss. This can improve relationships and communication about food and movement.

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Putting it all together

- Food insecurity and poor mental health are interconnected challenges that are often impacted with other socioeconomic factors
- Collaboration with others to create spaces and opportunities to address mental health needs along with other social determinants of health
- Individuals can get involved in various levels (individual, community, organizational, policy/government)

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Case Study Mental Health and Dietitian Perspective

- 13-year-old bi-racial female
- Lives with mom, 3 younger siblings
- 8th grade, multiple absences, failing grades
- Family context- mom unemployed, low food supply last several days of the month each month
- Talks to friends online, isolates self at home, does not spend much time outside of home
- Unhealthy lifestyle (patient perspective)
  - Poor sleep hygiene, missed meals, erratic eating pattern
- History of suicidal ideations and self-harm, depressive moods, low motivation, problematic family interactions physically aggressive w/ mom, sneaking food, unclean room, using the bathroom in her room, showers once a month

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Case Study- Mental Health and Dietitian Perspective

Problem
- No active suicidal ideations
- Low motivation (mental health perspective)
- Desire to have a healthier lifestyle (dietitian perspective)

Plan
- Walk 20 minutes a day daily
- Patient confidence rating 7 (1-10)

Next Steps
- Patient to work on plan
- Patient to return for scheduled BHC visit in 1 week
- Patient to return for nutrition visit in 1 month

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Thanks for joining us!

Questions?

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Upcoming Event

The Importance of Nutrition in Breast Cancer Survivorship

Wednesday, October 25, 2023
11:00 am - 12:00 pm EST

This webinar provides information on nutrition and lifestyle issues that can arise during breast cancer treatment and survivorship.

Continuing education credits will be available for this session!

EVENT PAGE:
https://oneop.org/live/154525

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Continuing Education

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- 1.0 CE credits from the **University of Texas at Austin Steve Hicks School of Social Work** for Social Workers, Licensed Professional Counselors and Licensed Marriage and Family Therapists.
- 1.0 clock hours from the **Commission for Case Manager Certification** for Board-Certified Case Managers.
- 1.0 CE credits from the **National Council on Family Relations** for Certified Family Life Educators.
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