

OMA Child Health Committee

The physician role in helping adolescents with the social and psychological consequences of obesity

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“There is no doubt that obesity is an undesirable state of existence for a child. It is even more undesirable for an adolescent, for whom even mild degrees of overweight may act as a damaging barrier in a society obsessed with slimmness.” Hilde Bruch, 1975¹

A 13-year-old girl arrives at her doctor’s office after having not been seen for about a year. She is now “chubby,” and complaining of abdominal pain. Her menarche was about a year ago. She seems to have changed from an outgoing, carefree girl to a shy, sensitive, and somewhat isolated girl. Her mother noticed that after completing a school project on nutrition, her daughter has been refusing to eat breakfast.

Questions for the treating physician

- ▶ Given the history, what are your concerns about this child?
- ▶ How will you manage this case?

For the physician treating children or adolescents who are considered overweight or obese, there are two important tasks to complete:

1. Distinguish the social and psychological consequences of being a “fat” child in a thin-obsessed society from any actual health risks related to body fat.
2. Provide practical advice on how to deal with each of these issues.

Social and psychological consequences of obesity

By reinforcing the view that it is shameful to be “fat,” our society sets up children and adolescents who have higher weights to become the targets of attack by their peers.

Indeed, a recent Canadian study noted that the social consequences of being seen as an obese child or adolescent include: being liked less by peers; being rejected by peers; and being subjected to various forms of aggression, for instance bullying, by peers.²

Bullying can target relationships through exclusion and withdrawal, or by spreading rumors and lies; or it can take more obviously aggressive forms like hitting, kicking, and pushing, or teasing and name-calling.³

While girls generally use relational forms of bullying, and boys generally use overtly aggressive forms of bullying, both types of bullying against fatter children and youth were elevated among young people involved in the Canadian study.⁴

Overweight and obese girls and boys aged 15 and 16 were also more likely than average-weight teens to perpetrate certain bullying behaviours, specifically making fun of others because of race, colour, or religion.⁵

Those who are socially vulnerable to being dominated may look for other socially vulnerable individuals to dominate.

Effects of weight-related bullying on social and psychological functioning

For girls, the consequences of having an unpopular body size begin early. Preadolescent overweight girls, but not boys, have more depressive symptoms than average weight girls and boys. Children of this age need the approval of their parents and other adults in their lives.

Given the intense cultural pressure on parents to have slim daughters, mothers and fathers may communicate negative judgments of their daughters' weights, possibly contributing to depression among these vulnerable girls.

In the context of the unrealistic body ideals for females that dominate our media, parents may also be unaware that weight gain just prior to puberty is part of the body's preparation for menstruation, and not an indication of poor health or future body size.

Just as parental approval is most important to developing self-esteem in pre-adolescence, peer approval is very important to the development of self-esteem in adolescence.⁶

Teens who fall into the overweight and obese categories (especially girls) have been shown to experience decreasing self-esteem and elevated levels of loneliness, sadness, and nervousness in the years leading from childhood to adolescence.⁷ They are also more likely to engage in high-risk behaviours like smoking and drinking.⁸ It would seem that as peer opinions take a more predominant role, the effects of bullying are more pronounced.

Studies from many countries have documented the effects of bullying on the lives of children and adolescents. Frequent bullying is associated with sleep difficulties, bed wetting, psychosomatic symptoms like headaches and stomach aches, anxiety, fear of going to school, low self-esteem, depression, and severe suicidal ideation.^{9,10,11}

Depression and severe suicidal ideation are most common among those who are both being bullied and perpetrating bullying.¹²

In this context, physicians may feel pressured to prescribe weight loss to their young patients who have higher weights, without appropriate prior screening.¹³ There are good reasons to resist this pressure.

While weight loss may be one useful focus for people whose obesity is the cause of physical disability, it is not useful more generally, and especially not with children and adolescents. This is because focusing on weight loss carries the risk of creating new problems: it generally leads to dieting, which is both ineffective and conducive to depression, and may increase the risk of subsequent eating disorders, including anorexia, bulimia, and binge-eating disorder, as well as sub-threshold variants of all three.¹⁴

In addition, because children and adolescents have not yet reached their full height, weight loss efforts undertaken by them may inadvertently interfere with their growth potential.

Dieting

While the data on dieting for adults consistently shows that dieting leads to weight loss followed by weight regain, there is less research on the effects of dieting on children and adolescents.

However, a recent prospective study of 8,203 girls and 6,769 boys (ages of nine to 14 at the start) over three years, showed that dieting is worse than ineffective for our youth.

Both frequent and infrequent dieters gained more weight over the course of the study, than did non-dieters. Dieters were significantly more likely than non-dieters to binge, and bingeing was a significant predictor of weight change.

When they were not bingeing or overeating, dieters were eating fewer fats and more carbohydrates than non-dieters. Even though dieters in the study were more physically active than non-dieters, they still ended up with higher weights.¹⁵

Other studies underline the risks of dieting for adolescent girls. Weight control attempts of adolescent girls, observed over a four-year period, actually predicted onset of obesity. The risk of obesity was 324 per cent greater for self-labeled dieters than for non-dieters, even after controlling for baseline obesity levels.¹⁶

Body dissatisfaction in combination with dietary restraint has also been found to be associated with depression, delayed puberty, and with decreased intake of calcium-rich foods, which can contribute to the development of osteoporosis.¹⁷

For adolescents in particular, dieting is neither effective in producing weight loss nor free of other serious risks. It can contribute to depression, eating disorders, and weight gain.

Distinguishing health improvement from the project of achieving the dream of thinness

Many people with higher weights are talented and productive contributors to society who have no significant health risks associated with their body size. Yet western and westernized societies tend to associate valued personal and social characteristics with thinness and reviled or devalued personal characteristics with fatness.

For instance, fat is associated with laziness, gluttony, disorganization, and lack of self-control, and tends to elicit a reaction of disgust.

Thinness, on the other hand, is associated with attractiveness, success, self-control, and virtue, and tends to elicit a reaction of approval.

Historical and cross-cultural studies show that at other times and in other places, fat has been associated with things like wealth, health, happiness, and conviviality.

All of these historical-bound or culture-bound and emotion-based associations are irrational. Yet, the current associations contribute to the judgment that every person with a higher weight should try to become thinner — whether the individual is at risk of ill health related to body fatness or not.

When patients try to lose weight, they are likely focusing on becoming thin as fast as possible, hoping that their self-esteem and social standing will increase, rather than focusing on improving their health. Their efforts are more likely to result in decreased health.

Case study

Effective history-taking will mean asking questions of both parent and child together and individually. Appropriate questions will include asking about:

- ▶ Their impressions of when the abdominal pain started (consider the possibility that physical symptoms such as abdominal pain may be related to teasing or bullying).
- ▶ When they noticed that the daughter stopped eating breakfast, and asking the daughter what she learned in her school project on nutrition (rule out connection between the school project and initiation of dieting to lose weight).
- ▶ Why the daughter has stopped eating breakfast, what she eats at lunch time and at supper .
- ▶ Whether the daughter is involved in any sports or if she plays games at school: “What do you like to do after school?” (assess physical activity level).

- ▶ Why the daughter thinks her mom says she seems more shy and sensitive than before (assess emotional state/possible bullying or social problems at school).

Communication tips for physicians

In a weight pre-occupied adolescent who is healthy, it is important to choose reassuring language when discussing the adolescent's growth and pubertal development. For example:

- ▶ "You seem very healthy to me. Your body is changing as you grow and go through puberty. Are you worried about any of the changes you notice in your body?"

Focusing on normal body changes in size and shape, rather than weight, allows the adolescent to express concerns with body image and to ask questions.

- ▶ "Teenagers tend to be very busy. Do you have time to include exercise or physical activity in your schedule?"

An open-ended statement like this communicates the concept of a healthy active lifestyle and allows a patient to communicate possible barriers to physical activity.

- ▶ "It is important to eat in a healthy way. Do you eat a variety of foods regularly?"

Clinicians should avoid categorizing foods as good versus bad foods (healthy versus unhealthy foods), keeping in mind that even so-called "junk foods" are fine in moderation. Clinicians should encourage adolescents who have an unhealthy pattern of eating to make manageable small changes that shift the pattern to a healthy one, rather than engaging in temporary restrictive or "fad" diets.

Communication pitfalls

While it is important to provide guidance for healthy diets and active lifestyles, it is important for physicians to avoid using language that may be misinterpreted by adolescents and lead to concerns about their weight or body image. For example:

- ▶ "Your height and weight have increased quite a bit since your last check-up, but I'm not worried."

Adolescents and pre-adolescents can be very conscious about the changes their bodies are experiencing. A normal growth spurt can lead to significant anxiety for teens and by focusing on growth parameters, the physician can add to a patient's preoccupation with their weight or height.

- ▶ "Be careful about what you eat because obesity is becoming a big problem for our society."

In a child who is not at risk of being obese or overweight, it may be disadvantageous to use words like overweight or obese, even in a general sense. Many adolescents who are a healthy weight believe erroneously that they are overweight, and fear becoming obese as they grow older.

If you hear:

- ▶ Parents are worried — take it seriously. Do a full physical exam.
- ▶ That a young person is particularly cold — take it seriously as it may be an indicator of significant weight loss.

- ▶ About sudden worsening of the dentition, consider the possibility that the patient is vomiting (bulimia).

These may all be early indications of the development of an eating disorder.

Conclusion

Through careful assessment, physicians can distinguish which of their higher weight patients are at risk of ill health related to body fat and which are not.

Physicians can help young patients and their parents distinguish the need to address body fat-related health issues from the project of achieving the “dream of thinness.” Even those patients whose health risks indicate a need for weight-management should be advised to avoid dieting.

Patients in both categories should be helped to resist believing irrational ideas about fatness, no matter how prevalent these ideas are.

Children and adolescents who have higher weights are likely to be suffering from the psychological effects of being targeted by bullying and harassment by both peers and adults in their lives. They may still benefit from family education and/ or individual counseling to help counteract the effects of bullying.

Physicians have an important role to play in decreasing the burden being carried by these young people.

Recommendations for Physicians Treating Overweight or Obese Children or Adolescents

- ▶ Avoid reinforcing cultural prejudices about fat, regardless of the patient’s weight or medical status.
- ▶ Focus on empirical results, e.g., cholesterol, LDL/HDL blood work, to assess presence of, or risk for, disease (do not say: “You’re at high risk for a heart attack because of your weight”). Patients and their families need real assessments of their health, and they need helpful resources to make changes to the factors that matter and that they can change (e.g., activity and what they eat).
- ▶ For children or adolescents who are healthy and have higher than average weights, assist the family in helping their child to accept his or her weight.
- ▶ Determine if obesity is unrelated to lifestyle choices, i.e. hypothyroidism, polycystic ovarian syndrome, depression, medication side-effects
- ▶ Focus on current state of health (do not say: “You’re overweight and at risk for”)
- ▶ Determine whether overeating and weight gain may be abuse-related — some patients use food and weight gain as coping strategies to deal with abuse.
- ▶ Determine the barriers to healthy eating and activity, e.g., low income, inadequate housing or cooking facilities, and sign the Special Diet Allowance form if applicable; provide information on assistance programs for children’s sports programs or free opportunities (parks, walking trails, food banks, etc.).
- ▶ Provide reliable healthy eating and physical activity information using Health Canada materials.
- ▶ Discourage use of herbal or over-the-counter weight loss pills; discourage restrictive diets.
- ▶ If needed, help the family to help their child or adolescent by increasing healthier food choices and increasing friend or family-oriented physical activities.
- ▶ If bullying is a problem, there are many websites and school programs that have suggestions for professionals, parents, and children about how to deal with bullying behaviours.

- ▶ Children and adolescents who are being bullied or are bullying may also benefit from counseling.

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