Childhood Obesity

Conducting a Psychological Assessment

Caroline Braet

Prof. Dr. Caroline Braet is a Psychologist and Professor at Ghent University who specialises in childhood obesity. She has been a founding member of ECOG since 1992.

She is scientific supervisor in the obesity treatment center ‘Zeepreventorium’ and participates in national working groups on pediatric obesity.
Learning objectives

This course should allow you:

- To distinguish between the various psychological pathways leading to overeating
- To be able to identify them, measure them and explain them to a given child or adolescent and its family
- To stipulate an adequate treatment plan
Description of the course

This course allows a caregiver **to consider:**

- the range of psychological processes, observed in children or adolescents with obesity
- a step by step assessment of the individual problem embedded in a family context
- personalized interventions
- following up the patient towards realistic and lasting objectives regarding weight and lifestyle changes.
OBESITY

intake > expenditure + genetic sensitivity

psychological factors

Role of individual factors

Role of the environment
1. Some children with obesity make efforts to control their weight through dietary restraint

2. Some children with obesity are prone to emotion-driven eating

3. Some children with obesity have no problems but…

   → their weight and eating patterns may be impacted by factors in their immediate family or peer environment

4. Some children with obesity display specific temperamental traits
1. Some children with obesity make efforts to control their weight through dietary restraint
2. Some children with obesity are prone to emotion-driven eating
3. Some children with obesity have no problems but...
   → their weight and eating patterns may be impacted by factors in their immediate family or peer environment
4. Some children with obesity display specific temperamental traits
overweight

dieting / restrained eating

low self esteem

binge eating

overweight

Social pressure

breakdown

How to measure?

• “Do you sometimes consciously try to limit, restrict or cut back the overall amount of food that you eat because you think this is better for your weight?”

• → Restrained eating

• “Do you sometimes experience loss of control?”

• → Binge eating

Questionnaires (8-18 years):

Eating styles (DEBQ, EDE-Q or EDE-interview):
Restrained eating? Binge eating?

Please check:
compensatory behavior, typical for Bulimia Nervosa?

See: Decaluwé et al (2003); Braet et al. (2007; 2008)
EATING QUESTIONNAIRE

Instructions: The following questions are concerned with the past four weeks (28 days) only. Please read each question carefully. Please answer all of the questions. Thank you.

Questions 1 to 12: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days) only.

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Observation or Diary:

• “How much do you eat every day?”
• “Do you sometimes skip meals or breakfast?”

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• 2. Some children with obesity are prone to emotion-driven eating
• 3. Some children with obesity have no problems but… their weight and eating patterns may be impacted by factors in their immediate family or peer environment
• 4. Some children with obesity display specific temperamental traits
How negative mood induces emotional eating (due to emotional problems)

How to measure?

“Do you sometimes eat snacks when you are feeling alone, stressed or bored?”

Please check:

is the child using psychotropic medications?

Observation or Diary:

“Why do you eat: is it due to hunger, or not?”

Questionnaires (8-18 years):

Self-worth

- global, physical appearance, social

Internalizing problems

- emotional problem-scales
depressive symptoms?, unhappy?, sleep? DSM-psychiatric disorders? Total mental illness?

Eating styles

- emotional eating?

When interested in the cause of the problems, a variety of screening tools could be administered: e.g. history of bullying, trauma, ASS, life-events, ...

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Case-Study
STEVE, 12-year old boy

• Overweight: 83%
• Only child
• Parents do not agree with how to support child with weight and eating
• Prefers carbohydrates and sugary foods

Note: It is common for families to have conflicts. However, if parental relationship is poor, this may impact how they parent their children.
Questionnaires (8-18 years):

1. Self-worth
2. Internalising emotional problem-scale
3. Eating styles
   (emotional or restrained eating?)

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## Eating Questionnaire (EDE-Q)

### Restraint (R) and Eating Concerns (EC)

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<tr>
<th></th>
<th>1-R</th>
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<tbody>
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### Weight Concerns (WC) and Shape Concerns (SC)

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<tr>
<th></th>
<th>11-WC/SC</th>
<th>12-WC</th>
<th>23-WC</th>
<th>24-WC</th>
<th>25-WC</th>
<th>26-WC</th>
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<tbody>
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Restraint score is based on 5 items

1 – R 0 1 2 3 4 5 6
2 – R 0 1 2 3 4 5 6
3 – R 0 1 2 3 4 5 6
4 – R 0 1 2 3 4 5 6
5 – R 0 1 2 3 4 5 6

Total score: ranges between 0 and 30
Mean score: Total score/5
Mean score: max: 6, min: 0
Psychology?

- Eating habits
  - Caloric intake
    - Genetic aspects
      - Protest & behavioral problems
        - Low energy-expenditure
          - Reactions parents/peers

- Restrainted eating
- Social contacts?
No emotional problems

<table>
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<th>Internalizing Problems</th>
<th>Externalizing Problems</th>
<th>Total Problems</th>
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<tbody>
<tr>
<td>Total Score</td>
<td>7</td>
<td>25</td>
<td>64</td>
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<tr>
<td>T Score</td>
<td>58</td>
<td>69-C</td>
<td>65-C</td>
</tr>
<tr>
<td>Percentile</td>
<td>79</td>
<td>97</td>
<td>93</td>
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B = Borderline clinical range; C = Clinical range

Broken lines = Borderline clinical range
external eater
family traditions
education strategies?
emotional eating?

social contacts?

restrained eating

protest & behavioral problems

eating habits

caloric intake

low energy-expenditure

genetic aspects

reactions parents/peers

OBESITY
• 1. Some children with obesity make efforts to control their weight through dietary restraint
• 2. Some children with obesity are prone to emotion-driven eating
• 3. Some children with obesity have no problems but... their weight and eating patterns may be impacted by factors in their immediate family or peer environment
• 4. Some children with obesity display specific temperamental traits

Mechanism?

How parent/child interaction can induce emotional eating and prevent the child learning good self-regulation

Parent child conflicts $\rightarrow$ Maladaptive emotion regulation $\rightarrow$ Emotional eating (EAH-C)

$** p < .01; * p < .05$
How to measure?

“Does the family complain that this child is difficult to educate?”

Parenting behaviour during mealtime?

Discuss:
• Being consequent?
• What if too permissive?
• What if over-controlling?
The Mealtime Interaction Coding System can be used to rate video-taped parental practices at real mealtime (or during role-play):

Ratings for Parental ‘Control’ and ‘Support’

- ‘Behaviour Control’
- ‘Interpersonal Involvement’

See: MICS; Dickstein, Hayden, Schiller, Seifer & San Antonio, 1994)
Questionnaires (8-18 years):

1. How are the **parental feeding styles** (parenting)?
2. **Parental problems** because of parenting stress, depression and other mental health factors....
3. **Socio-economic** background information

See:
Parenting?

Extra psychological treatment?

Pure Negative Affect

Mixed Restrained Negative Affect Subtype

Intensive treatment

Standard treatment
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Dual pathway model

Bottom up ‘drives’

Temperament « hot system »

DRIVE & FOOD APPROACH

Top down 'control'

Brain « cold system » INHIBITION PROCESSES

Bottom up 'drives'

Temperament « hot system » DRIVE & FOOD APPROACH

How to measure?

• “Do you sometimes struggle to resist the urge to eat after you have seen or smelled food?”

Impulsive eating, not driven by hunger:

1. **Eating Style** (External Eating)
2. **Temperament** (Response Reward /Behavior Approach Scale)
3. **Brain functions** (Power of Food Scale)

Low Inhibition:

1. **Eating Style** (low Restrained Eating)
2. **Temperament** (Behavior Inhibition Scale)
3. **Brain functions** (Self Control Scale, BRIEF)

To conclude: several psychological profiles

Disinhibited eating
Parenting?

Extra psychological treatment?

Pure Negative Affect
mixed
Restrained Negative Affect Subtype

Retrain your brain
Brain games?

Standard treatment

Intensive treatment
To conclude: several psychological profiles

Discussion

- Make a psychosocial profile of the child (and family)
- Develop stepped care approach
- Do some subtypes have a different developmental trajectory/outcome?
- Do we need specific questions for adolescents prior to
  - treatment (e.g. self-efficacy?, beliefs?, social network? barriers?)
  - surgery? (e.g. quality of life?)

Questions

1. A child with overweight:
   - You always have to evaluate if there is a binge eating problem
   - Only when the child has high restrained attitudes, consider binge eating
   - Binge eating will be observed mostly in the most severe group (severe obesity)

2. When a child suffers from emotional eating:
   - You always have to evaluate if there is a family problem
   - Consider first which emotions are negative and where they come from
   - You do not have to handle them, as it is the result of stigmatisation that will stop if the child lose overweight
3. Compared with restrained eaters, emotional eaters will need:
   - More psychological help
   - Less psychological help
   - Both need equal psychological help

4. What is most evidenced so far:
   - Childhood Obesity is always an expression of family problems
   - Childhood Obesity is always an expression of family habits
   - For each child you have to assess whether there are family issues (or not)

5. When facing an 8 years old child that can not resist food:
   - You hope that it will improve as they are still young or immature
   - You advice the family to limit the food in the house
   - You recommend specific inhibition training
Present ppt is based on:

BARI-AD: Leitlinien-basiertes Interview als Grundlage psychologischer Stellungnahmen vor einem Adipositas-chirurgischen Eingriff bei Adoleszenten

Elisabeth Ardelt-Gattinger¹,²; Erich Gattinger⁴; Barbara Andersen²,³; Karl Miller²,⁴,⁵; Christoph Kreuzer²,¹³; Markus Meindl¹; Roman Metzger⁶; Susanne Ring-Dimitriou²,⁷; Wolfgang Siegfried⁸; Louisa Studtmann¹; Martin Wabitsch⁹; Sylvia Weiner¹⁰; Johanna Brix¹¹,¹²; Daniel Weghuber²,¹³
Subtyping Children and Adolescents Who Are Overweight: Different Symptomatology and Treatment Outcomes

Caroline Braet and Wim Beyers
Ghent University

Children and adolescents who are overweight are a heterogeneous group. Whether pretreatment characteristics, such as dietary restraint and psychopathology, are related to differential treatment outcomes was not studied before. Using cluster analysis, the authors of this study examined the validity of subtyping along dietary restraint and internalizing psychopathology in 2 independent samples of treatment-seeking children and adolescents who were overweight (Study 1: n = 200; Study 2: n = 120). Three subtypes emerged: a dietary restraint/internalizing (DR/IN) group, a pure internalizing (IN) group, and a nonsymptomatic (NS) group. The DR/IN subtype showed more problems than the NS subtype, with complete consistency across the 2 studies for 1/4 of the validating variables. Although total weight change was not different across subtypes, compared with NS, the DR/IN and IN subtypes had a less positive weight prognosis during follow-up. Restraint scores only showed increases over time in the initially low-restraint IN group. These findings suggest that individual characteristics, such as degree of dietary restraint and internalizing psychopathology, can be useful in (a) classifying children and adolescents who are overweight, (b) stipulating specific treatment guidelines, and (c) making differential prognoses.