Most Tender Balance: Behind-the-Scenes Treatment of Children and Teens with Obesity

Your child is overweight and you don't know what to do… everything you try seems to backfire.

This article is designed to help parents and practitioners understand **the ways parents can effectively aid a child or adolescent in dealing with a weight problem** even if the young person is not directly involved in treatment.

The growing epidemic of obesity among children and adolescents demands that clinicians develop increasing expertise in helping these young people. When professionals attempt to intervene to combat overweight or obesity, they must move cautiously to avoid triggering eating-disordered behaviors such as overeating or under eating. More child-friendly interventions are in order. This paper explores the intervention approach I call working behind-the-scenes.

Just as lighting and stage crews collaborate with costume and makeup artists to create the scene for a dramatic performance, behind-the-scenes work with the appropriate professionals allows parents to play a key role in shaping the drama of their child's life and health. A primary advantage of the behind-the-scenes method is that the child can often be left out of treatment proper, yet ultimately benefit from treatment.

The most important aspect of any successful treatment, including behind-the-scenes work, is first viewing the young person in a multifaceted, holistic way. I use multi-modal treatment for treating children and adolescents with obesity and weight management issues. This process involves soliciting viewpoints from practitioners such as the physician, dietician, and psychotherapist. Through such a partnership, more child-friendly interventions can be designed.

However, multi-modal treatment also includes participation from the other very important members of the team, the parents. As Virginia Satir wisely told us years ago, the parents are the architects of the family[1]. In behind-the-scenes work, I work comprehensively with the whole family. Individual treatment, which can be very useful at times, and even the treatment of choice for some, unfortunately can sometimes result in minimal consideration for a young person's surroundings and home life. For example, when Hannah talked to her therapist about her home life, she gave the impression that the family rarely ate meals together. When the therapist interviewed Hannah's parents, she learned the family ate together three times a week, though Hannah often begged to be excused from dinner. The exciting family-oriented Maudsley approach, which treats anorexic children and teenagers under the age of 18 living at home, employs this parental power in a very proactive way. It has achieved impressive results for anorexia nervosa.[2] Behind-the-scenes work also attempts to harness parental power to improve the child's health.

I recommend caution when one is considering weight loss for children and adolescents. Weight loss itself could interfere with normal development and growth. For instance, in puberty, when girls are accumulating a good deal of their life time bone mass, a great reduction in calories could cause decreased growth and weaker bones. Whenever possible, I recommend weight maintenance while height increases. It can be useful for a team of multi-modal providers be included in decision-making about weight loss for individuals who are not fully grown and developed.

During outpatient treatment of obese children and adolescents, my goal is to support healthy eating, active living, and size acceptance for all, principles derived from the work of Frances Berg.[3] To accomplish these aims, I harness parental power and work with the multi-modal team (a physician and a dietician in addition to myself, the psychotherapist) to modify the food environment. One practitioner takes the lead and organizes communication channels with the other practitioners and with the parents.

Assuming the psychologist is the lead practitioner, she works with the treatment team and the parents to develop a plan for the entire family for more active living. They explore ways to increase the activity level of the child, if deemed necessary. Then she works with the family to implement the plan and creatively amends it as the process unfolds over time.
A family plan for more healthful eating, which includes building in reasonable amounts of treats and sweets, is developed. Each family's food likes and dislikes, shopping habits and values about food are taken into consideration in developing this plan.

The psychologist also explores parental attachments to dieting. For instance, a father might be into the latest diet fad (or be in rebellion against dieting) and need professional guidance to reconcile this with the desire to help his struggling son or daughter. Child and adolescent weight management is most effective when the entire family improves their eating habits, so that the child does not feel singled out. The psychologist and others on the treatment team can all be instrumental in helping the family to eat in a healthier manner.

The third element of multi-modal treatment involves dealing with the psychological aspects of weight and body. In my experience, the higher the body-esteem, the easier weight management becomes. It is challenging for a child or adolescent who dislikes her body and its size to even consider improving body-esteem. The therapist, dietician and physician can all encourage this position. The therapist can work with the parents to create an atmosphere of size acceptance, which is affirmed as well by the physician and dietician. The child can come to understand that changes can be made for the health of the family, rather than the child being wrong for being overweight. In the end this really is about health. The therapist can help the parents begin to teach the child media literacy (the ability to critique TV shows, ads, etc. rather than taking them at face value, especially as regards dieting and body image).

Additional psychological issues may be at play. These include the child's tension around food, the use of food for after-school gratification, and other dysfunctional uses of food by the child or

family. Even without the child's direct involvement in treatment, the psychologist can help the family deal with these issues in a healthier way. For instance, the therapist may bring to light a parent's own low body-esteem and help him or her with it. This may help the parents develop a healthier perspective on themselves, which would lower tension in the family, freeing energy for them to develop better ways to deal with their child's eating and body esteem issues.

The psychologist and other members of the team can provide input to enhance the treatment process. However, at times, families may not be able to access or afford several members of the treatment team. They might work only with the physician, dietician, or therapist, with perhaps infrequent visits to other team members. In this case, the team member who is the primary contact will work with the whole range of elements as well as possible, while networking with the others on the treatment team for consultation and joint planning.

I have seen very successful outcomes from behind-the-scenes interventions. However, at times, it is important that the child be in session with parents and speaks with the practitioner. This can be the case when behind-the-scenes treatment is providing insufficient information, or the child expresses an interest in meeting with practitioners for direct help. Similarly, in some situations working with the child directly may be the treatment of choice, especially if the patient is an older teen. Teens may want to be included in order to "have a voice", and some may do better with their own therapy which includes occasional family meetings. On the other hand, some teens may be so resistant to psychotherapy or other treatment that a behind-the-scenes approach is the only avenue available to concerned parents. Each situation must be evaluated on a case-by-case basis, and re-evaluated as treatment progresses to see if it is effective.

Here are some examples of behind-the-scenes work.

Ten-year-old Ethan

Ethan is the son of divorced parents. The pediatrician felt that Ethan was overweight and his mother, Danielle, agreed but she had not been able to successfully help him with his weight. The pediatrician referred Danielle, his dad, and stepfather to me for help.

When Danielle called to make the appointment, she explained that Ethan lived in two different homes, and she felt the different eating styles were contributing to his weight problem. I learned that she had been very frustrated in trying to help him with his weight and felt that she was out of options. Her friend's teenage son had an eating disorder and she was really frightened that pushing Ethan to eat less might create one in him. I asked Ethan's parents and step-parent to come without him to examine the big picture.

At the first session, Ethan's biological father, Ray, expressed surprise and annoyance that Ethan was left out of the initial visit, but as the visit progressed, he began to see how important it was for the parents to first understand their own goals and feelings. It emerged that Ray was also threatening Ethan with "having to go see a shrink if he didn't watch what he was eating and start exercising." Ray angrily complained that he had bought Ethan an expensive bike but he wasn't

using it — instead, Ethan preferred playing video games.

Ethan's stepfather, Steve, had several medical problems and had struggled with his weight all his life but currently was doing well going to the gym during the week. However, he had trouble controlling his eating and sticking to his food plan. Ethan's mother, Danielle, was a petite woman who was currently helping her husband, Steve, to follow a high-protein diet, which changed the usual type of food and snacks available in their household.

With three parents involved, each with a different relationship to food, eating, exercise, and weight, there was a lot to sort out.

At the first meeting, I focused on two issues: What factors contributed to Ethan's eating and exercise patterns, and what were the parents' expectations?

One issue was that Danielle had eliminated all the snack foods with carbohydrates from her household. This meant that Ethan consumed a reduced-calorie diet during the week, providing insufficient calories to support his growth. At Ray's house, with unlimited access to carbohydrates, Ethan hoarded food and overate.

Also, Ray worked at least six days a week, and sometimes part of Sunday morning. He expected Ethan to play on his own, but Ethan didn't have many friends in that neighborhood, so he stayed in and snacked. A plethora of candy wrappers in the wastebasket told the story of his after-school purchases. In addition, Ray expected Ethan to just gain control of the situation and do something about being fat.

My first job was to get Ethan off the low-carbohydrate diet his mother, Danielle had put the family on. I emphasized to the parents the importance of a balanced diet and how restrictive eating often leads to over eating.

The next item I tackled was exercise. I worked with Ray on his expectations for Ethan, and helped him to understand that expecting him to exercise alone was not realistic for a boy of Ethan's age. During the next two sessions, family-based plans were developed for each household. Ray decided on a Sunday family walk. Steve interested Ethan in the idea of a karate class. Danielle worked to enroll Ethan in the class, and the other parents agreed to support this emotionally and practically through driving Ethan to class regardless where he was staying.

Ray and Danielle's parental guilt about the divorce also came to the fore. Ray admitted that he felt comforted in seeing Ethan indulging at his house: "It really made me feel good to see Ethan grazing, like he felt comfortable in my house, and like he had forgiven me for the divorce." I encouraged Ray to have several conversations with Ethan about the divorce, and to let go of his own guilt. It was heartwarming to see the other parents help Ray forgive himself. In addition Danielle was able to see how her anger at Ray had stopped her from communicating with him about Ethan's needs. She began to communicate more directly with him.

In the first few sessions, parents reported that Ethan was making no progress. In fact, he was complaining more about being "forced" by Ray to exercise. This makes sense because the parents were just beginning to understand the issues at play and to formulate some initial strategies.

After a couple of weeks of family walks with Steve and Danielle, Ethan began complaining less and even looked forward to the walks, which were often followed by a healthy family lunch at a favorite restaurant. In fact a couple of months later Ethan was the one initiating the walks, and complained if they did not happen.

He was willing to try karate and was a mixture of interested and frightened of looking inept. The parents told him he should try it for a few months and it was up to him if he wanted to continue. The karate teacher was a overbearing and Ethan became uncomfortable. Danielle and Steve tried to work it out with the teacher, but it just was not a match for Ethan. They switched him to another karate school which Ethan liked better and where he made a new friend.

Ethan asked Danielle why she had gotten new (complex carbohydrate) foods. He thought that was very strange and was worried that they could "make Steve sick". He begged his mom to take them away. Steve and Danielle explained that there would be "Steve-friendly" foods for Steve, "Ethan-friendly" foods for Ethan, and "Mom-friendly" foods for Danielle. They could also share and taste each other's special foods and there were tons of foods that everyone liked and could eat. This seemed to calm Ethan down a bit, though he seemed skeptical. As the months went on, he relaxed and got used to the new regime. He sometimes spotted a special "Steve-friendly food" at the supermarket and pointed it out to his mom.

Ethan, too, liked grazing at Dad's house, and food was something he enjoyed sharing with Dad. As Ray encouraged Ethan to eat a healthy after-school snack, he watched Ethan slowly adjust to this. At first Ethan wanted the planned snack plus the grazing, but was told that he needed to wait until dinner; however he could graze on the veggie platter which was on the dining room table. His dad told him that this was so he would not spoil his appetite for dinner, and never mentioned the words "weight, overweight, or overeating". Ethan told his dad that he thought both families were "crazy health nuts".

Though I never met Ethan, I was very pleased to work with him. The work with his parents brought them together for the sake of his health and showed them they could be effective as a team. It also helped them address some old wounds and issues, such as Ray's guilt, that would have only gotten in the way of Ethan's development whether on the level of food, relationships, or on other levels.

I spent about twenty sessions working with Ethan's parents and stepparent. There was also considerable phone contact to help tweak the plan and deal with issues between sessions. After our more intense initial work, I continued to meet with Ethan's parents bi-weekly and then monthly. After that, we met every three months, then every six months, and then as needed, which turned out to be about once a year. As Ethan grew in height, his weight increased more

slowly. He looked thinner and was no longer in the overweight category. His parents and physician were pleased with the many changes that had occurred.

Patients rightly ask, "How long will this take?" Some families do well with three to five sessions with the psychologist. Others families need more support and a greater opportunity to work on family dynamics which are interfering with the child's inability to use food and exercise in a healthy way and to have a healthy body esteem.

Sometimes a child has psychological and social problems which contribute greatly to the obesity. In these cases, parents often need more sessions with the psychologist to help them sort out how much they can do to as a part of the weight management work or if they need to bring in additional resources. These other interventions can be such things as a social skills group or individual therapy for the child.

No matter how few or many sessions constitute the initial treatment, follow-up is key and related to a good long-term outcome. Monthly follow-up sessions often work well for parents. Limited financial resources sometimes prevent families from having the ideal number of sessions, and in this case parents need to speak frankly about this to the psychologist so all can work together to get the most benefit from these more limited sessions.

Sixteen-year-old Jessica

Jessica is a moody high school student who loves art and music. She has few friends and those she has don't last long. Jessica is very shy and really dislikes her overweight body. She spends a lot of time fantasizing about being thinner and how this would bring her more friends, perhaps even a boyfriend, and an easier life altogether.

Her parents had suggested therapy many times over the last five years and even persuaded Jessica to go once or twice. However, Jessica felt she was not getting anything out of it and dropped out of treatment.

When the parents came to see me, they were very concerned and felt that time was running out for them to help Jessica directly, for she was already a junior in high school. In addition, her weight was increasing, though her height was not increasing and her pediatrician was concerned. Jessica's blood pressure was too high and there was a family history of diabetes.

The parents and I devised a four-part plan:

1) Exercise: They would encourage family exercise by walking around their local shopping area to do errands, followed by a visit to a shop Jessica really liked. In bad weather they would walk around the local mall and shop, or see a movie together. These outings were not always enjoyable for the parents or Jessica and so the plan was changed a bit, with one parent taking Jessica out and the other getting a break. They told Jessica that they felt family time was important and getting out of the house was good for them all. They tweaked the plan again and

found that when mom took Jessica out for a manicure and a walk, they both had fun and it presented an opportunity for mom to bond with Jessica.

2) Body-Esteem: Jessica's mom, Bonnie, tendency was to make repeated comments and judgments about bodies and how they looked. Though, Bonnie was never directly critical of Jessica, this was making Jessica feel bad about her own body. I coached Bonnie on the importance of body acceptance and encouraged her to share this value with Jessica through low-key and sincere comments. This improved Jessica's body esteem over time. It gave her mom an opportunity to show her love and concern in a more positive way.

3) Social Functioning: As we talked together, the parents and I came up with the idea that Jessica might benefit from a social skills group. We investigated the groups in the area and found one led by a very experienced social worker who had been leading teen groups for fifteen years. Bonnie and I both interviewed the leader and felt this could be a match for Jessica.

Jessica was reluctant to be in a group "full of losers". The parents were insistent that she try and pointed out to her very frankly that they thought she lacked skills which were necessary for developing friendships and that they wanted her to get these skills before college. Jessica very reluctantly interviewed for the group. She begrudgingly began the group and after a few months, it appeared to her parents that it was helping her. Slowly her friendship patterns evolved. It was two steps forward and one step back, but Jessica was on her way.

4) Food: The parents decided to work on these other levels and to leave Jessica's eating habits as they were for the first few months. They were busy initiating the exercise program and finding the social skills group. When they began to take on the food, the first change they made was involving Jessica in helping to cook a couple of meals a week. Both parents used to enjoy cooking and had done less cooking as their lives had gotten busier. They were able to shop and cook with Jessica who began to be proud of her ability to make some special dishes. They began to go to Farmer's Market with or without her, and began to emphasize more fruits and vegetables in the house.

Jessica's little sister, Emma, was a very athletic girl and though she loved Jessica very much, she was so busy with her friends and activities that they spent very little time with each other. Emma was jealous of the attention Jessica was currently getting and lamented, "She's your little darling. You take her out a lot and you're spoiling her. I never get anything. I don't matter to you. Why should I try so hard when you don't care?" The parents realized they needed to reassure Emma and give her more direct attention. They again invited Emma to go on some of their family outings that she had initially refused to join. They also blended in errands specifically for her. As Jessica's social skills increased, she reached out to Emma and became more of a big sister than she had been in years.

Jessica was able to lose six pounds in the year I worked with the family. This was actually a significant amount since she was still growing. Her blood pressure decreased and her doctor gave her a lot of positive feedback about this. Best of all, from her point of view, she was able to make

and keep friends. She told her parents it didn't have anything to do with the social skills group really but rather, she had just grown up. He parents smiled and congratulated her on her improved social life, knowing all the time that the group and the hard work they put into behind-the-scene work had paid off handsomely.

Conclusions

As a psychologist, I have worked for 20 over years behind the scenes with parents concerned about their children's food, eating, weight and body image. During the first sessions, we map out the problem and begin to develop possible solutions. In the next sessions, we create a game plan which parents begin to implement at home with their child. This game plan is revised in subsequent sessions. New creative ideas are added, while ideas that do not work are subtracted. Working actively together helps parents feel empowered, as they take the reins and see themselves more as teachers trying new strategies with their pupil. This approach is often comforting to parents, for they know that they are doing everything they can without directly involving the child in therapy. It also lays a firm foundation for continuing work the child may need. This could include family therapy, individual therapy for the child, nutrition consultation with a dietician, or ongoing monitoring with the physician.

There are both advantages and disadvantages to every kind of treatment including behind-the-scenes work.

Advantages of behind-the-scenes work include:

1. With professional assistance, the parents are empowered to think and work with their child's issue. This helps increase their sense of competence and build their parenting skills.

2. Once parents learn to more accurately understand and work with their child, they can detect early signs of distress with food or in other areas, and manage minor slip-ups before these become major problems.

3. The child does not meet with practitioners, and thus does not run the risk of feeling like a patient or a sick person.

4. This work also forms a base of parent-practitioner teamwork and trust which can set the stage and facilitate the process if the child needs further treatment.

Disadvantages of behind-the-scenes work include:

1. Practitioners do not have the benefit of understanding the child and her world directly.

2. Some parents feel overwhelmed and experience this work as yet more burdensome. Therefore, they may not engage fully in working behind the scenes. If this is the case, it might be better for the child to be in individual treatment with occasional parental consultation.

3. Discouragement if behind-the-scenes work does not help might make it harder for parents to then utilize family therapy or individual therapy to help their child.

4. Families can be intimidated by an active model such as this, which demands parental involvement, and may bring up feelings and family dynamics previously hidden. In some cases, the parents may also need time to work through their own issues. While this can be fruitful, it can be an agenda parents are not interested in at that point.

Behind-the-scenes work provides families and clinicians with another tool for helping deal with the challenges obesity presents. Every family needs a tailored approach. Since I also facilitate individual and family therapy, I work with parents to determine which approach would be best for them.

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* I welcome your perspectives about your own behind-the-scenes work. What do you think of this approach? Have you ever tried it? If not do you think it may have value? If so, has it helped your situation? What are the advantages and disadvantages you have experienced? Thank you for your interest. - Jane

Let us know by clicking here.