Parenting Styles and Treatment of Adolescents with Obesity

Susann Regber
Kristina Berg-Kelly
Staffan Mårild

Professional caregivers have an important task in building a trusting relationship with parents and adolescents and in supporting parents in their parental roles. Our clinical experience of some 300 adolescents with obesity between 9 and 18 years of age and their parents has convinced us that consideration of parenting styles is fundamental in the treatment of children and adolescents with obesity. Typical case situations supporting the significance of parenting styles and illustrating the relationships between parents and adolescents with obesity can be identified. Group sessions with parents are the preferred mode for discussing typical parenting issues in the management of obese adolescents. The purpose of this paper is to describe different parenting styles, and to present a set of typical case situations and treatment strategies for nurses working with adolescents with obesity.

The increasing prevalence of overweight and obesity among children and adolescents is a matter of great concern. The World Health Organization (WHO) regards obesity as an epidemic, equivalent in importance to traditional public health issues such as malnutrition or infectious diseases (WHO, 2000). A recent estimate of the prevalence of overweight and obesity in some 140,000 adolescents between 10 and 16 years of age in 34 countries revealed that the adolescent obesity epidemic is a global issue (Janssen et al., 2005). The authors concluded that efforts must be multiplied at all levels to promote physical activity, a healthy diet, and healthy body weight.

Egger and Swinburn (1997) have suggested an ecological approach to the obesity pandemic. Their model proposes three main influences: (a) biological, (b) behavioral, and (c) environmental. A shift from the traditional focus on the individual to the environmental influences is necessary to fight the obesity pandemic. Modern society is “obesogenic” with micro-environments close to the individual and macro-environments (society). The micro-environment includes household rules for watching TV and video, the use of cars instead of walking, and family eating and recreation patterns. The macro-environment is represented by societal regulations like food laws, food taxes, subsidies, and the infrastructure of cycleways and walkways. In the treatment of adolescents with obesity, parents are key persons regarding changing the micro-environment. Involving parents in treatment may therefore have a huge impact on the eating habits and physical activities of adolescents.

Definition of Obesity

At the Queen Silvia Children’s Hospital in Göteborg, Sweden, we use the international age- and gender-specific body mass index (BMI) cut-off points, at the age of 2-18 years, to define overweight and obesity. These definitions were proposed by the International Obesity Task Force (IOTF) (Cole, Bellizzi, Flegal, & Dietz, 2000). The different child BMI cut-offs correspond to the adult cut-off points of 25 and 30 kg/m² defining overweight and obesity respectively (WHO, 2000). The Centers for Disease Control and Prevention (CDC) (2005) recommends the use of BMI-for-age percentiles, where children and adolescents between the 85th percentile and < 95th percentile are defined as being at risk of overweight, while those at the ≥ 95th percentile are defined as overweight. In this paper, we therefore use the IOTF term “overweight,” which corresponds approximately to the CDC term “risk of overweight,” and the IOTF term “obesity” for the CDC term “overweight.”

Psychosocial Development in Adolescents

In planning treatment, professionals must be familiar with the role of age and developmental phase of the individual adolescent in to address the specific health consequences of obesity and the long-term consequences in the optimal manner. Neinstein, Juliani, and Shapiro (1996) described three psychosocial developmental phases and several tasks that characterize the various phases of adolescence. The three phases are (a) early adolescence (approximate 10-13 years of age), (b) middle adolescence (approximate 14-16 years of age), and (c) late adolescence (approximate 17-21 years of age). The tasks that are in conjunction with the psy-
Figure 1. Health Consequences Associated with Adolescent Obesity

Health Consequences Associated with Adolescent Obesity

Psychological problems
- Poor self-esteem
- Depression
- Eating disorders

Gastro-intestinal problems
- Gallstones
- Steatohepatitis

Endocrine problems
- Type 2 diabetes
- Precocious puberty
- Polycystic ovaries (girls)
- Hypogonadism (boys)

Neurological problems
- Headache

Pulmonary problems
- Sleep apnea
- Asthma

Cardiovascular
- Hypertension
- Dyslipidemia
- Coagulopathy

Musculoskeletal Disorders
- Flat feet

chosocial developmental phases include (a) achieving independence from parents, (b) adopting peer codes and lifestyles, (c) assigning increased importance to body image and acceptance of one's body image, and (d) establishing sexual, ego, vocational and moral identities. Elkind (1967) described an egocentric way of thinking in adolescence that might have social implications for adolescents. Egocentric adolescents are unable to distinguish between their own thoughts and those of others. Elkind also explained that adolescents often feel as if they are being observed by a critical "imaginary audience," constantly attentive to how they look, talk, and behave. This may lead to a lack of self-confidence in social situations.

Consequences of Obesity

From the adolescent perspective, the most severe consequences of obesity are the psychological and social issues, including poor self-esteem and stigmatization (Strauss, 2000). Strauss conducted a 4-year follow-up study of 1,520 children, ranging from 9-10 years of age at the initiation of the study. This study reported increasing levels of loneliness, sadness, and nervousness among adolescents who were obese.

Health consequences. The health-related quality of life of severely obese children and adolescents has been shown to be lower than that of healthy children and adolescents and equivalent to that of subjects with cancer (Schwimmer, Burwinkle & Varni, 2003). The medical consequences of obesity begin to affect physical health because most of the overt adult obesity-related morbidity, such as hypertension, type 2 diabetes, hyperlipidemia, gall bladder disease, osteoarthritis and musculoskeletal disorders, starts to develop in childhood (Ebbeling, Pawlak & Ludwig, 2002) (see Figure 1).

Long-term consequences. The social and economic consequences of obesity during adolescence are greater than those of many other chronic physical disorders and one explanation is that discrimination may account for these results, according to Gortmaker, Must, Perrin, Sobol, and Dietz (1993). The researchers prospectively examined the relationship between obese adolescents (370 subjects) among 10,039 adolescents and young adults, and their social and economic characteristics and self-esteem between 1981 and 1988. They found that obese adolescents had completed fewer years of education, married less often, and had lower household incomes and lower self-esteem in early adult life than their non-obese counterparts, regardless of socio-economic origin. In a recent study, however, Viner and Cole (2005) suggested that the adversity of obesity might be less than previously reported. The authors studied a British cohort of 16,567 babies born in 1970 that were followed up at 5, 10 and 20-30 years, measuring obesity at 10 years and 30 years. Self-reported socio-economic, educational, psychological, and social outcomes were measured at 30 years. They found that obesity limited to childhood has little impact on adult outcomes, although persistent obesity in women is associated with poorer employment and relationship outcomes.

Requirements for Professional Caregivers

Caregivers need to develop higher skills in behavioral management strategies and parenting techniques to support parents more effectively in their roles. Story et al. (2002) studied attitudes, perceived barriers, perceived skill levels, and training needs in the management of children and adolescents with obesity among health care professionals in the USA. The researchers found that pediatric practitioners view child and adolescent obesity with concern and feel that intervention is important, but that there are various barriers to be overcome. The reported barriers were lack of parental involvement, lack of patient motivation, lack of insurance support for reimbursement, and lack of time. The health care professionals wanted higher proficiency in the use of behavioral management strategies and guidance in parenting techniques and the addressing of family conflicts (see Table 1). The results of the study have been summarized with recommendations for the management of child and adolescent obesity (Barlow & Dietz, 2002).

Communication skills. In our experience, it is important that information to parents and adolescents about the health consequences of obesity be presented with an empathetic attitude and with a knowledge of the specific maturation process during adolescence. An adolescent with obesity also must be helped to see that his/her situation can change. It is a challenge for pediatric nurses and other health professionals to provide incentives for empowerment and to help these individuals to obtain motivation and strength to improve their self-esteem and achieve effective weight management. Building up a trusting relationship and helping each particular adolescent find his or her positive personal power to transform a negative self-image into a positive one paves the way for treatment.

Motivational interviewing. The method of asking the patient key questions about the importance of change, with the aim of moving the patient in the direction of readiness to change his or her behavior, is known as motivational interviewing (Sindelar, Abrantes, Hart, Lewander & Spirito, 2004) and it is useful in the treatment of adolescents with obesity. Motivational interviewing also is a convenient method in the dialog with parents to communicate the fact that they are regarded as the central agents of change and the key to weight reduction for their adolescents.

Treatment Programs for Adolescents with Obesity

In 2000, the Queen Silvia Children's Hospital established a team for the treatment of children and adolescents with obesity. A dietician, physiotherapist, and two pediatric nurse practitioners (PNNPs) were recruited and received financial support from research funds. To date, more than 300 children and adolescents from 9-18 years of age have been enrolled in various weight management programs. Most of the patients are referred by the school health care and outpatient pediatric departments.

Table 1. Requirements for the Caregiver

<table>
<thead>
<tr>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical knowledge of adolescent health and medical health consequences of obesity</td>
</tr>
<tr>
<td>Ability to support empowerment of the adolescent</td>
</tr>
<tr>
<td>Skills in motivational interviewing</td>
</tr>
<tr>
<td>Ability to support parents in becoming central agents of change</td>
</tr>
<tr>
<td>Proficiency in behavioral management strategies</td>
</tr>
<tr>
<td>Guidance in parenting techniques</td>
</tr>
<tr>
<td>Communication skills in addressing family conflicts</td>
</tr>
</tbody>
</table>

PEDIATRIC NURSING/January-February 2007/Vol. 33/No. 1
Description of programs. We offer two treatment programs, "The Basic Program" and "The GRIND-study Research Program." The Basic Program targets parents and their adolescent children, aged 13-18 years. This program offers a series of five sessions to adolescents and their parents to provide basic facts about (a) health consequences, (b and c) healthy diet; (d) physical activity, and (e) lifestyle behavior modification. The PNP's conduct the parent and adolescent groups' lifestyle behavior modification sessions, which meet separately. The pediatrician, dietician, and the physiotherapist give the other lectures. These sessions are held with parents and adolescents together. In parallel, the families also are offered medical examinations with blood samples, a test of physical fitness, and one individual appointment with each of the following practitioners: a pediatrician, a PNP, a dietician, and a physiotherapist.

The research program ("The GRIND-study," group vs. individual treatment) offers children aged 9-12 and their parents the opportunity to participate in a 12-month program with random assignment to either group or individual treatment. Each group has 12 parents and 12 children. In the individual treatment group, following the pediatrician's diagnostic evaluation, the dietician, the PNP, and the physiotherapist meet with the parent and child alternately once a month for 1 year. In the group treatment, adolescents meet with the physiotherapist for aerobics. The PNP and dietician provide advice to parents about a healthy diet and parenting skills for lifestyle modifications in the family. The group treatment includes 20 weekly meetings during the first 6 months, followed by 4 meetings during the next 6 months.

Tools in health education. We use a printed folder presenting examples of recommended menus. The folder is used in the treatment of both programs. A recommendation is given to all age groups to have breakfast, school lunch, and dinner as the principal meals, and to add a piece of fruit or one sandwich once in between these meals. The importance of eating more vegetables and fresh fruits in general and of adding vegetables to every meal is emphasized. Candies, snacks, white bread, and sweetened soft drinks should be limited to once a week and, regarding candy, the limited amount of 1 hectogram (~3½ ounces) is the rule. One page in the folder also gives recommendations on physical activity, such as always taking the stairs instead of the elevator, walking or cycling to school, participating actively in physical activities of all kinds, such as swimming and playing outdoors, and also reducing sedentary activities like computer games, TV, and video.

Success rate of the treatment programs. As of October 2004, 280 children and adolescents have been registered for treatment with our team since January 2000. Of these, 180 children and adolescents have been followed for at least one year. We have calculated the preliminary treatment outcome in terms of the BMI expressed in a BMI-standard deviation score (BMI, SDS) for these children and adolescents. At referral, the group mean BMI, SDS was m = 3.33 (SD, 0.59), while, at the very first visit to the team, the group mean BMI, SDS was m = 3.28 (SD, 0.61). On the very last visit, after 1-4 years, mean 2.4 years, the group mean BMI SDS was m = 2.90 (SD, 0.72). The mean ages of the children and adolescents were m = 11.6, 12.5, and 14.9 on the three different occasions mentioned above. So approximately two-thirds displayed a reduction in BMI, while one-third had increased their BMI (unpublished data, Mårdh, S.).

Parental role in treatment. The parents in our treatment programs have often expressed guilt about the obesity of their daughter or son. In addition, the parents have felt worried about the health of their adolescent. Many parents also have expressed a sense of having lost control of the situation. Usually, the adolescent has been gaining weight over such a long period of time that the parents have felt unable to stop the process. The willingness of parents to participate in treatment has therefore often been a positive sign. However, many parents are unaware of how much effort and how many changes will be required of them, as well as of their adolescent. In spite of this, parental participation in the treatment of obesity in children and adolescents has been studied in various intervention programs and has proven to be important for the long-term success of weight reduction.

Brownell, Kelman, and Stunkard (1983) found that a program of behavior modification with parental involvement could lead to significant weight reduction in obese adolescents. There were three different experimental conditions with adolescents 12 and 18 years of age with or without their mothers: (a) mothers and adolescents met concurrently in separate groups, (b) mothers and adolescents met together in the same group, and (c) adolescents met alone. The group in which the mothers and adolescents were separated showed the best results, with a mean weight reduction of 20%, as compared with the other two groups where the mean weight loss was only 5%. Epstein (1996) reported significantly larger weight reduction in a 10-year follow-up in a group in which both parent and child were targeted for weight loss compared with a group where children were targeted alone and a non-targeted control group. Golan and Crow (2004) targeted parents alone, following a family-based, health-centered approach where parents were encouraged to practice authoritative parenting style. The results were compared with a control intervention where only children were targeted. Seven years after the intervention, the mean reduction in percent overweight was greater at all follow up points in children of the parent-only group compared with the children-only group.

Parental support. As caregivers in our treatment programs we give parents concrete advice and support in their parenting role, such as recommending parents to praise a positive behavioral change or encourage non-sedentary activities that children and adolescents can do together. Another piece of advice is not to include food, ice cream, or sugar-sweetened soft drinks as rewards or to regulate moods. When advising parents, attitudes and basic values in parenting are important issues to cover. Golan and Weizman (2001) emphasize the support of parents in parenting-skills and confidence in bringing up their children in their family-based treatment model for the management of childhood obesity.

Parental group counseling. The aim of the group sessions is to make parents aware of their parenting style and to give them the opportunity to share experiences with other parents of adolescents with obesity. Together with other parents, the feeling of personal guilt is reduced and problem-solving discussions can be fruitful.

One way of opening this dialog with parents is to present and discuss models of parenting styles. The model of the four parenting styles we used was modified by Berg-Kelly (1998) (see Table 2). Using an overhead projector, the figure of parenting styles can be explained to the assembled parent group. The model is well suited to parental group counseling with par-
ents. When presenting the model, it is also important to explain that parents might recognize themselves in more than one parenting role, although they might still feel that one of the parenting styles fits them more closely. Because one set of parents could represent two different parenting styles and because quite a large number of parents are divorced, the team must allow both parents to express their own view of the issues that are discussed in the session. Our experience is that group sessions tend to be positive in atmosphere, neutralizing possible negative aspects and conflicts between parents. Silent parents might take part in the group sessions and through the participation, develop new ideas and attitudes to manage the problem.

Another important matter to address is the situation of siblings in the family. We discuss the importance of having the same habits and lifestyles for all the family members, regardless of whether or not they are overweight.

Models of Parenting Styles

The model and method for parenting role support that we propose was derived from the application of a model in which four possible parenting models are defined and explained (Baumrind, 1971; Berg-Kelly, 1998; Maccoby & Martin, 1983). In 1971, Baumrind developed four models of parenting: authoritarian, authoritative, permissive, and rejecting-neglecting (indifferent) parenting styles (see Table 2). Maccoby and Martin (1983) have summarized these styles as follows:

- **Authoritarian parents.** This parenting style gives priority to obedience, work, and traditions. Parents shape and control their children in accordance with a set of standards and rules. The rules are not to be discussed or arrived at by argument and interaction. On the contrary, rules are imposed upon the child as mandatory and the child or adolescent is not consulted. Authoritarian parents discourage verbal give and take between parent and child.

- **Authoritative parenting style.** These parents are very demanding and very unresponsive, which implies that they use verbal directions or orders as opposed to offering suggestions that allow the child some freedom of choice. The authoritative parenting style is considered to have negative effects on the self-esteem of children.

- **Permissive parents.** This parenting style is considered more responsive than demanding. Parents are tolerant and accepting, and avoid imposing controls or restrictions. They allow their children and adolescents to regulate their own behavior and have very few rules governing time schedules, such as bedtime rules, rules for mealtimes, TV watching, and so on. A permissive parent can be either warm or cool and uninvolved. According to Maccoby and Martin (1983, p. 45), "In some cases it undoubtedly reflects parental inattention and indifference, rather than commitment to children's rights." The permissive parenting style has more negative than positive effects on the social outcome and is associated with children being aggressive, impulsive, and lacking in independence and a sense of responsibility.

- **Indifferent (rejecting-neglecting) parents.** Indifferent parents are cold and uninterested in the needs of their children and adolescents, reflecting a desire to keep the child or adolescent at a distance. They try to minimize time and interaction with the child or adolescent. This type of parent is characterized as uninvolved, meaning that they have a low degree of commitment to their role as parent. There is a risk of a child or adolescent being neglected by this type of parent. Children and adolescents brought up by parents with this parenting style have been shown to have negative effects in terms of the social outcome, such as lacking in frustration tolerance and emotional control, lacking interest in schoolwork, and lacking in long-term goals for the future. In adolescence, they are often involved in antisocial behavior, such as excessive drinking and delinquency (Maccoby & Martin, 1983 p. 50).

Case Illustrations

The following case illustrations are age-specific, typical situations that are relevant in the treatment of adolescents with obesity. The first six cases could be used in the dialog and education program for parents. The seventh case is only designed for internal discussions by the team and illustrates a set of parents where one has the permissive parenting role and the other the indifferent parenting role.

**Case 1: Permissive parenting model.** Maria is 13 years old and refuses to let her mother be present when she weighs herself. How is a parent supposed to react to this refusal and how can the team support the situation in treatment?

**The perspective of the adolescent:*** Maria may be refusing for any of a number of reasons. One is that she feels embarrassed and has a sense of failure when it becomes apparent that she has gained weight. Second, if it is clear that she has gained weight, and this is discussed openly, Maria will be urged to make changes she is not yet motivated to consider. Because she has been raised in a permissive parenting style, she is accustomed to saying no when demands are made of her.

**The perspective of the parent:*** Because Maria's parents have used a permissive parenting style, Maria is able to take command and continue to refuse. If her mother suddenly...
begins to use a different parenting style, there would probably be a conflict and permissive parents usually want to avoid conflicts for as long as possible. As was previously mentioned, parents may feel guilty about their child’s weight gain and feel that they have lost control. If so, they might accept Maria’s refusal because it is a way for them to go on avoiding taking control.

The perspective of the caregiver: In this case, the adolescent’s decision to keep her weight a secret from the parent makes it difficult to maintain an open atmosphere and discuss treatment strategies effectively. The caregiver can support the parent by discussing the situation with the adolescent, explaining the importance of having confidence in his or her parent, and being open about weight, because this will make the treatment easier. The caregiver also can support the adolescent by setting reasonable goals to give the adolescent a fair chance of handling the situation. A first goal might be to say, “Let’s agree that you will now stop gaining weight and not let yourself weigh more than you do at today’s appointment.” By using a motivating dialog, most adolescents accept and agree with this goal as they find it feasible. The next time, new goals can be set in agreement with the adolescent. Another proposal to minimize conflicts in relation to the weighing situation is to ask the parents to buy a set of scales and take responsibility at home for regular weighing and to ask the adolescent to keep a record of his or her weight in between the appointments at the clinic.

Case 2: Permissive parenting model. Anna, who is 10 years old, refuses to eat any vegetables apart from cucumber and sweet corn. She says she doesn’t like vegetables or fruit. What should her parents do?

The perspective of the adolescent: Anna can see no reason why she should eat something she doesn’t like. She generally chooses only the food she likes and has done so for several years without interference from her parents. She cannot see any reason for putting any food she does not like on her plate.

The perspective of the parents: Anna’s parents cannot see that they have done anything wrong by giving Anna only the food she prefers until now. They thought Anna would learn to eat vegetables when she was older. Telling her that she has to try vegetables would probably lead to a conflict, which they want to avoid. They did not realize vegetables and fruit have to be introduced into a child’s eating habits at an early stage and that parents have to be firm to establish this habit in the family. Changing Anna’s attitude has become a major problem.

The perspective of the caregiver: It is not uncommon for adolescents with obesity only to eat vegetables and sometimes even fruit very sparsely. These adolescents will only learn to eat a varied, healthy diet through parental mediation and by parents also changing their own modeling behavior. If the parents do not include vegetables in their own meals, it is difficult to encourage their adolescent child to do so. Caregivers must therefore tell the parents that they are role models with regard to this particular habit. Caregivers indirectly support parents by working on convincing the adolescent that eating vegetables and fruit is an important part of their work to normalize their weight.

Case 3: Authoritative parenting model. Andreas, 11 years old, joined a basketball club. After attending three sessions he got tired of playing basketball and wanted to quit. The registration fee had already been paid. How should Andreas’ parents react?

The perspective of the adolescent: Andreas might have imagined that he would be an instant success at his new sports activity. When he discovers there are difficulties to overcome, he looks for an easy way to quit. He cannot run quickly, perspires heavily, gets out of breath easily, and has poor self-confidence. Another problem is that Andreas is embarrassed about taking a shower with other children.

The perspective of the parents: Andreas needs help to overcome his unwillingness, and he should be encouraged to give both basketball and himself a fair chance before quitting. Praising the adolescent for becoming involved in an activity is one way of giving him or her positive encouragement. By asking what was fun and what was less fun, the parent can help the child find solutions to obstacles that might have initially been unspoken. For instance, the parents could suggest taking a shower at home instead of at the club.

The perspective of the caregiver: This is a good type of case to discuss with parents. Many parents recognize this type of experience. This kind of behavior is not limited to adolescents with obesity, which can be emphasized. Adolescents normally test different sports or leisure activities before finding something with which they are happy. Parents can make an agreement with their child before pay-
eats snacks and drinks high calorie soft drinks. What is an appropriate parental reaction to Marcus’ behavior?

Comment: An authoritarian parenting style is the most appropriate in this situation. It is appropriate to forbid eating and drinking in front of the computer. In addition to this rule, it is also necessary to have rules that limit the amount of time a child spends at the computer. At a younger age, the parents can use rules and stick firmly to them, which is sometimes more difficult as the children get older. These two cases show the necessity of being flexible in the parenting role, taking the age of the adolescent into account.

Case 6: Authoritative parenting model. When the family is eating dinner, Jimmy, 14 years old, prepares his own sandwiches instead of eating the dinner that has been prepared. This is not an occasional behavior for Jimmy. It has become a routine and everyday behavior. Is it acceptable? What advice can be given by caregivers?

The perspective of the adolescent: Jimmy believes that he is old enough to decide what he wants to eat. He is unaware of how this type of eating is actually maintaining his obesity and leads to intermittent eating during the evening because he has not had a proper dinner. He may be completely unaware that this behavior is also quite challenging and annoying for the rest of the family. He may be too proud to admit he needs support in reducing his weight.

The perspective of the parents: Jimmy’s habit was established gradually and is now a constant source of conflict in the family. The parents describe Jimmy as hard to please. It does not matter what kind of dinner they make, Jimmy chooses to eat something else. Jimmy’s constant refusal has made the parents give up.

The perspective of the caregivers: As caregivers, we stress the importance of eating structured, cooked meals. When an adolescent behaves this way, he or she is working against our treatment plan. The adolescent must be asked about willingness to change habits so as to promote weight normalization—in other words, about motivation for change. One way to increase the motivation of the adolescent is to provide information about why it is better to eat cooked food at regular times every day. In this case, we propose that the parents actually act in an authoritarian way. If, day after day, the adolescent refuses to eat the dinner, the parents may have to forbid the adolescent from eating sandwiches and the adolescent may have to go hungry instead. Although this would give rise to conflict, a conflict that stops behavior that counteracts everyone’s desires can be worthwhile.

Case 7: Indifferent parenting model. The seventh and final case illustration is meant to be analyzed and worked through by the team alone. This problem sometimes arises in parents of adolescents with obesity. Jenny, 11 years old, has a BMI of 33, extreme obesity for her age. She lives with her biological mother and father and is an only child. The professional team is finding it difficult to get Jenny and her parents to make the necessary changes to stop her accelerated weight gain. After having met with the family a couple of times, it becomes clear that the mother has a serious alcohol addiction. Fortunately, she is already in a therapy program and getting help. Jenny’s mother feels extremely guilty for having neglected Jenny for a long time. Her parenting role is related to compensating for her long periods of alcohol abuse, and thus she is quite permissive. The team then turned to the father, to ask him to provide the structure in the home, but he refused. He is unwilling to make the changes that include him. His strategy has been to escape all the problems by working late or going with friends to sporting events. He will not listen to the team’s requests to be more supportive of Jenny. He clearly seems indifferent to Jenny’s needs. The only positive sign of change is that Jenny’s weight gain has become a little bit slower than it was before the family entered the obesity treatment program. The team has to deal with a family situation in which there will be little if any support from the parents. How can the team support Jenny and her parents?

The perspective of the caregivers: Many treatment programs for adolescents with obesity exclude families in which the parents show no motivation to participate. The lack of motivation can be attributable to indifference or major personal problems. If these families could be included in treatment programs, their adolescents would have access to the support from the health care team that they lack from their own parents. A child’s right to adequate health care is not negotiable, even when their parents are not supportive.

Thus, supporting the parents in their parenting role is the first option and must be given to the parents by trying to meet with them several times and to keep a dialogue in an open atmosphere to give the parents the opportunity to help their child. If, in spite of this there is no sign of compliance from the parents then, according to Swedish law, caregivers have to report cases like this to the social authorities, in the best interest of the child and in agreement with the United Nations (UN) convention on the rights of the child.

Nursing Implications

Adolescent obesity has serious consequences in terms of global health. The primary aim of treating adolescents with obesity is to stop further weight acceleration and in the long run try to normalize the weight. Realizing this objective calls for consistent efforts to choose healthy lifestyle alternatives. Adolescents with obesity must receive support from parents and adults in their environment to become competent and motivated to choose healthy eating- and physical activity patterns. Caregivers play an important role in educating and motivating the adolescents. However, parents are key persons in the treatment of adolescents with obesity, both as models for a healthy choice of food and physical activity and for changing adolescent habits. Recognizing different parenting styles is important. Pediatric nurses and other health professionals can support parents by explaining the effect of different parenting models and teaching them parenting skill techniques. By using case illustrations and models for parenting styles, caregivers can help parents to be more involved and engaged to participate actively in treatment.

References


Be A Hero
Recommend Relief!

Diaper Rash Problems?

Recommend

DR. SMITH'S
DIAPER OINTMENT

Problem Solved!

- Easy to apply - easy to wash off
- Creates an invisible, effective barrier to protect chafed skin, and seal out wetness
- Contains no steroid or antibiotic
- No unpleasant odor, or "globiness"

Available at these and other Retailers Nationwide
Ask a store manager for availability.

For samples or information, call 1-800-434-BETA (2382) or visit our website: www.beta-derm.com

Beta DERMACEUTICALS, INC.