Childhood Obesity: A Issue for Child Protection?

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Objectives

- Explore the epidemic of childhood obesity from medical, psychological & social perspectives
- Debate whether childhood obesity meets the criteria of abuse and/or neglect
- Discuss possible individual and systemic interventions to address this problem
Basic Terminology

- Body Mass Index (BMI)
- Growth Charts
- “Overweight” – BMI at or above the 85th percentile for children of the same age and sex
- “Obese” – BMI at or above the 95th percentile for children of the same age and sex
Body mass index-for-age percentiles:
Boys, 2 to 20 years

A 10-year-old boy with a BMI of 23 would be in the obese category (95th percentile or greater).

A 10-year-old boy with a BMI of 21 would be in the overweight category (85th to less than 95th percentile).

A 10-year-old boy with a BMI of 18 would be in the healthy weight category (5th percentile to less than 85th percentile).

A 10-year-old boy with a BMI of 13 would be in the underweight category (less than 5th percentile).
Childhood Obesity Statistics

- The problem according to the CDC:
  - In past 30 years, obesity has doubled in children and tripled in adolescents
  - 1/3 of children & adolescents are overweight
How big is the problem?

- As of 2010, #1 cause of preventable death in the US
- 9-10 million children are overweight/obese
- Is expected to decrease life expectancy
- 80-90% of obese teens will become obese or morbidly obese adults
- It’s causing a diabetic epidemic
- Bariatric surgery has been done on children as young as 12 years old
- The makers of the lap-band are asking the FDA for the ability to market their product to 14 year olds
- More and more bariatric centers are accepting adolescent patients – rates have tripled in recent years
Child Obesity Statistics & Teenage Obesity Statistics by Age and Gender

![Graph showing obesity rates by age and gender from 1963-70 to 2007-2008.](image)
Childhood Obesity in NJ

The NJ Childhood Obesity Study (2012)
- Overall rates of overweight and childhood obesity are higher in 5 NJ cities than national averages
- BMI >85% (overweight & obese) children in:
  - Camden - 39.8%
  - Newark - 44.2%
  - New Brunswick - 46.4%
  - Trenton - 47.3%
  - Vineland - 43.6%
Causes of childhood obesity

- Biological:
  - Genetic predisposition to obesity

- Environmental – “Obesogenic Environment”
  - Consumerism and marketing to children
  - Long work days for parents
  - Fast food, economics & poverty
  - “Stranger danger” keeps kids inside
  - Passive recreation/ “screen time” = 4 hrs/day
  - School lunches
  - Decreased emphasis in school on physical education
  - Marketing of fad diets and quick fixes
Causes of childhood obesity (cont.)

- Psychological
  - Food as comfort & nurturance/ “Emotional Eating” as acceptable
  - Overeating as mechanism & there is a lack of other “healthy” coping skills and emotional regulation skills
  - Parenting beliefs of indulgence/Parents don’t limit set appropriately
  - Shame and embarrassment often lead to silence and denial of weight issues
  - Feelings of hopelessness
Culture & Childhood Obesity

- CDC study (2009-2010) of 6-17 yr olds:
  - African Americans: 25.7% obesity
  - Mexican American - 23.4% obesity
  - Caucasian: 14.6% obesity

- CDC (2012)
  - African American girls 80% more likely to be overweight than Caucasian girls

Dietary patterns
Culture & Childhood Obesity

- Cultural beliefs about:
  - Meaning ascribed to food
  - Food availability & traditional foods
  - The ideal body
  - Parenting style
  - What is healthy
  - The importance of physical activity
  - Differing perception of what is obese

- American culture of excess & consumerism

- Effect of poverty on weight
Consequences of Childhood Obesity
Medical Consequences

- Diabetes Mellitus
- Metabolic Syndrome
- PCOS
- Hyperandrogenism
- Effects on growth & puberty
- Fatty liver
- Hypertension
- Hyperlipidemia
- Sleep Apnea
Complications of Childhood Obesity

Psychosocial
- Poor self esteem
- Depression
- Quality of life

Neurological
- Pseudotumor cerebri
  - Risk for stroke

Cardiovascular
- Dyslipidemia
- Hypertension
- Left ventricular hypertrophy
- Chronic inflammation
- Endothelial dysfunction
  - Risk of coronary disease

Renal
- Glomerulosclerosis
- Proteinuria

Gastrointestinal
- Pancreatitis
- Steatohepatitis
- Liver fibrosis
- Gallstones
  - Risk for cirrhosis
  - Risk for colon cancer

Endocrine
- Type 2 diabetes
- Precocious puberty
- Polycystic ovary syndrome (girls)
- Hypogonadism (boys)

Musculoskeletal
- Forearm fracture
- Blount’s disease
- Slipped capital femoral epiphysis
- Flat feet
  - Risk for degenerative joint disease

Hernia

DVT/PE

Stress incontinence
  - Risk of GYN malignancy
Psychological Consequences

- Circular relationship between behavior, cognitions, emotions & overeating
- Psychological correlates of childhood obesity (two common profiles of overweight children)
- Poor self-esteem
- Depression
- Anxiety
- Behavior problems
- Impaired peer relationships
- Quality of life
Social Consequences

- Weight Discrimination
  - Rebecca Puhl (Yale researcher) – study showed that overweight people are 26 times more likely to report discrimination that normal weight counterparts
  - “Overweight children feel inferior and they tend not to aspire to such heights because they don’t believe they deserve it.” - Kelly Brownell (Rudd Center for Food Policy and Obesity at Yale)
But is childhood obesity really child abuse?
Definitions of Child Neglect

- Physical Neglect – consists of a willful failure to provide proper food and sufficient food, clothing, or maintenance.

- Medical Neglect – Failure to provide medical attention or failure to do or permit to be done any act necessary for the child’s physical or moral well-being.
Examples of Neglect

- Parents are not feeding child correctly—child is underweight/possible malnutrition and even FTT
- Failure to seek medical attention for a child’s medical condition and not following through with treatment for an illness (e.g., infection), a medical condition (e.g., asthma) or an injury
- Failure to administer prescribed medications
- Failure to address dental or vision needs
Definition of Child Abuse

Child abuse – an injury by other than accidental means which causes a substantial risk of death, serious or protracted disfigurement, or protracted impairment of physical or emotional health or impairment of the function of any bodily organ.”
Arguments for CPS involvement

1. Obesity is a form of medical neglect with serious & significant long term risks – it is the mirror image of malnutrition, starvation and failure to thrive (FTT).

2. These parents are clearly raising their children wrong – it’s bad parenting to keep feeding an overweight child fatty foods.
Counterarguments

1. There is no immediate or urgent risk associated with obesity as there is with FTT. It is unreasonable to intervene on the basis of possible long-term consequences.

2. The 14th Amendment - Parents can raise their children as they see fit.
Case Study #1 of State Intervention (in NY):

- Brittany – 9 yrs old, 261 lbs, BMI = 50 (99th percentile)
- Medical comorbidities: gallstones, excessive fat in liver, sleep apnea, acanthosis nigricans, signs of depression
- Family Hx: Father was significant disabled with multiple health problems and mother weighed over 430 lbs.
- PCP = Family as noncompliance with rec
Case study #1 (cont.)

- State alleged parents did not comply with getting her a gym membership, taking her to gym 3x a week & participating in nutritional program
- Placement in foster care due to “severe life-limiting dangers due to parental lifestyle & persistent neglect”
- Appellate division reverse this decision and found her parent acted in “good faith”
- Brittany lost weight (lowest 238), returned home and within 6 months regained all the weight
Case Study #2 of State Intervention (CA)

- Christina - 13 years old, weighed 680 lbs
- Single mother who was also sole caretaker of her elderly, ill parents
- Mother consented to Christina dropping out of school
- Christina hadn’t left the house in > 3 months
- “How could you let your daughter get so fat?”
Case study #2 (cont.)

- Christina died of Congestive Heart Failure in 1996
- Found on the bedroom floor covered in feces and bed sores
- Felony charges brought against the mother for the “condition” not the “size” of child’s body
- Mother = guilty of misdemeanor child abuse and served minimal sentence (it was judged her actions were passive not active)
Case Study #3 (Ohio)

- 8 year old Ohio boy, weighing 218 lbs
- Only medical condition at the time = sleep apnea
- CPS worked with family for >1 yr to decrease weight
- Removed from his mother in 2012 on his 9th birthday
- Lost 50 lbs in foster care (placed with relative)
- Returned to mother under CPS supervision
- Given free YMCA gym membership, free nutritional and health counseling
Small Group Activity

- Developing guidelines to determine if childhood obesity is child abuse/neglect:
  - How overweight is too overweight? When should CPS get involved? What is the weight threshold?
  - Noncompliance with treatment recommendations vs. weight loss – what’s the standard of progress?
  - What role does the child’s age play? How much responsibility is the parents’ and how much is the child’s?
Small Group Activity (cont.)

- Developing guidelines to determine if childhood obesity is child abuse/neglect:
  - When should teachers, school nurse, doctors, etc… have intervened (especially in the case of Christina)?
  - At what point should CPS remove a child and place them in foster care? What would this decision be based on and who (doctors, caseworkers, judges, therapists) should be weighing in on this critical decision?
  - Is foster care better or worse than a child having bariatric surgery?
How can we intervene?
Levels of Interventions

- Primary Prevention
- Secondary Prevention
- Tertiary Prevention
Possible interventions

- PRIMARY PREVENTION
  - Nutrition education
  - Physical education
  - In-school educational programs

- SECONDARY PREVENTION
  - Acknowledge a potential problem (early detection & prompt treatment)
  - Education for parents about medical & psychological risks with even mild childhood obesity
Possible Interventions

- TERTIARY PREVENTION – effective treatment for the problem as soon as it starts:
  - Nutritional education (for parents & children)
  - Physical therapy/increased activity
  - Appropriate medical specialists
  - Pediatric Weight Management Programs
  - Parenting skills (e.g., limit setting, praise)
  - Psychotherapy
Pediatric Weight Management Programs

- Components of these programs
Additional points on interventions

- Engage parents as partners (not enemies) – parents as part of the solution
- Need for cultural sensitivity
- Families already involved with CPS should have caseworker or DCP&P nurse address weight as a serious health issue (in consultation with child’s PCP)
- Need for broader social policy changes and a shift in American ideals – movement away from an “obesogentic” environment
What can I do?

Mental health/child advocates/other professionals working with families/CPS workers:

- Shift perspectives from mental illness to a health & wellness model
- Expand our role to include helping people make health-related changes
- Voice concerns in non-judgmental manner
- Work collaboratively with other disciplines to address childhood obesity
Future Directions…

- CPS and professionals to work together to define when childhood obesity becomes neglect and/or abusive:
  - Clear definition (age, BMI, previous attempts to get treatment, compliance, health factors)
  - Close, ongoing collaboration between health professionals and CPS
  - Guidelines for intervening and providing needed family & individual services
  - Determine the threshold of when to remove a child from their parents
Conclusions

- Causes of childhood obesity are multidimensional & complicated
- Childhood obesity carries significant medical, social and psychological consequences (short-term & long-term) for children
- Issues of culture need to be considered
- Difficult to definitively define childhood obesity as child abuse - several controversial cases raise important concerns
- More active, directive interventions are need at every level
References

- Brownwell, K.D. “When poverty leads to obesity,” in Culture Matters in the Obesity Debate, LA Times, Sept. 21, 2007
References (cont.)


References (cont.)


References (cont.)

Thank you for attending!

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