

# Understanding Childhood Obesity: A Strength Based Approach

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April 10, 2025

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Weight

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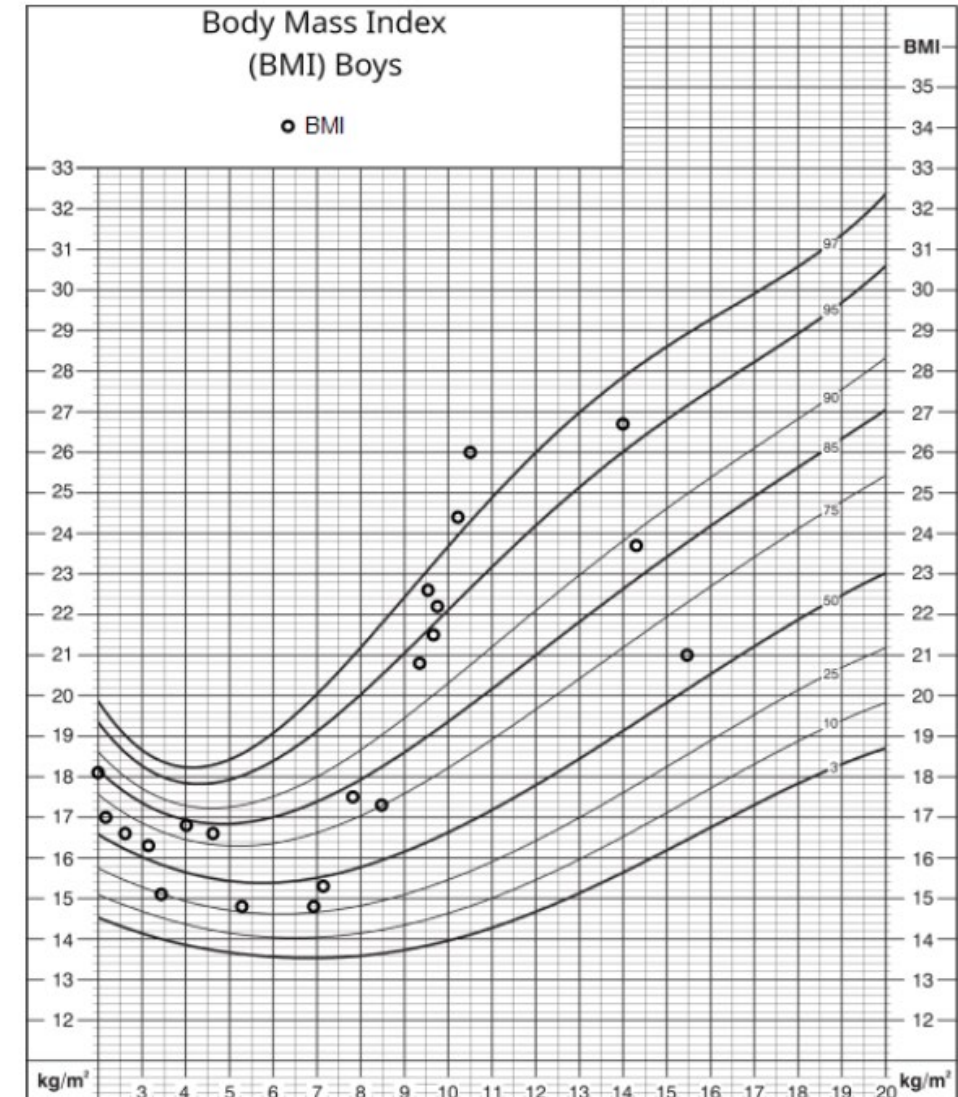
IHS Pediatrics Chief Clinical Consultant  
Albuquerque Area CMO

# Overview

- Obesity as a complex, chronic disease
  - Context:
    - Systems factors
    - Pathophysiology
- Evaluation of Obesity
  - Weight bias and stigma
- Using the evaluation to foster motivation
- Discussion

Child Growth Chart

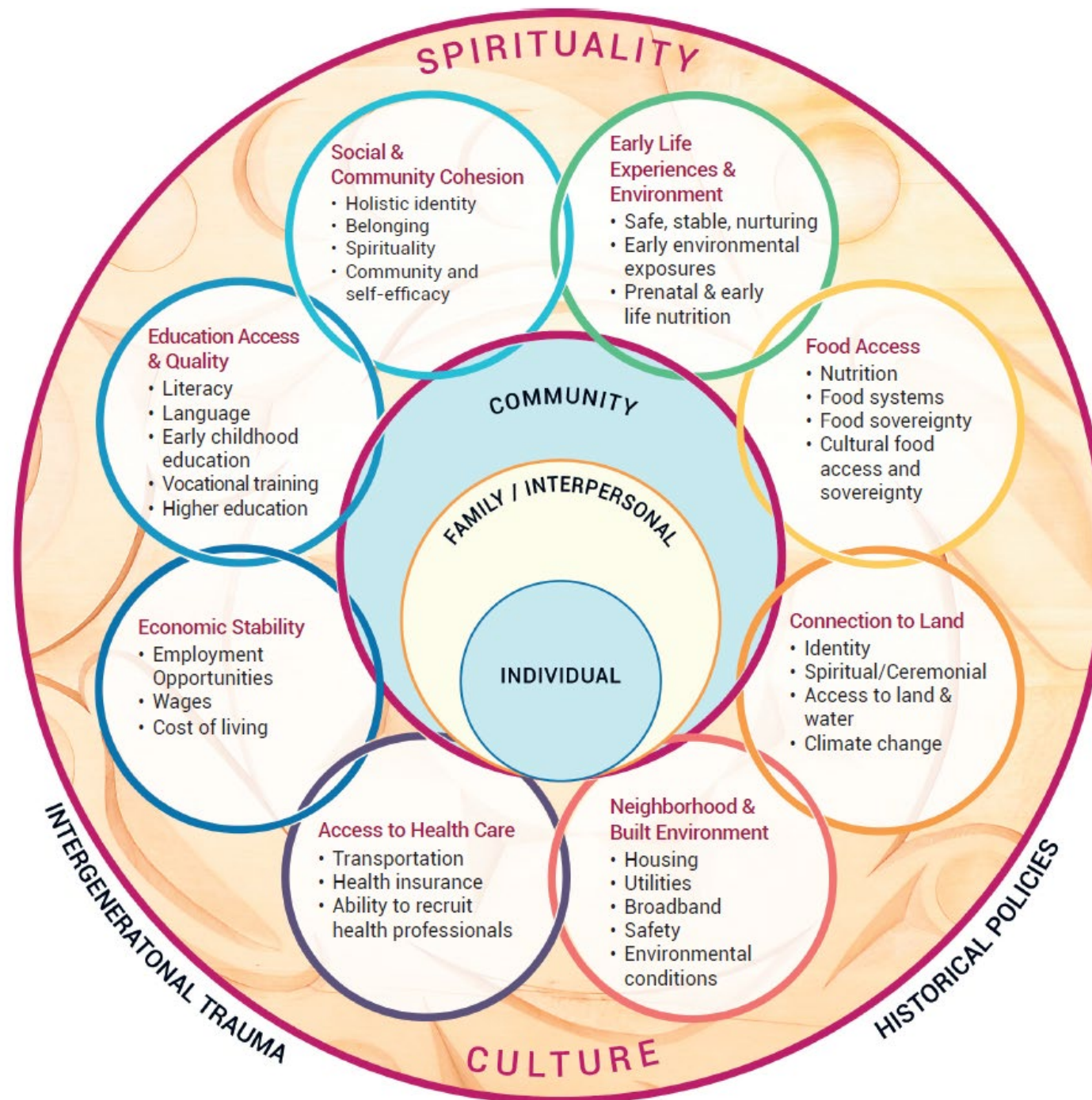
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# Whole Child Approach

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- Understanding the underlying genetic, biological, environmental, and social determinants that pose risk for obesity is the bedrock of all evaluation and intervention.
- Allowing the family to have a safe space to understand and process the complexity of obesity and its chronicity requires tact, empathy, and humility.
- Using the whole child approach
  - Enables the patient and family recognize risk factors in their environment and behaviors
  - Honor cultural preferences
  - Institute changes independently as well as under the guidance of a trusted and well-trained advocate.



# New from previous recommendations

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- We understand more fully the implications of obesity as a chronic disease.
- We understand the physiological impacts of social determinants of health on obesity more completely.
- We know more fully that weight bias and stigma is pervasive and harmful and can be a barrier to treatment.

# Obesity is a complex chronic disease

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- Obesity is often an indicator of structural inequities like unjust food systems, health inequities and environmental & community factors.
- Genetics, obesity-promoting environments, life experiences combined with inequities and structural barriers to healthy living all contribute to overweight and obesity.
- **Understanding the underlying genetic, biological, environmental, and social determinants that are risks for obesity is the foundation of evaluation and treatment.**



# Algorithm for the Evaluation and Treatment of Children and Adolescents with Overweight and Obesity

## SCREENING

P&PHCPs *should* measure height & weight, calculate BMI, and **assess BMI percentile** using age- and sex-specific CDC growth charts or severe obesity growth charts **for all children 2-18 years** (KAS 1)

BMI ≥85th percentile?

No

Repeat at least annually

Yes

## DIAGNOSIS

Overweight

Obesity

Severe Obesity

BMI ≥85th to <95th percentile

BMI ≥95th percentile

BMI ≥120% of the 95th percentile

## EVALUATION

Components of Comprehensive Evaluation

Overweight

Obesity

<10y ≥10y

<10y ≥10y

Comprehensive history, MBH screening, SDOH evaluation, physical examination, & diagnostic studies (KAS 2)

✓

✓

✓

✓

Blood pressure (KAS 8)

✓<sup>a</sup>

✓

✓<sup>a</sup>

✓

Fasting lipid panel (KAS 3, 3.1, 5)

✓

⚖️

✓

FPG, OGTT, or HgbA1C (KAS 3, 3.1, 6) & ALT (KAS 3, 3.1, 7)

⚖️<sup>b</sup>

✓

Elevated BP?<sup>c</sup>

Yes

No

Refer to AAP High BP CPG<sup>d</sup>

Repeat at every visit

Abnormal labs?<sup>e</sup>

Yes

No

Refer to Appendix 3

*May* repeat testing in 2 years or sooner if changes in exam/risk

## TREATMENT

P&PHCPs *should* treat overweight/obesity & comorbidities concurrently (KAS 4) following the principles of the **medical home** and the **chronic care model**, using a **family-centered** and **non-stigmatizing** approach that acknowledges obesity's **biologic, social, and structural drivers**. (KAS 9)

Components of Comprehensive Treatment

Overweight

Obesity

<6y 6 to <12y ≥12y

<6y 6 to <12y ≥12y

Motivational Interviewing<sup>f</sup> (KAS 10)

✓

✓

✓

✓

✓

✓

Intensive Health Behavior and Lifestyle Treatment<sup>g</sup> (KAS 11)

⚖️

✓

✓

⚖️

✓

✓

Weight Loss Pharmacotherapy<sup>h</sup> (KAS 12)

✓

Offer referral to Comprehensive Pediatric Metabolic & Bariatric Surgery programs<sup>i</sup> (KAS 13)

✓<sup>i</sup>

# Our Patient: SG

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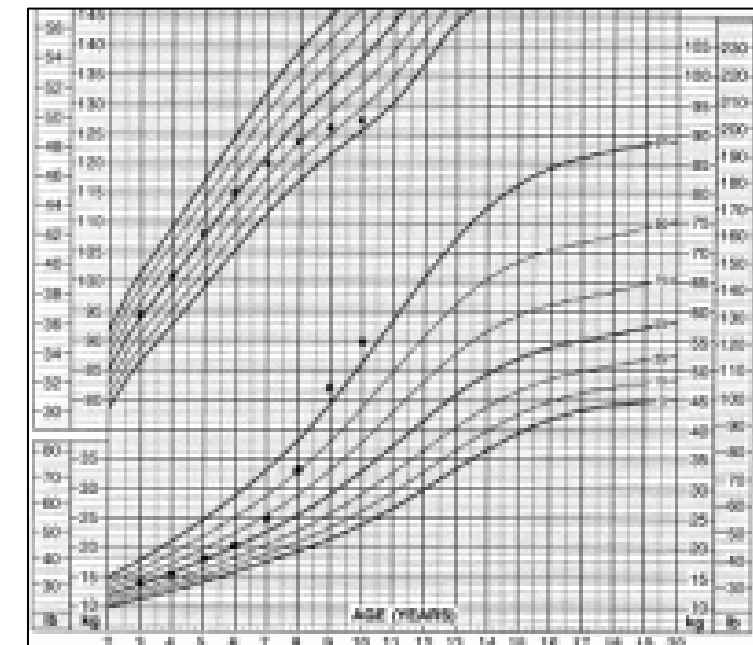
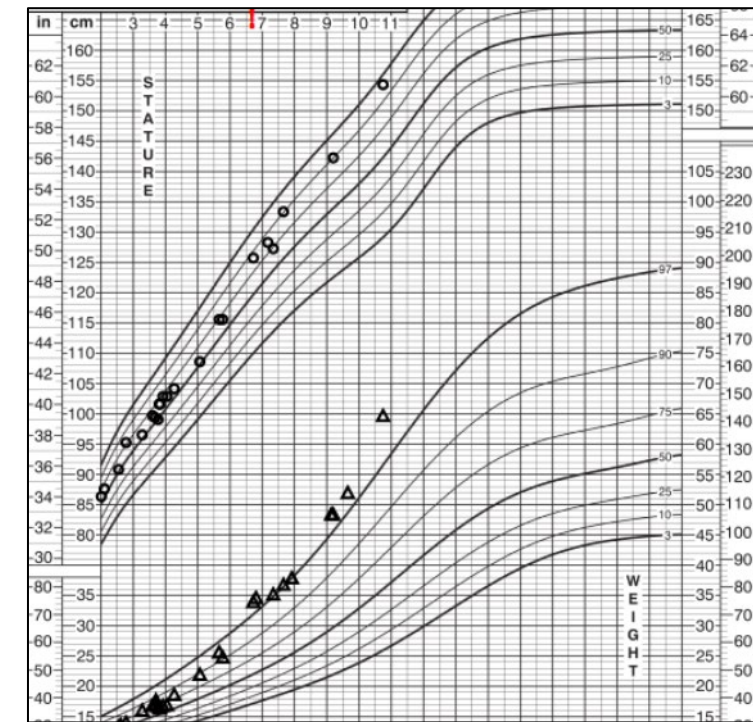
- 8 yo boy presents with his mother for a Well Child Check
- Chief complaint: *“What concerns, if any, do you have about your child’s growth and health?” and “Is there anything about your body or how you feel that you want to talk about?”*
  - Only concern is mild, intermittent abdominal pain and constipation.
- HPI:
  - Last seen **1 year ago for primary care (and three months ago for a sick visit)**
    - Diet and exercise recommendations made
    - **No specific changes made since then**
  - **Feels limited in sports or running** due to being “slow” and “my asthma.”
  - Initial conversation does not reveal any symptoms of depression, anxiety, or history of bullying
  - Growth trajectory

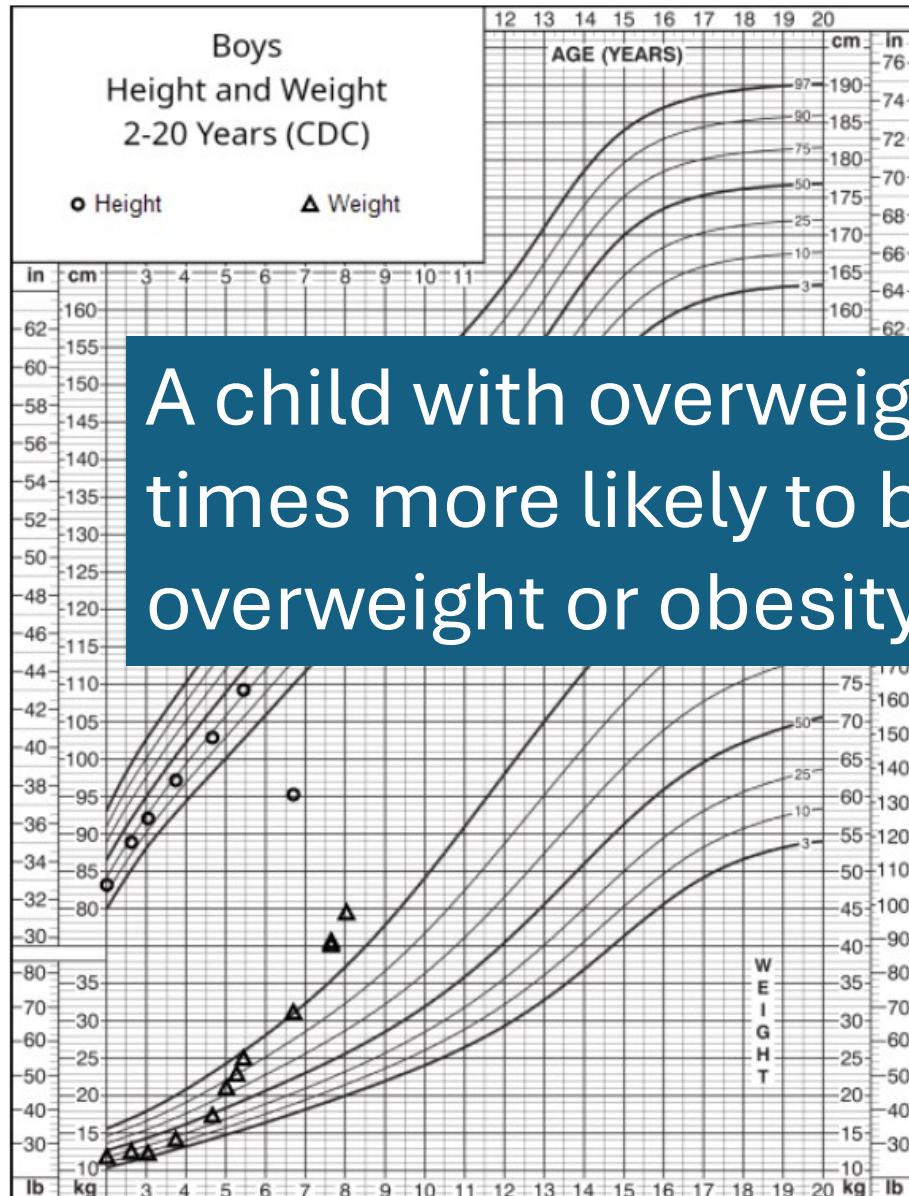


# The Growth Curve Tells a Story

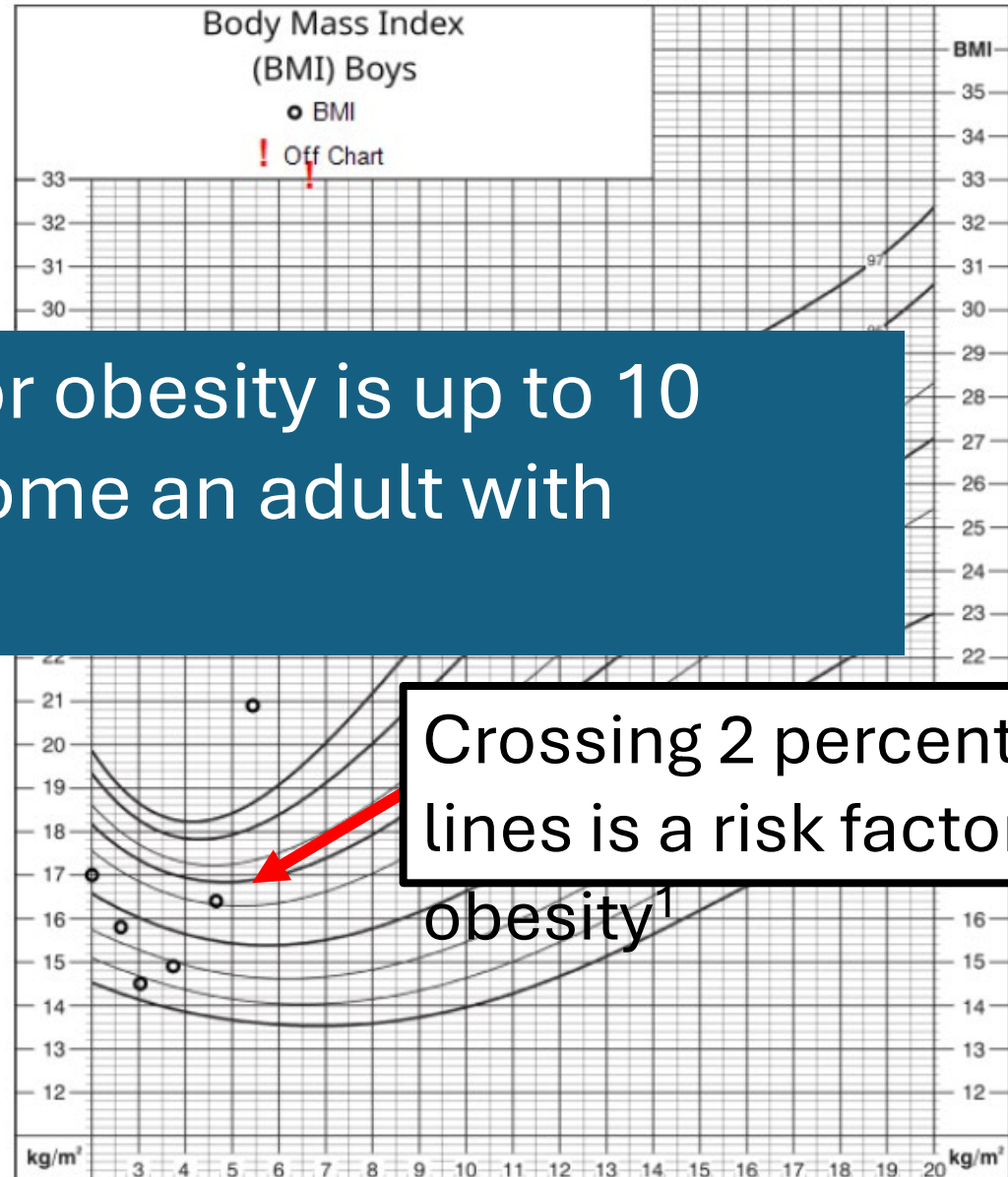
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- DDX of obesity starts with linear growth trajectory
  - Underlying endocrinopathy will often have decreased linear growth
  - Over nutrition will often have consistent or accelerated growth
  - Rare genetic causes are more likely if severe obesity occurs under age 5
  - Changes can reflect significant life events/ disruptions in one's environment or disordered eating





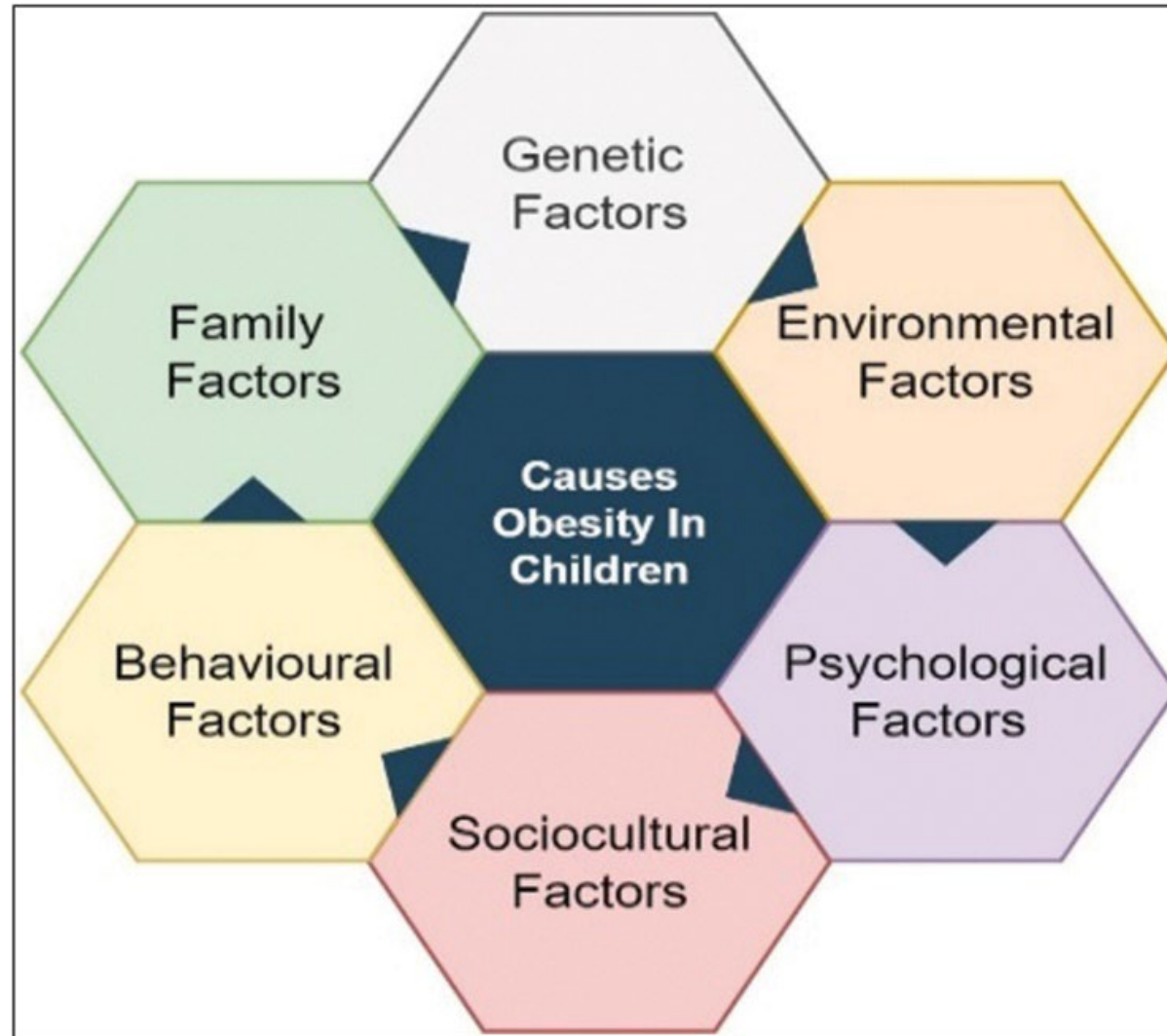
A child with overweight or obesity is up to 10 times more likely to become an adult with overweight or obesity.<sup>2</sup>



Crossing 2 percentile lines is a risk factor for obesity<sup>1</sup>

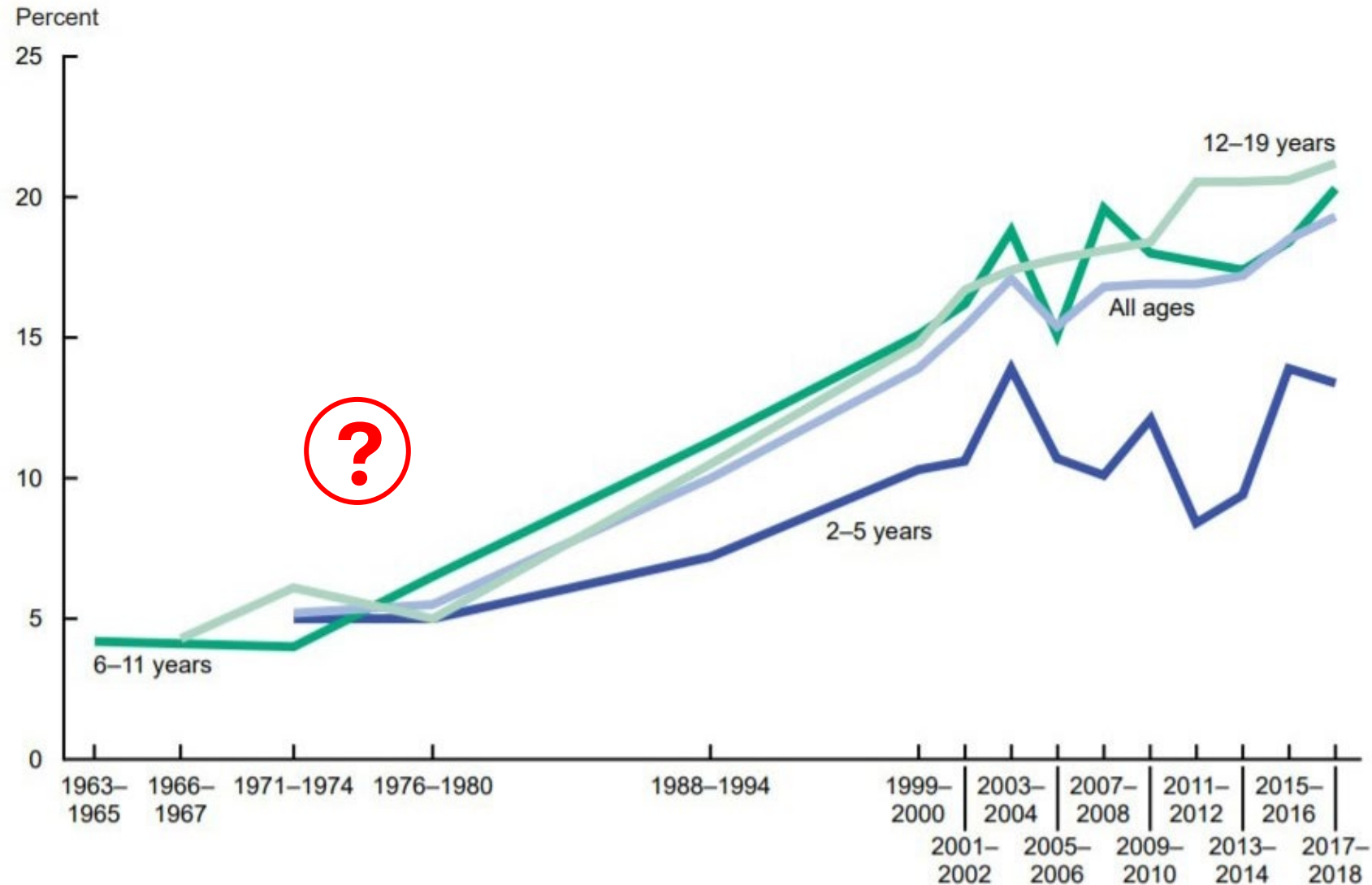
1. Taveras EM, Rifas-Shiman SL, Sherry B, et al. Crossing growth percentiles in infancy and risk of obesity in childhood. *Arch Pediatr Adolesc Med*. 2011;165(11):993-998.
2. Singh AS, Mulder C, Twisk JW, et al. Tracking of childhood overweight into adulthood: a systematic review of the literature. *Obes Rev*. 2008;9:474-488. American Academy of Family Physicians. Recommendations for clinical preventive services. Available at: [www.aafp.org/online/en/home/clinical/exam/k-o.html](http://www.aafp.org/online/en/home/clinical/exam/k-o.html)

# A (Very) Complex, Chronic Disease



# Trends in obesity among US children and adolescents 2–19 years of age

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# Obesity among AI/AN children

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- Highest prevalence among all groups
  - ... with younger onset

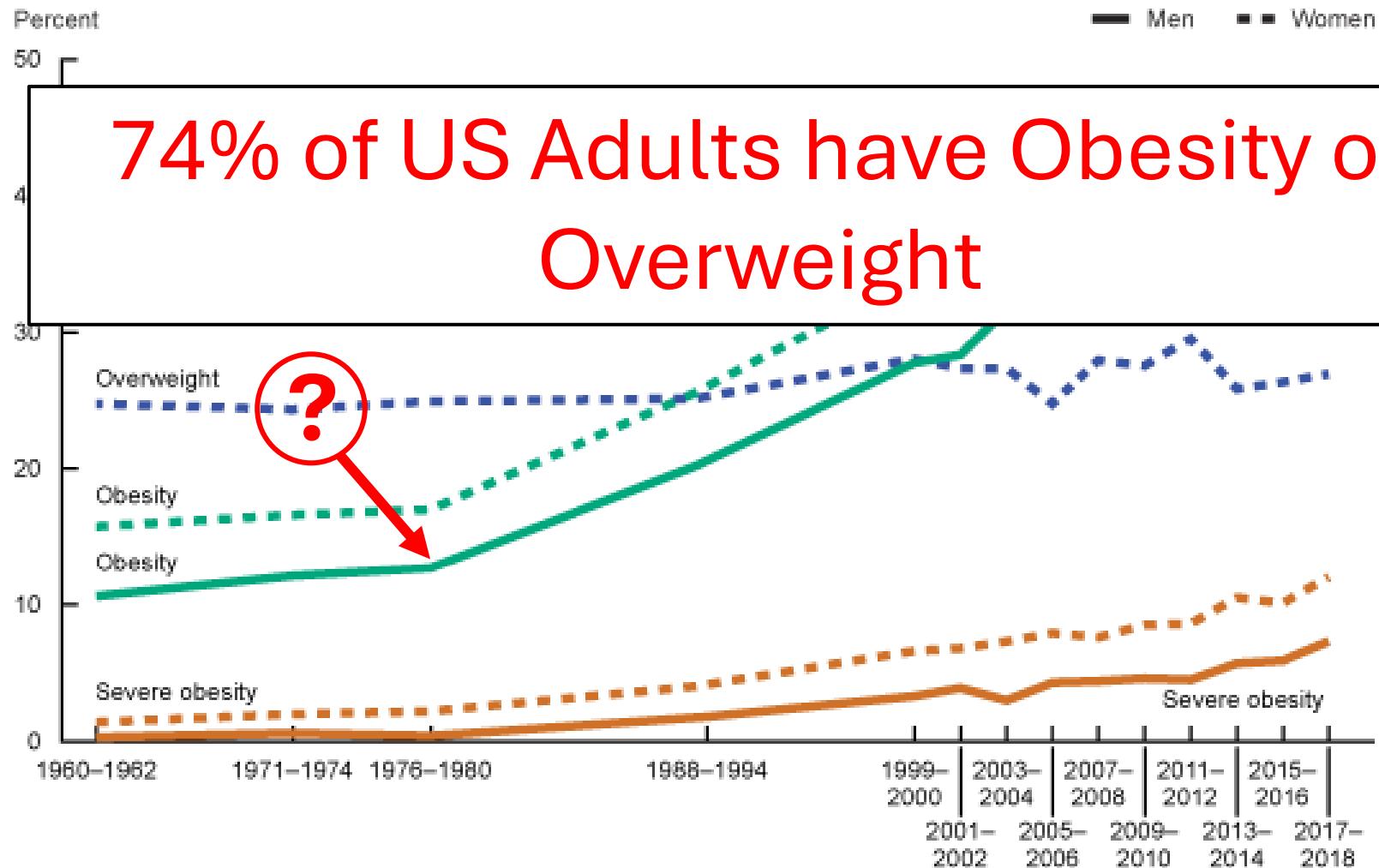
**Disparities are a reflection of the society in which they exist, not of the community they affect.**

- 18% had overweight
- 31% had obesity
- 20% 6-11 years old had severe obesity
- Poverty levels correlated with higher prevalence of obesity/overweight<sup>2</sup>

1. Bell S, et. Al. AAP Caring for American Indian and Alaska Native Children and Adolescents. Pediatrics. 2021 Apr;147(4):e2021050498. doi: 10.1542/peds.2021-050498.

2. Fyfe-Johnson AL, et. al. Social Determinants of Health and Body Mass Index in American Indian/Alaska Native Children. Child Obes. 2023 Jul;19(5):341-352. doi: 10.1089/chi.2022.0012. Epub 2022 Sep 28.

# Age-adjusted trends in overweight, obesity, and severe obesity among men and women aged 20–74





# Obesity is a Complex, Chronic Disease

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- When three-quarters of people struggle with a system, the cause is not with the people. It is with the system which is working against them.
  - Our society (including healthcare) routinely attributes obesity to insufficient willpower, effort, education, or strength.
  - We do not recognize the “design error” in our system.
  - Compassionate, non-stigmatizing care should be grounded in this understanding.

# ”Systems Issues” Contributing to Childhood Obesity

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Over the past 60+ years, dramatic changes have occurred in:

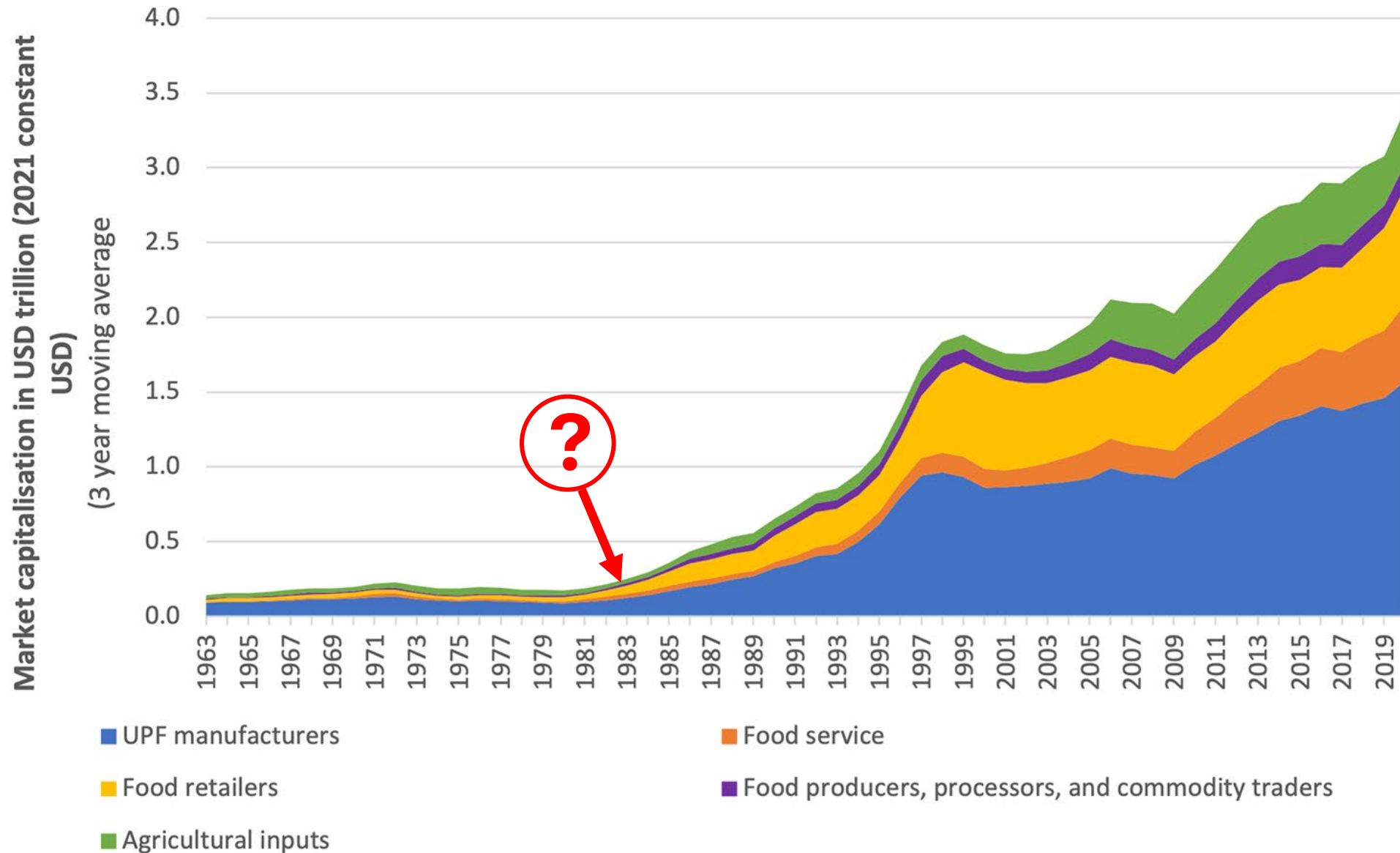
1. The amount of food provided
  - Average caloric intake has increased by 20% since 1980<sup>1</sup>
2. How children spend free time
  - Roughly 8 hours of screen-time per day among teens<sup>2</sup>
3. The nature of the food itself
  - Now over 70% Ultraprocessed food<sup>3</sup>
4. Psychosocial factors
  - Within the context of existing historical and intergenerational trauma

1. Duffey KJ, Popkin BM. Energy density, portion size, and eating occasions: contributions to increased energy intake in the United States, 1977-2006. PLoS Med. 2011 Jun;8(6):e1001050. doi: 10.1371/journal.pmed.1001050.

2. National Education Association: <https://www.nea.org/nea-today/all-news-articles/all-scrolling-how-screen-time-impacts-students>

3. Wang L, Martínez Steele E, Du M, Pomeranz JL, O'Connor LE, Herrick KA, Luo H, Zhang X, Mozaffarian D, Zhang FF. Trends in Consumption of Ultraprocessed Foods Among US Youths Aged 2-19 Years, 1999-2018. JAMA. 2021 Aug 10;326(6):519-530. doi: 10.1001/jama.2021.10238. PMID: 34374722; PMCID: PMC8356071

# Growth of the Food Industry



Wood, B., Robinson, E., Baker, P. et al. What is the purpose of ultra-processed food? An exploratory analysis of the financialisation of ultra-processed food corporations and implications for public health. Global Health 19, 85 (2022).

# How do ultra-processed foods contribute to obesity?

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- Because ultra-processed foods are like pre-digested foods





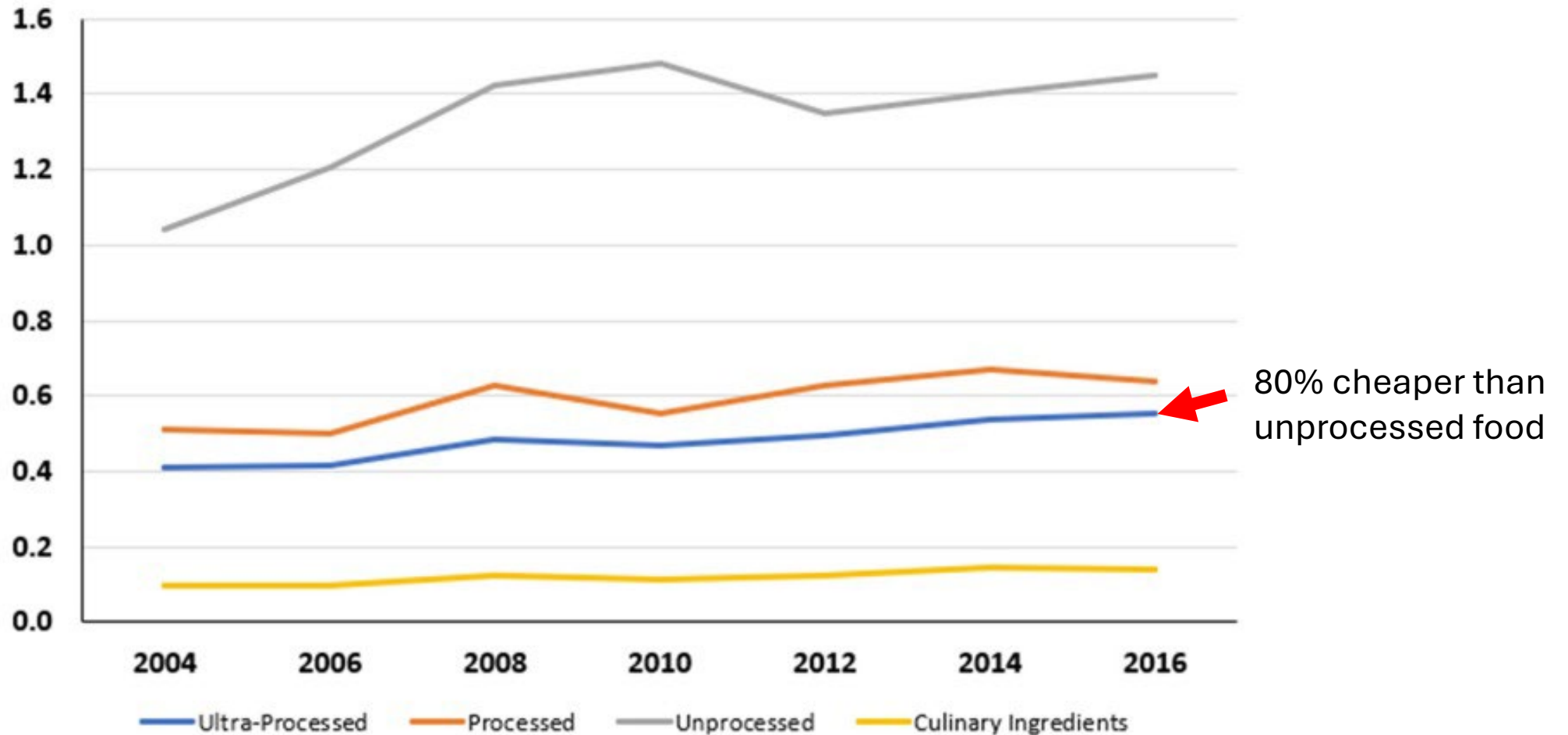
# The healthy choice is rarely the easy choice

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- SG's mom, living on a remote reservation community, shopping for 7
- Weekly budget for groceries: \$900
- As she does her weekly shopping at the store 25 miles from home, 85% of the food sold is ultra-processed



# Relative Food Costs (\$/100 kcal)





# What would you choose?



- Option A
- Hamburger Helper
- Cost: \$17
- Prep Time: 30 minutes
- Kid's reaction:



 5.0 average rating

**“Thanks mom!”**

- Option B
- Baked chicken with green beans and brown rice
- Cost: \$35
- Prep Time: 60 minutes
- Kid's Reaction:



**“What's this? Do we have anything else?”**



# Legacy of Historical and Intergenerational Trauma

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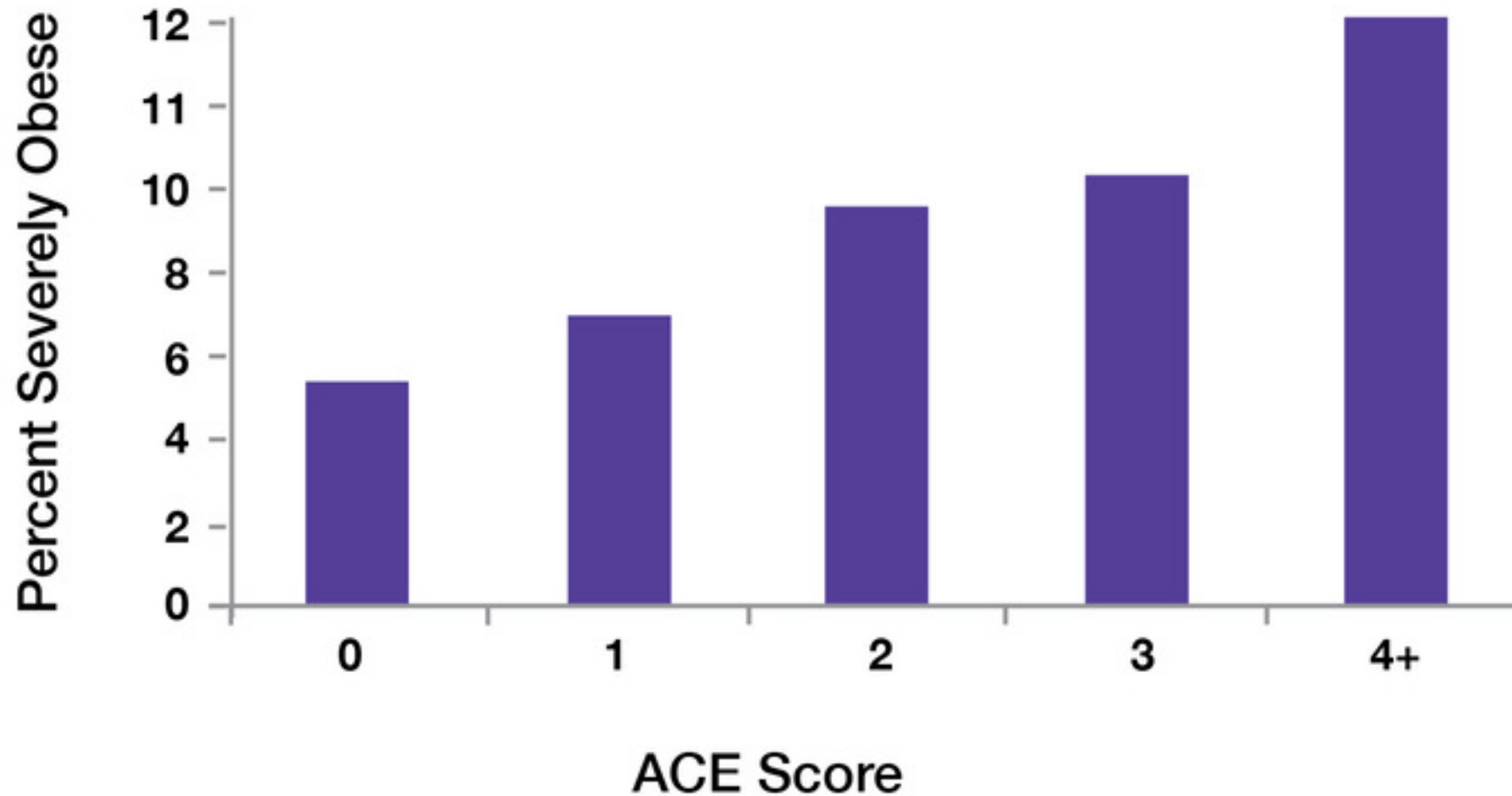
- Violent loss of land and food sovereignty
- Systematic destruction of culture, traditional wisdom, parenting skills
  - By 1925, over 80% of AIAN youth attended boarding schools<sup>2</sup>
- Introduction of alcohol
- Poverty
- Racism



Photo: <https://www.heraldnet.com/news/tulalip-woman-helped-uncover-dark-history-of-indian-boarding-schools/>

1. Maillacheruvu, Sara Usha. The Historical Determinants of Food Insecurity in Native Communities. Center on Budget and Policy Priorities. October 4, 2022. Available at: <https://www.cbpp.org/research/food-assistance/the-historical-determinants-of-food-insecurity-in-native-communities>

## Adverse Childhood Experiences & Prevalence of Adult Severe Obesity - BMI > 35



Source: 1998 CDC, Adverse Childhood Experiences Study

<https://marygiuliani.net/addiction-obesity-ace-study/>

# Evolving Definition of Obesity

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- **Obesity Medicine Association**

- “a chronic, relapsing, multifactorial, neurobehavioral disease, wherein an increase in body fat promotes adipose tissue dysfunction and abnormal fat mass physical forces, resulting in adverse metabolic, biomechanical, and psychosocial health consequences.”<sup>1</sup>

- **AAP**

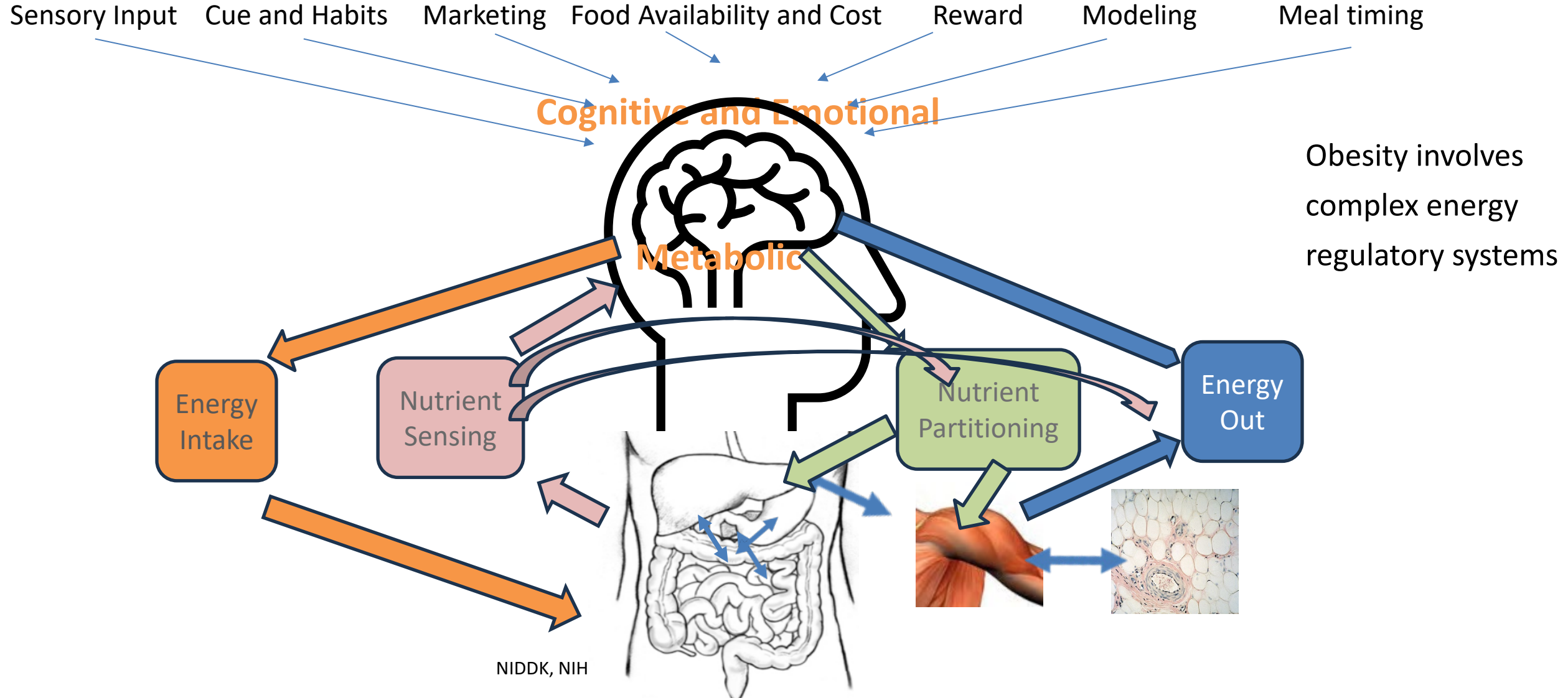
- “Obesity is a chronic disease that results in altered anatomy, physiology, and metabolism, all of which adversely affect the physical and mental health trajectory of children and adolescents.”<sup>2</sup>

1. <https://obesitymedicine.org/2017/08/29/definition-of-obesity/>

2. Obesity Management and Treatment During COVID-19 <https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/obesity-management-and-treatment-during-covid-19/>

# Obesity Disease Pathophysiology

## Environment and Lifestyle





# Adipose tissue secretes hundreds of adipokines

## Secretory Cells of Adipose Tissue:

- Adipocytes
- Precursor Cells
- Endothelial Cells
- Macrophages
- Foam Cells
- Neutrophils
- Lymphocytes
- Fibroblasts
- Others

### Cytokine and Cytokine-Like Proteins

- TNF- $\alpha$
- IL-6
- MCP-1
- Resistin
- Progranulin

### Proteins of the Fibrinolytic System

- PAI-1
- Tissue factor

### Complement and Complement-Related Proteins

- Adipsin
- Complement factor B
- ASP
- CTRPs

### Enzymes

- DPP-4

### Lipid Transport

- Apolipoprotein E
- Cholesterol ester transfer protein
- Lipoprotein lipase

### Endocannabinoids and other lipids

- Anandamide
- 2-AG
- Free fatty acids

### Proteins of RAS

- Angiotensinogen

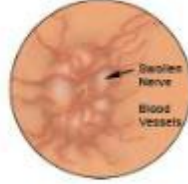
### Adipokines

- Leptin
- Adiponectin
- Visfatin/Nampt/PBEF
- Vaspin
- RBP4
- FGF21
- BMPs
- Nesfatin-1

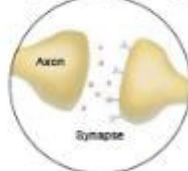


# Obesity Comorbidities

Idiopathic Intracranial Hypertension (IIH)



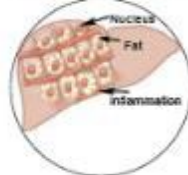
Depression, Anxiety, Low Self Esteem



Acanthosis Nigricans



Non-alcoholic Fatty Liver Disease (NAFLD)



Blount Disease



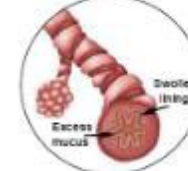
Slipped Capital Femoral Epiphysis (SCFE)



Obstructive Sleep Apnea (OSA)



Asthma



Dyslipidemia



Cardiomyopathy



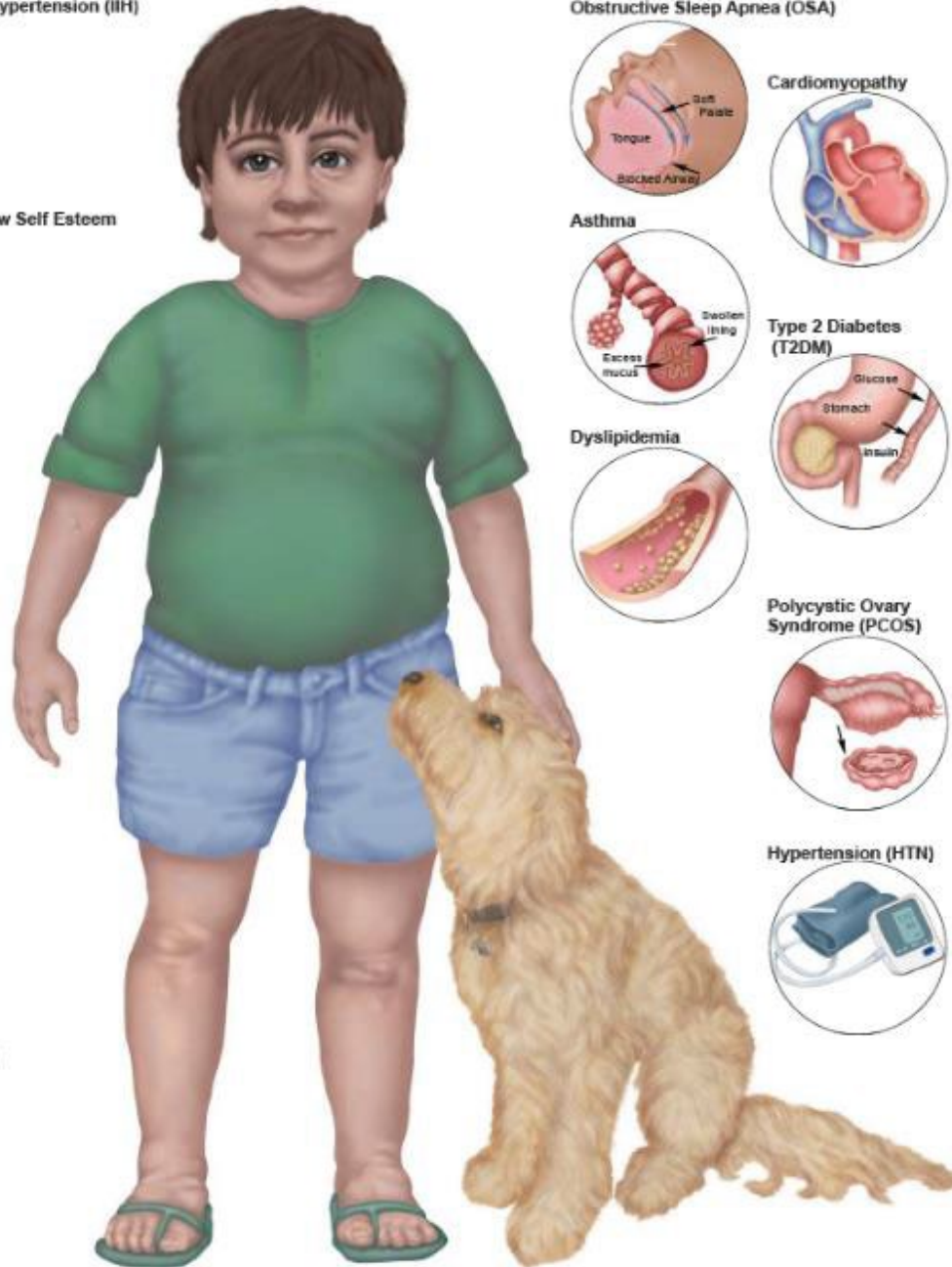
Type 2 Diabetes (T2DM)



Polycystic Ovary Syndrome (PCOS)

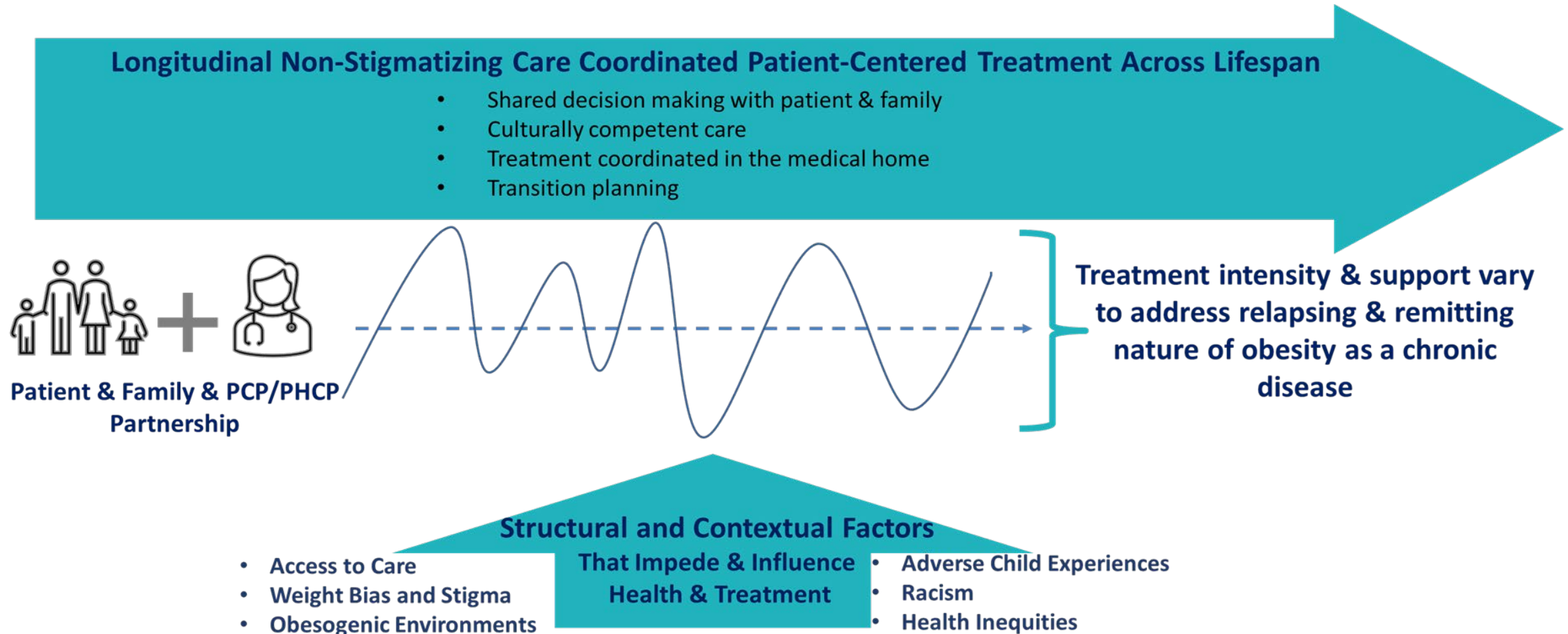


Hypertension (HTN)



# Obesity is a Chronic Disease

➤ Offer treatment early and immediately – there is no benefit to watchful waiting



# Our Patient: SG

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- PMHx:
  - Born via NSVD at 37 weeks due to preeclampsia and **GDM**
    - *GDM doubles the probability of childhood overweight/obesity at ages 2–5 years old.*<sup>1</sup>
  - **Mild Intermittent Asthma**
- Medications:
  - Budesonide/Formoterol MDI prn
- Social History:
  - Lives on a rural reservation community in New Mexico
  - In 3<sup>th</sup> grade, **No academic concerns** Family connected with heritage and participates in cultural activities
  - Family connected with heritage and participates in cultural activities
  - Lives with his mom, grandparents, and three siblings (age 11, 16, 19)
    - **Father died in 2021 from complications of EtOH**
  - **Mom is working two jobs. Grandparents provide the majority of day-to-day care**

1. Mantzourou M, Papandreou et al. Maternal Gestational Diabetes Is Associated with High Risk of Childhood Overweight and Obesity: A Cross-Sectional Study in Pre-School Children Aged 2-5 Years. Medicina (Kaunas). 2023 Feb 24;59(3):455. doi: 10.3390/medicina59030455.

# Our Patient: SG

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- **Family History:**
  - Type 2 DM: Father, grandmother and grandfather
  - Both parents, two siblings, one grandparent with obesity
  - Grandmother requiring dialysis due to Type 2 DM
- **Diet:** Most meals and snacks are provided by his grandparents
  - Sleep: 9pm- 6:00 am. **Keeps tablet in bed** "to help him sleep." Sleeps until noon on weekends
  - Screen time: Hard to determine, but probably **3 hours on school nights and over 8 on weekends**
  - Snacks: **Chips, Hot Cheetos, cookies and cakes are common.** Occasional fruits
  - Meal time: **Family dinners cooked at home** (burgers, chicken, stews common), large portions.
  - **Sugar Sweetened Beverages:** Juice and soda readily available and served with meals
  - **Fast food:** 1-3 times per week
- **Exercise:**
  - Enrolled in local youth sports leagues (basketball, flag football).
  - Has basketball hoop in driveway
  - Plays outside with neighborhood friends and cousins
  - Likes to go fishing with his grandfather

# Our Patient: SG

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- Behavior Health History:
  - While discussing his food and activity preferences and brainstorming possible goals ...
    - "When I say I want to have something healthy, my sisters and brother say 'that's because you're too fat.'"
    - Previous attempts to limit soda in the house led siblings to blame him for "ruining it for everyone."
    - While his grandparents readily offer sugary foods and drinks, he often feels reprimanded when his mom comes home
    - When feeling stressed "food helps me feel better."
  - Significant history of trauma related to Substance Use Disorder among close family and the death of his father

# Obesity Evaluation & Addressing Weight Stigma and Bias go Hand in Hand





# Assessment & Evaluation KAS Topics



BMI Measurement



Comprehensive Evaluation  
(PE, ROS, Hx, etc)



Risk Assessment  
(Whole child)



Comorbidity Evaluation  
(labs, tests)

# Don't Forget the Purpose of the Evaluation

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Designed to build relationship and gain insight, so you can help!

- Building Trust:
  1. Express your authenticity
    - Respect and value the uniqueness of each child and family
  2. Demonstrate empathy
    - Validate the challenges and that they are doing their best!
    - Celebrate their strengths
  3. Instill Confidence
    - That you have the knowledge to help them find and meet their goals



# The Clinic Environment

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- Team Approach
  - Negative messages from any aspect of the visit can be damaging
    - Staff attitudes and beliefs matter
    - Emphasize that everyone has a role to play (e.g. receptionist, support staff, lab)
  - Identify Office and Clinical Champions to ensure a welcoming environment
- Office Space and Flow
  - Are you able to schedule frequent follow-up visits?
  - Comfortable seating, medical equipment, and accommodations
  - Positive messages and posters
  - Consider a healthy habits questionnaire a part of the usual care

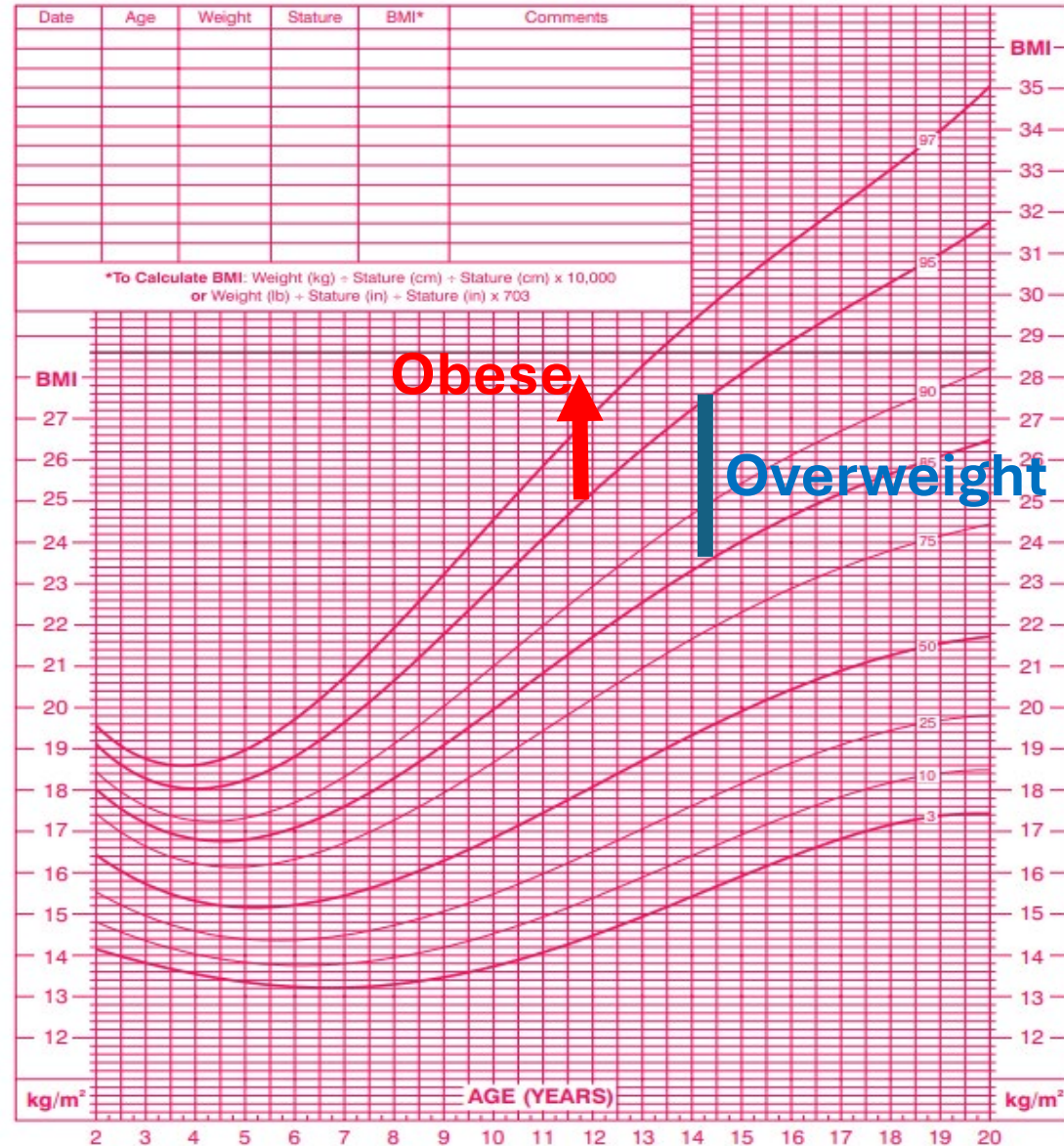




### 2 to 20 years: Girls

NAME

RECORD #



SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). <http://www.cdc.gov/growthcharts>

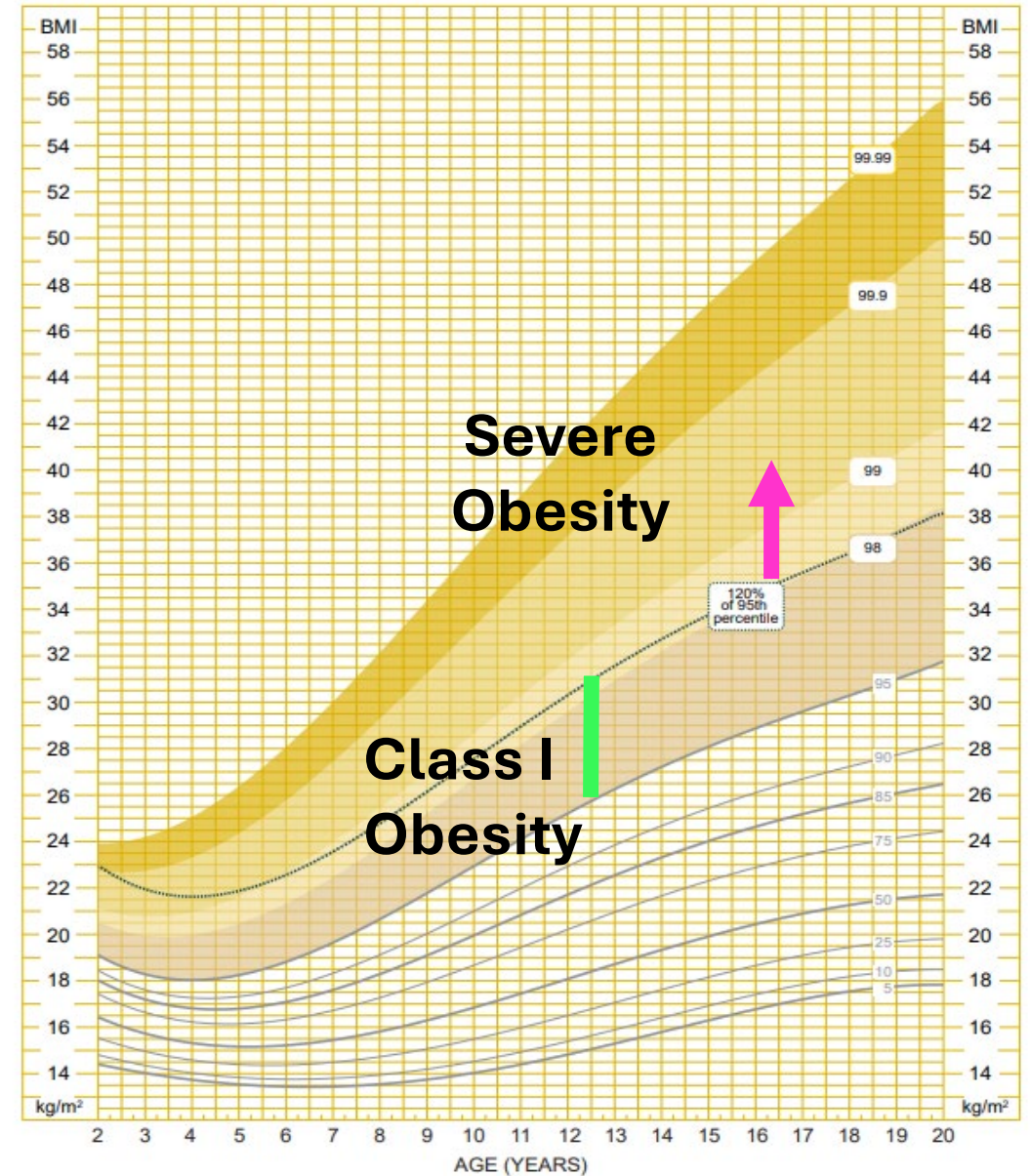


**Girls: Ages 2–20 years**

Body mass index-for-age percentiles

NAME

RECORD #



Data source: National Health Examination Survey and National Health and Nutrition Examination Survey.

Data source: National Health Examination Survey and National Health and Nutrition Examination Survey.  
Developed by: National Center for Health Statistics in collaboration with National Center for Chronic Disease Prevention and Health Promotion, 2022.





# Evaluation of Patients With Overweight or Obesity

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Non-stigmatizing conversation about weight with patients and families:

1. **Ask permission** to discuss the patient's BMI and/or weight.
2. **Avoid labeling** by using person-first language ("Child with obesity"; not "obese child" or "my patient is affected by obesity; not "my patient **is** obese").
3. Use words that are **perceived as neutral** by parents, adolescents, and children (e.g. "unhealthy weight, gaining too much weight for age, height, or health)."

**Keep the focus on health, not weight**

# Diagnosis and Evaluation

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- **Key Action Statement (KAS) 2:  
Evaluation of Overweight and Obesity **Grade B****
  - Evaluate children 2 to 18 y of age with overweight and obesity for obesity-related comorbidities by using a comprehensive patient history, mental and behavioral health screening, SDoH evaluation, physical examination, and diagnostic studies

# Evaluation of Patients With Overweight or Obesity

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## Medical History

- Chief Complaint
- History of the Present Illness
  - Review of Systems\*
- Past Medical History
- Medications
- Family History
  - 40-70% genetic contribution to obesity risk<sup>1</sup>

- Social History\*

- Nutrition and Physical Activity History\*

- Behavioral Health History

## Readiness for Change

- *Motivational Interviewing*

## Physical Exam\*

## Labs

1. Maes HH, Neale MC, Eaves LJ. Genetic and environmental factors in relative body weight and human adiposity. *Behav Genet.* 1997; 27(4):325–351

Review of Systems - Relevant Findings	
System	Symptoms of Obesity-related Conditions
<b>General</b>	Poor/slowed linear growth velocity, hyperphagia from early childhood, developmental delay, obesity onset <age 5 years or syndromic features
<b>Respiratory</b>	Shortness of breath, snoring, apnea, disordered sleep
<b>Gastrointestinal</b>	Asymptomatic vague abdominal pain, heartburn, dysphagia, chest pain, regurgitation, abdominal pain, enuresis, encopresis, anorexia, right upper quadrant pain; hyperphagia
<b>Endocrine</b>	Polyuria, polydipsia
<b>GYN</b>	Oligomenorrhea, dysfunctional uterine bleeding
<b>Orthopedic</b>	Hip, thigh or groin pain, painful or uneven gait, knee pain, foot pain, back pain, proximal muscle wasting
<b>Mental health</b>	Sadness, depression, anhedonia, body dissatisfaction, school avoidance, poor self-image, impulse eating, distractibility, hyperactivity, purging, restricting intake, binge-eating, night eating, flat affect
<b>Urinary</b>	Nocturia, enuresis
<b>Dermatologic</b>	Rash, darkened skin on flexural surfaces, pustules, abscesses, hirsutism in females, flesh-colored striae, purplish striae, skin fold irritation
<b>Neurologic</b>	AM headache, daytime sleepiness, persistent headache

Sarah E. Hampl, et. al. CPG  
 Pediatrics February 2023; 151 (2):  
 e2022060640. 10.1542/peds.2022-0606

# Social History

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- Family and Home Environment
  - Family meals, routines and limits are protective.<sup>1</sup>
- Food Environment and Preferences:
  - Relationship with food
  - What are the healthy foods that you like? (fruit and vegetable menu)
- Nutrition and Physical Activity History
  - Diet history\*
- Screen Time
- Sedentary Behavior
- Sleep Duration
  - Shorter sleep time is associated with obesity in children.<sup>2</sup>
- Psychosocial Stress
  - Bullying
  - Depression and Anxiety
  - Trauma
- SDoH
- ACEs

1. Bates CR, Buscemi J, Nicholson LM, Cory M, Jagpal A, Bohnert AM. Links between the organization of the family home environment and child obesity: a systematic review. *Obes Rev.* 2018;19(5):716–727

2. Magee L, Hale L. Longitudinal associations between sleep duration and subsequent weight gain: a systematic review. *Sleep Med Rev.* 2012;16(3): 231–241



- Start by discovering and celebrating the current strengths
  - Cultural activities and sources of strength
  - Healthy foods they like
  - Fun activities
  - Discover their Interests in learning
    - Cooking
    - Gardening
    - New activities
    - Opportunities for family time

# SUPER FOODS

## ALIMENTOS

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### BEANS&PEAS • FRIJOLES&LEGUMBRES



- ☐ Black Beans / Frijoles Negros, Habichuelas Negras
- ☐ Black-Eyed Peas / Frijoles de Ojo Negro
- ☐ Chickpeas / Garbanzos
- ☐ Edamame / Edamame, Frijoles de Soya
- ☐ Kidney Beans / Frijoles Rojos, Habichuelas Rojas
- ☐ Lentils / Lentejas
- ☐ Lima Beans / Habas
- ☐ Navy Beans / Frijoles Blancos, Habichuelas Blancas
- ☐ Peas / Chícharos
- ☐ Pigeon Peas / Gandules
- ☐ Pink Beans / Frijoles Rosados, Habichuelas Rosadas
- ☐ Pinto Beans / Frijoles Pintos, Habichuelas Pintas
- ☐ Split Peas / Guisantes Partidos

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### NUTS&SEEDS • NUECES&SEMILLAS

- ☐ Almonds / Almendras
- ☐ Brazil Nuts / Nueces de Brasil
- ☐ Chia Seeds / Semillas de Chia
- ☐ Flaxseeds / Semillas de Lino
- ☐ Hazelnuts / Avellanas
- ☐ Peanuts / Cacahuates
- ☐ Pecans / Nueces Pecanas
- ☐ Pumpkin Seeds / Semillas de Calabaza
- ☐ Sunflower Seeds / Semillas de Girasol
- ☐ Walnuts / Nueces



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### GRAINS • GRANOS

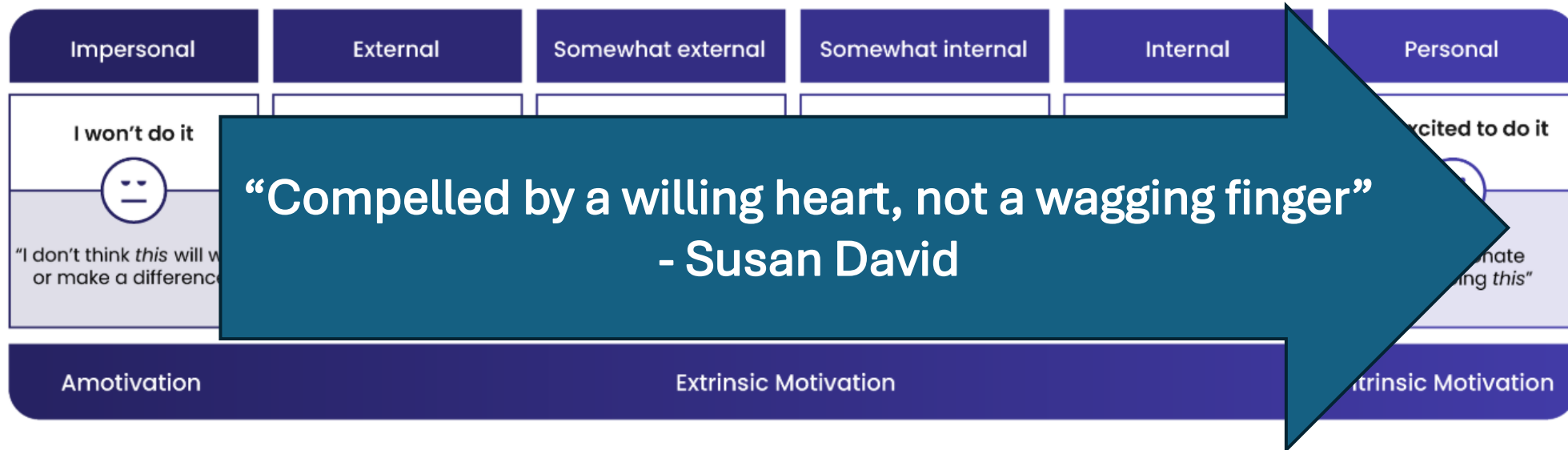
# Nutrition and Physical Activity History

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- 24 Hour Recall: “Walk me through what you ate and drank yesterday.”
  - Fruits and vegetables
  - Snacking
  - Regular, balanced meals (Food insecurity)
    - Meal skipping
    - Selective eating
    - Disordered eating
  - Beverages (especially sweet drinks)
  - Frequency of eating out, fast food
  - Eating as a family
  - Portion size
  - Influence of grandparents or other caregivers on diet
- Screen Time: “What kind of screens, video games, or devices do you use?”
  - Using screens in bed
  - Any parental control settings

Relevant Physical Exam Findings	
Vital signs	Anthropometric
<ul style="list-style-type: none"> <li>• Hypertension</li> <li>• Increased heart rate</li> </ul>	<ul style="list-style-type: none"> <li>• Changes in height velocity</li> <li>• Changes in weight gain</li> </ul>
Gastronintestinal	Genitourinary
<ul style="list-style-type: none"> <li>• Hepatomegaly</li> </ul>	<ul style="list-style-type: none"> <li>• Buried penis</li> </ul>
HEENT	Chest
<ul style="list-style-type: none"> <li>• Papilledema</li> <li>• Dental caries</li> <li>• Tonsillar hypertrophy</li> </ul>	<ul style="list-style-type: none"> <li>• Gynecomastia</li> <li>• Cervicodorsal hump</li> </ul>
Musculoskeletal	Skin
<ul style="list-style-type: none"> <li>• Gait</li> <li>• Lordosis</li> <li>• Hip pain and/or limp</li> <li>• Genu varum/valgum</li> <li>• Ped planus</li> </ul>	<ul style="list-style-type: none"> <li>• Acanthosis</li> <li>• Hirsutism/acne</li> <li>• Striae</li> <li>• Intertrigo</li> <li>• Pannus</li> </ul>

# “Motivationally- Supportive” Approach to Evaluating Obesity



# Honoring Basic Psychological Needs

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HUMAN BEINGS HAVE THREE BASIC NEEDS:

## COMPETENCE

People need to gain mastery and control of their own lives & their environment.  
Essential to wellness.

## AUTONOMY

People need to feel in control of their own life, behaviours and goals. This is about choice.

## RELATEDNESS

People need to experience a sense of belonging and connection with other people.  
*Feeling cared for by others  
& to care for others.*

Based on the work of Richard Ryan and Edward Deci.



# A Good H&P is not Worth Undermining Autonomy

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- Ask permission to discuss topics
- Open-ended questions
  - Red flag: you're doing most of the talking
- Importance & confidence scales
- Let the patient sent the agenda
  - Offer choices if necessary (topic-cards)

## AUTONOMY

People need to feel in control of their own life, behaviours and goals. This is about choice.

# Create a Strengths Inventory

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- Highlight all the things that are already going well
  - Healthy foods and activities which they like
  - Positive family routines
  - Positive relationships
  - Cultural Heritage
- Celebrate their pre-existing knowledge-base
- Explore past successes
- Acknowledge strengths

## COMPETENCE

People need to gain mastery and control of their own lives & their environment.  
Essential to wellness.

# The Messenger is at least as Important as the Message

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- Ask fun questions too
  - Do they have any pets?
  - What's the farthest they've been from home?
- Reflective listening
  - "Here is how I heard what you were saying..."
    - Patients are more likely to be motivated by hearing what they have said, instead of what other people have told them.
- Express that they are not alone in their challenges
- Convey your enthusiasm to work side by side with them over time

*Let your questions spring from genuine interest and curiosity, not a need to collect data*

## RELATEDNESS

People need to  
experience a sense  
of belonging and  
connection with  
other people.

*Feeling cared for by others  
& to care for others.*

# Medical Home

Longitudinal comprehensive patient-centered obesity treatment  
coordinated in the medical home

Adjunct tools to leverage where appropriate and in conjunction with foundational elements

Pharmacotherapy

Surgery

+

+

Provision or referral to intensive Health Behavior and Lifestyle  
(HB&L) treatment ( $\geq 26$  contact hours over 2-12 months)

Use of MI for shared decision making &  
ongoing behavioral counseling

Ongoing assessment of individual, social and contextual risk factors  
and evaluation for comorbidities & comorbidity treatment

+

Layer in  
multidisciplinary  
care &  
community  
resources  
as available and  
tailored to  
patient/family  
strengths and  
needs.

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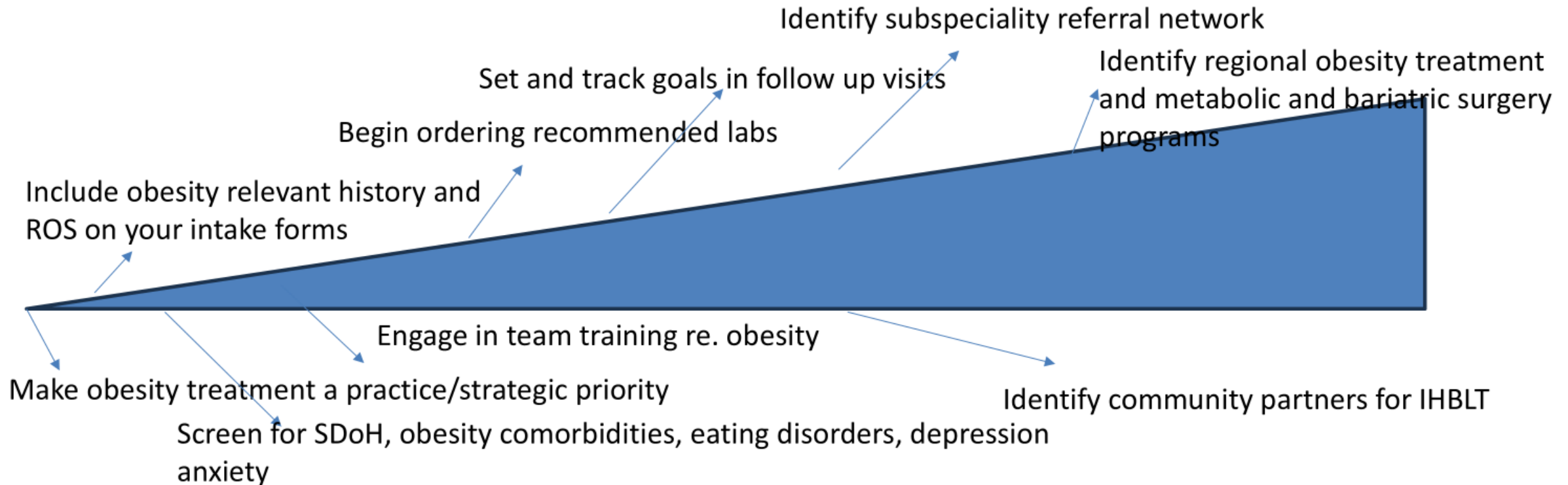
Foundational  
(Concurrent Core Elements)

# Treating Childhood and Adolescent Obesity

Know where you are and start there.

This is a marathon not a sprint.

Practice change is most successful when goals are achievable, clear, measurable and supported by the team and the system you are working in.





# Resources: AAP Institute for Health Childhood Weight

Website: <https://ihcw.aap.org>  
[www.aap.org/obesitycpg](http://www.aap.org/obesitycpg)



American Academy of Pediatrics  
Institute for Healthy  
Childhood Weight