3

Psychosocial Factors Related to Obesity in Children and Adolescents

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As outlined in Chapter 2, the long-term medical consequences of obesity are well-documented, with precursors for adult disease becoming increasingly prevalent in overweight youth. It is asserted, however, that the greater immediate and observable costs of pediatric obesity are psychosocial (Dietz, 1998). The purpose of this chapter is to review the known psychosocial correlates of pediatric obesity derived from the empirical literature. These psychosocial correlates cross a number of domains and environments that are central to understanding healthy child and adolescent development. We have organized the chapter to reflect specific psychosocial factors within the family and peer environments and then psychosocial functioning at the individual level. Throughout the chapter and in our summary, we discuss the implications of these data for weight management treatment as well as important directions for future research.

Psychosocial Functioning in the Family Environment

We are only beginning to understand the parental and familial psychosocial characteristics that typify the obesigenic family environment. This is surprising given the compelling empirical evidence supporting family-based intervention, which identifies parental behavior as a key component of effective treatment (Epstein, Valoski, Wing, & McCurley, 1994; Golan, Weizman, Apter, & Fainaru, 1998; Wrotniak, Epstein, Paluch, & Roemmich, 2004). As is discussed in Chapter 12, pediatric obesity is linked to family
socioeconomic and demographic factors. Further, it is well-established that parental obesity holds strong predictive power in the development and persistence of obesity in the child and adolescent years, arguably the result of a gene-environment interaction. These important data describe a broad context of familial correlates and risk factors for pediatric obesity. As detailed below, there is increasing evidence that additional psychosocial factors characterize the family environment of obese youth.

**Maternal Distress**

Two groups of researchers examined parental psychological functioning in clinical samples of obese children and adolescents, and they found that a remarkable percentage of mothers (28–50%) reported clinically significant levels of psychological distress (Epstein, Myers, & Anderson, 1996; Zeller, Saelens, Roehrig, Kirk, & Daniels, 2004). These mothers did so at higher rates than mothers of nonoverweight youth, (Zeller et al., 2007). In contrast, the prevalence of clinically significant paternal distress was within normative base rates (Epstein, Klein, & Wisniewski, 1994b; Zeller et al., 2007). These data are concerning, as maternal psychopathology is known to disrupt parenting and the parent-child relationship and can lead to poor physical and psychological health outcomes in children (Beardslee, Versage, & Gladstone, 1998; Burke, 2003). It is therefore not surprising that maternal distress has been linked to pediatric obesity treatment outcomes. For example, higher maternal distress was associated with poorer child weight loss (Epstein, Wisniewski, & Weng, 1994), and although maternal distress improved during active family-based weight management treatment, these gains were not maintained post-treatment (Epstein, Paluch, Gordy, Saelens, & Ernst, 2000). In contrast, we documented that higher maternal distress does not predict attrition from treatment (Zeller, Kirk, et al., 2004). One could therefore hypothesize that a mother may keep her family in treatment when she is distressed because she likely benefits from the support and structure provided. However, this distress may reduce the effectiveness of parenting skills she needs to support her child in adopting a healthier lifestyle. Future research should examine the links between maternal distress and parenting and determine whether maternal distress is typical of families with obese youth who are not accessing care.

**Family Functioning**

Several groups of researchers have examined the family functioning of obese youth. Family functioning, or the family emotional climate, is typically defined by dimensions such as support, conflict, cohesion, and control (Kronenberger & Thompson, 1990). Within the broader pediatric literature, high levels of familial cohesion and support and low levels of conflict are documented protective factors for child/adolescent adjustment and the management of pediatric chronic illness (Drotar, 1997; Wysocki, 1993).