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## Childhood and Adolescent Obesity Prevention in Twin Falls, Idaho

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COUN 6785: Social Change in Action:  
Prevention, Consultation, and Advocacy

**Social Change Portfolio**

Allison Welch

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## OVERVIEW

**Keywords:** childhood, adolescent, obesity, prevention, Twin Falls, Idaho, social-ecological model, risk factors, protective factors, advocacy

### Childhood and Adolescent Obesity Prevention in Twin Falls, Idaho

**Goal Statement:** The social change goal for Twin Falls County is to prevent obesity among children and adolescents by decreasing the percentage of child and adolescent obesity based on BMI from 12.7% to under 10% by December of 2026.

**Significant Findings:** Obesity is a national crisis that directly impacts the current and future quality of life for children and adolescents. In Idaho, the youth obesity rate is 12.7%, which comes in 5.8% lower than the national average youth obesity rate (State of Childhood Obesity, n.d.; CDC, n.d.). Although the percentage of obese children in Idaho is slightly less than the national average, the obesity rate in Idaho is rapidly growing (County Health Rankings & Roadmaps, 2018). There are vast physical and mental health consequences of childhood obesity including increased risk for body dissatisfaction, depression, social marginalization, discrimination, disordered eating, and weigh-based teasing (Knol et al., 2016). It is recommended that prevention efforts draw upon the strengths of entire communities to support families with preventing childhood and adolescent obesity. When it comes to effectively preventing child and adolescent obesity, parents are crucial targets for intervention (Ohri-Vachaspati et al. 2015; Noh & Min, J. 2020).

**Objectives/Strategies/Interventions/Next Steps:** The objective is to prevent childhood and adolescent obesity in Twin Falls by strengthening protective factors and reducing risk factors at

individual, family, school, and community levels. From an ecological perspective, prevention efforts must address reciprocal causation, or the fact that individual behavior shapes and is shaped by multiple levels (National Cancer Institute, 2005). Behavioral coaching is an evidenced- and community-based option for obesity prevention (Social Programs that Work, 2018). Home Sweet Home (HSH), an obesity prevention program that targets parents and grandparents of young children living in a rural town, is another effective prevention program (Knol et al., 2016). Both HSH and behavioral coaching fit a positive psychology framework that draws upon strengths and resources within a family and community. Any advocacy work for obesity prevention in Twin Falls needs to address the accessibility of physical activities and healthy food. Accessibility is a community responsibility that can be address by city policy makers and local convenience and dollar stores where food insecure individuals are more likely to shop for their groceries (Lyonnais et al., 2020).

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## INTRODUCTION

### Childhood and Adolescent Obesity Prevention

Obesity, a condition that negatively affects an individual's physical and mental health, is a growing problem in Twin Falls, Idaho. Like the United States as a whole, Twin Falls County is experiencing an obesity crisis. According to the Centers for Disease Control and Prevention ([CDC], n.d), the national obesity rate has increased by 12% from 2000 to 2018. The Twin Falls County obesity rate has increased from 21% in 2011 to 33% in 2020 (County Health Rankings & Roadmaps, 2018). While it took the nation 18 years to increase the obesity rate by 12% (CDC, n.d.), it only took Twin Falls 9 years to increase the obesity rate by 12% (County Health Rankings & Roadmaps, 2018). Unfortunately, obesity is not only an adult problem; 18.5% of

children and adolescents experience obesity (Centers for Disease Control and Prevention [CDC], n.d.). According to the State of Childhood Obesity (n.d.), 12.7% of youth in Idaho, ages 10-17, have obesity. To understand the obesity crisis in Twin Falls, it is necessary to analyze it from a social-ecological model, which posits that human development is bidirectionally influenced on individual, family, peer, school, and community/cultural levels (Swearer & Hymel, 2015). Due to the severity of obesity related physical and mental health consequences and the rapidly increasing obesity rate, obesity prevention is needed for children in Twin Falls. This social change portfolio will outline the scope and consequences of childhood obesity, apply the social-ecological model to childhood obesity in Twin Falls, apply theories of prevention, discuss diversity and ethical considerations, and outline advocacy efforts.

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## PART 1: SCOPE AND CONSEQUENCES

### Childhood and Adolescent Obesity Prevention

Obesity is a growing problem in Twin Falls County. According to County Health Rankings and Roadmaps (n.d), Twin Falls county has an adult obesity rate of 33%, which is 4% higher than the obesity rate for the state of Idaho. The youth obesity rate is 12.7%, which comes in 5.8% lower than the national average youth obesity rate (State of Childhood Obesity, n.d.; CDC, n.d.). The 33% obesity rate of Twin Falls County is a major increase from Idaho's 1990 obesity rate of only 9.3% (Idaho Department of Health and Welfare, n.d). The obesity crisis also seems to be equally affecting males and females in Twin Falls County with a 2013 rate of 26.9% and 26.2% respectively (Idaho Department of Health and Welfare, n.d). Some of the physical health risks associate with obesity include infertility, sleep apnea, asthma, diabetes, stroke, heart disease, and osteoarthritis (Idaho Department of Health and Welfare, n.d). Certain types of

cancer are also obesity-related conditions that can lead to preventable, premature death (CDC, n.d).

Obesity has a bidirectional link to mental health problems. While weight stigma and physical disability may contribute to decreased mental health, poor mental health may facilitate obesity (Breland et al., 2020). Poteet et al. (2020) reported that obesity in children can lead to mental health problems such as depression and low self-esteem, and social problems such as bullying. Bjertnaes et al. (2020) found greater peer problems associated with higher values of body mass index (BMI) in adolescents. Specifically, they reported that conduct problems were associated with increased BMI in boys, while peer and emotional problems were associated with increased BMI in girls (Bjertnaes et al, 2020). Knol et al. (2016) stated that obese children may experience body dissatisfaction, depression, social marginalization, discrimination, disordered eating, and weigh-based teasing. Because obesity is such a severe health risk that is on the rise, prevention efforts need to target children and adolescents, so they never experience obesity in the first place. The social change goal for Twin Falls County is to prevent obesity among children and adolescents by decreasing the percentage of child and adolescent obesity based on BMI from 12.7% to under 10% by December of 2026. This goal will be achieved through education, community support, family support, access to healthy foods, and opportunities for physical activities.

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## PART 2: SOCIAL-ECOLOGICAL MODEL

### Childhood and Adolescent Obesity Prevention

Obesity is not an individual problem created in isolation, rather it is complexly influenced by biological, social, and economic factors. Ohri-Vachaspati et al. (2015) stated that the social-ecological model (SEM) postulates that individual outcomes are affected by interactions within a

larger economic, social, and cultural context. Additionally, SEM views difficulties occurring through interactions between an individual's biological makeup and their multifaceted environment (Swearer & Hymel, 2015).

### **Individual Influences**

On an individual level, genetic predispositions (including ethnicity) influence a child's risk for obesity. An individual's physical activity level can also serve as a risk or a protective factor. Having ethnic minority status (particularly Black and Hispanic) and low physical activity are both risk factors for obesity (Noh & Min, J. 2020). Conversely, high physical activity was found to be a protective factor for childhood obesity (Noh & Min, J. 2020). Aboueid et al. (2019) found that an individual's ability to set small, realistic goals was an additional protective factor for weight management. Many individual risk and protective factors, such as genetics and physical activity level, are largely influenced by one's family.

### **Family Influences**

Families can both add to a child's risk for obesity or protect against it. Ohri-Vachaspati et al. (2015) found that when it comes to childhood obesity, the largest influencers were parental characteristics followed by parental perceptions about access to healthy food and physical activities. Thus, when trying to prevent obesity in children, parents are crucial targets for intervention (Ohri-Vachaspati et al. 2015; Noh & Min, J. 2020). Aboueid et al. (2019) found that low socio-economic status (SES) was also a risk factor for obesity. Because children are not responsible for their SES, a child's SES is better viewed as a family risk or protective factor. Having an older mother and a fragile family structure (single or divorced mother with low SES) were both found to be risk factors for childhood obesity, while younger mothers and supportive families protected against childhood obesity (Noh & Min, J. 2020). JaKa et al. (2019) found that



pediatric obesity decreased in proportion to the amount of time parents spent on phone intervention sessions where they learned how to support their children's weight management. JaKa et al. (2019) also found that change in child BMI percentile was associated with the number of unique activities parents implemented between sessions. These findings both support the idea that parents play a crucial role in childhood obesity prevention. In fact, another risk factor for childhood obesity is lack of parental understanding about the challenges and problems of obesity (Silver & Cronin, 2019).

### **Peer Influence**

In addition to families, peers can also be risk or protective factors for childhood obesity. Friends who are physically active and share healthy food protect their peers from obesity by encouraging a more physically active lifestyle (Noh & Min, J. 2020). Conversely, peers who are sedentary socializers (play video games instead of football), would contribute to an individual's risk factor. Having friendly peers also largely influences whether a child's experience at school will be positive or negative.

### **School Influence**

Children spend a large part of their lives in school. Noh and Min (2020) found that supportive school environments serve as a protective factor against childhood obesity while stressful school environments add to a child's risk for obesity. Additionally, schools are a critical factor in obesity prevention because education was found to be a protective factor (Aboueid et al., 2019). As schools provide a robust education in a supportive environment, they protect children from obesity.

## **Community/Cultural Influences**

On a community level, higher SES, easy access to healthy food, and having ample health care teams that support parental weight management all protect against childhood obesity. Choo et al. (2020) reported that certain behaviors are embedded within certain population groups and that interventions must be structured around specific barriers within specific populations. Many children in Twin Falls come from families with a lower SES, which is a risk factor for obesity (Aboueid et al., 2019). Choo et al. (2020) found that socioeconomically vulnerable children may engage in emotional eating to fill other deprivation. In Twin Fall, the quick, easy, affordable food does not contain enough vegetables. Silver and Cronin (2019) found that for low income families (sometimes working multiple jobs), the logistics of getting kids to after school programs could be excessively difficult. Communities can either act as a protective factor by offering supportive schools, healthy and affordable food options, and accessible after school programs that provide physical activity, or communities can contribute to the risk of obesity by creating a culture of sedentary lifestyles with no support for healthy eating.

Protective and risk factors from each level overlap and have bidirectional influences. For example, an individual's SES is impacted by their family as well as the employment opportunities available in the community. Likewise, schools are affected by the individual students attending the school, the teachers available to teach, and the money that is raised from local taxes. Schools influence and are influenced by individuals, peers, families, and communities. Silver and Cronin (2019) discussed the need to tailor childhood obesity prevention to the complex dynamics and needs of families, which include logistical priorities, parental role modeling, intergenerational tension, and divergent views about obesity. Each level of the socio-ecological mode influences and is influenced by the other levels.

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## PART 3: THEORIES OF PREVENTION

### Childhood and Adolescent Obesity Prevention

When conceptualizing obesity prevention, it is important to ground all prevention efforts in a sound theoretical orientation. Theories are a systematic way of making sense of a situation that allows prevention planners to develop and evaluate appropriate, innovative, evidence-based interventions (National Cancer Institute, 2005). According to Raczynski et al. (2013), sound theoretical rationales should guide all activities that are implemented as part of preventative programs. It can take multiple theories to adequately conceptualize and address various aspects of prevention (National Cancer Institute, 2005).

There are several theories that are effective for childhood and adolescent obesity prevention. Hage and Romano (2013) proposed that using positive psychology as a theoretical foundation allows prevention workers to build up positive aspects of individuals, families, and communities that will act as protective factors—thus preventing the problem. Framing intervention efforts in a positive psychology framework will allow adherence to the American Counseling association (ACA) *Code of Ethics* (2014) standard B.5.b, which requires counselors to be sensitive to the diversity of families and respect a parent or guardian's right to make decisions for the welfare of their children. Positive psychology theory will allow prevention efforts to tap into the unique strengths of parents, grandparents, cultures, and communities. From an ecological perspective, prevention efforts must address reciprocal causation, or the fact that individual behavior shapes and is shaped by multiple levels (National Cancer Institute, 2005). Because of reciprocal causation at many levels of the ecological model, evidence-based approaches to obesity prevention require community engagement, collaboration, and cultural relevance (Raczynski et al., 2013).

In addition to positive psychology, the theory of planned behavior (TPB) can be used to accounts for cultural relevance as well as other multivariate influences on obesity from the social-ecological model. TPB posits that the more an individual plans to perform a certain behavior, the more likely they are to engage in the activity (Andrews et al., 2010). When applying TPB to obesity prevention, attention must be given to parental attitudes, subjective norms, and perceived behavioral control (Andrews et al., 2010). Additionally, a parent's response efficacy, or their belief that their interventions will be efficacious, is a critical component of successful weigh loss behavior (Andrews et al., 2010). Accounting for individual beliefs and behaviors as well as community factors, is crucial for obesity prevention programs to be effective (Raczynski et al., 2013). Andrews et al. (2010) found TPB to be an effective theory in predicting the influence parental social norms, attitudes, and beliefs have on childhood BMI.

Another theory that has been effective in obesity prevention programs is the social cognitive theory (SCT). Knol et al. (2016) found the application of SCT to be effective in childhood obesity prevention. SCT suggests that individual behavior is shaped by the ability to regulate behavior and shape one's environment (Knol et al., 2016). Knol et al. (2016) believed that SCT blended well with the social-ecological model because they are both ideal theories for intervention within a home environment. When implementing an obesity prevention program within a home environment, multiple levels of the social-ecological model can be address including individual factors, family factors, and cultural factors.

Two examples of programs that have shown efficacy addressing obesity are behavioral coaching and Home Sweet Home (HSH). Social Programs that Work (2018) listed behavioral coaching as an evidenced- and community-based treatment for obesity. By using a randomized controlled trial with 415 obese patients, implementation of this program lead to significantly

more weightless two years later than the control group. One limitation of this study is that it was used to decrease obesity among adults. However, a similar concept could be applied to parents of children at risk for obesity.

The second example of an effective program was HSH, a SCT obesity prevention program that specifically targeted parents and grandparents of young children living in a rural town. This program implemented mindful eating, education, and small-group discussions. Knol et al. (2016) reported that HSH participants increased their mindful eating habits, decreased the availability of unhealthy food in the home, and decreased their sedentary behavior. The strength of HSH is that it is culturally sensitive and able to meet the needs of a specific population (Knol et al., 2016). Both HSH and behavioral coaching fit a positive psychology framework of drawing upon strengths and resources within a family and community.

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## PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

### Childhood and Adolescent Obesity Prevention

While this social change portfolio targets all children and adolescents in Twin Falls, research indicates that the Hispanic community is particularly at risk for obesity. Hull et al. (2018) reported that Hispanic children not only have higher obesity rates, their obesity also starts earlier and increases more rapidly. In 2013, Hispanics in Twin Falls County experienced obesity at a higher rate (35.3%) than Caucasians (26.8%) (Idaho Department of Health and Welfare, n.d). The higher rate of obesity found in Twin Falls' Hispanic community is consistent with national trends. According to the CDC (n.d.), Hispanics have a national obesity rate of 44.8% versus 42.2% for non-Hispanic Whites.

Because of the vulnerability of the Hispanic population in Twin Falls, ethical practice requires obesity prevention efforts to be culturally relevant to this group. Section A of the *ACA Code of Ethics* (2014) states that ethical counselors must actively attempt to understand their client's culture and background as well as their own culture and background. By recognizing and addressing the unique needs of minority groups in Twin Falls, this prevention proposal will meet standard A.1.a, which requires counselors to respect the dignity and promote the welfare of all their clients (ACA, 2014). Additionally, ethical standard B.5.b, requires counselors to be sensitive to the cultural diversity of clients and their families while respecting the rights of parents to make decisions regarding their children's welfare. Finally, standard A.7.a. states that counselors can advocate at individual, institutional, and societal levels to promote the healthy development of their clients (ACA, 2014). Vera and Kenny (2013) recognized that prevention practitioners have the responsibility to ethically address complex social forces such as racism and poverty when planning and implementing social prevention practices.

Several mechanisms are needed to increase the cultural relevance for obesity prevention with the Hispanic population in Twin Falls. Barkin et al. (2012) found that parent-child dyads attending a skills-building, culturally tailored intervention at a local community recreation center was successful at reducing children's BMI short-term (there was no long-term follow up). While prevention efforts in Twin Falls can address culturally tailored skill-building for parent-child dyads, there is no local community center to support such gatherings. However, Cotter et al. (2018) found that holding community obesity intervention programs within the affordable housing community where participants reside led to increased participation, satisfaction, and trust.

Many researchers identified the need for participants to have easy access to intervention programs. After completing a randomized trial for childhood obesity prevention, Hull et al. (2018) reported that while 24 hours of contact is ideal to achieve weight loss, 25.6% of their participants did not attend any group sessions and 20.6% of their participants only attend one or two sessions even with reminder phone calls before the meetings. Hull et al. (2018) found that some of the barriers that inhibited participation for Hispanic families included not having adequate access to transportation (including lack of a valid driver's license), participants having competing family commitments, mothers being too busy cooking family dinners, and parents having to work during the meetings. Po'e et al. (2010) also found a lack of participation to be a barrier to success with obesity prevention in the Hispanic population. The results reported by Hull et al. (2018) and Po'e et al. (2010) are consistent with the situation in Twin Falls. Thus, any culturally sensitive intervention would need to address competing demands on time and a lack of transportation. Participation needs to be convenient and accessible for participants. Both behavioral coaching and HSH are programs that can be implemented via phone conversations and through visiting participants in their homes—thus reducing the barriers that impede participation.

One potential way to increase participation and increase the cultural relevance for the Twin Falls Hispanic population is to form partnerships across multiple levels of the socio-economic model, including, home, school, and community. To adequately address childhood obesity, key stakeholder groups need to be unified in their efforts (Po'e et al. 2010). Key stakeholder in this prevention project would include families with children and adolescents, local pediatricians, bilingual community members, schools, nutritionists, local food banks, counselors, and local food factories providing food and funding. Local food suppliers can also contribute

healthy food during meetings. Cotter et al. (2018) found that having time for socialization and meals or snacks contributed to successful prevention programs among Hispanics.

Coalition building can be a low cost and high yield way to get participation from community members who are looking for meaning and ways to connect with their community (Po'e et al. 2010). Partnerships between community members and community resources adds to the sustainability of the prevention project (Po'e et al., 2010). Participation from Hispanic community members can also help address the ethical issue of imposing practitioner values on the prevention population. According to Vera and Kenny (2013) the practitioner's values must be adequately addressed in the prevention efforts so that they are not accidentally imposed on the target population, causing unnecessary harm.

Finally, through community collaboration, culturally sensitive informed consent can be obtained. Through community collaboration, bilingual community members can also facilitate offering the program in multiple languages (Cotter et al. 2018). Vera and Kenny (2013) stated that obtaining informed consent is complicated in prevention efforts because there is no single identified client. Through collaboration efforts participants can receive bilingual consent forms via their annual pediatrician checkup (if they have health insurance) or through their school counselor. Participants can also learn about the inherent limits of confidentiality when participating in group settings.

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## PART 5: ADVOCACY

### Childhood and Adolescent Obesity Prevention

When it comes to advocating for obesity prevention among children and adolescents in Twin Falls, there are several barriers at institutional, community, and public policy levels. These



barriers must be identified and addressed in order to adhere to the last domain of the Multicultural and Social Justice Counseling Competencies (MSJCC), which outlines competencies that must be practiced by counselors to demonstrate cultural awareness, competence, sensitivity, and social justice practices. The MSJCC outlined a competent counselor's responsibility to intervene with and for clients at many levels of society including institutional, community, and public policy levels.

At an institutional level, Ganter et al. (2015) reported that one barrier is a poor relationship or mistrust between health care providers and low-income or minority patients. Barriers found at community levels include unsafe neighborhoods, fear of violence, and high traffic areas, which prevent children and adolescents from playing outside (Ganter et al., 2015). Pirog and Good (2013) defined public policy as a broad term that encompasses local legislation, rules, and regulations. Using this definition, one barrier to obesity advocacy work at a public policy level is a lack of laws pertaining to obesity. There are no laws that prevent advertising unhealthy foods to children. Children are so susceptible to advertising that Pirog and Good (2013) reported that adolescent smoking increased from 1% to 13% when Joe Camel was introduced to advertise cigarettes. Clearly, children need to be protected from harmful advertising. Furthermore, there are no extra taxes on foods with high sugar content and there are no tax breaks or financial incentives for selling, distributing, and purchasing healthy foods.

By identifying these barriers, advocacy action can be taken to address childhood and adolescent obesity prevention on institutional, community, and public policy levels. Specifically, care can be given to ensure equitable prevention efforts are availed to marginalized and privileged youth at each level (MSJCC, 2015). At an institutional level, healthcare workers and program providers can be trained to be empathetic and culturally sensitive to all clients,

including using culturally acceptable terminology when discussing a child's weight (Ganter et al., 2015). Increased cultural sensitivity and empathy will build trust, which will allow prevention workers to address family beliefs that perpetuate obesity. Ganter et al. (2015) reported that one such belief is found among some Hispanic families who are likely to view heavy children as being healthy children. Trust will also help families to implement the nutrition and lifestyle advice given by physicians and prevention practitioners (Ganter et al., 2015).

On a community level, city planners can take special caution to provide safe access to parks, trails, and other outdoor recreational opportunities. Currently in Twin Falls, many sidewalks will abruptly end and some walking trails are on the other side of a busy road with no crosswalk or stoplight. These safety concerns discourage parents from allowing their children to run around outside (Ganter et al., 2015). Additionally, Ganter et al. (2015) found that when communities offered free activities for children, a lack of transportation prevented participation. Any advocacy work for obesity prevention in Twin Falls needs to address the accessibility of physical activities and healthy food. This could be done through better access to trails and parks and through better access to transportation.

Finally, public policy prevention could address local and state laws about advertising unhealthy food to children as well as by making laws that incentivized healthy foods. Rules could not only prevent the media from harming children by advertising unhealthy food to them, the media could also be used to promote healthy foods and lifestyles. Pirog and Good (2013) reported that due to advocacy efforts, access to cigarettes declined by making them more expensive through taxation. Foods full of sugar could be subject to additional state taxes. Similarly, the state of Idaho could offer tax breaks to companies that grew, sold, and distributed vegetables and other healthy foods. People's eating habits would likely change if it was

economically more feasible to purchase healthy foods than junk food and if these foods were offered at local convenience stores and dollar stores where food insecure individuals are more likely to shop for their groceries (Lyonnais et al., 2020).

Childhood obesity is a complex crisis with multiple, bidirectional influences. To prevent childhood and adolescent obesity, theories of prevention need to account for all levels of the social-ecological model as well as address barriers at institutional, community, and public policy levels (National Cancer Institute, 2005). Ultimately, the prevention of obesity requires collaboration, creativity, and cultural sensitivity. This prevention portfolio grounds the unique needs and strengths of Twin Falls, Idaho in evidenced-based theories of prevention to bring protection to children and adolescents who are at risk for obesity.

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