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## Obesity Prevention and Health Promotion: How Family Life Educators View Their Role

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## Obesity Prevention and Health Promotion: How Family Life Educators View Their Role

### Abstract

Parenting and family life educators should be part of the multi-disciplinary solution to childhood overweight. Their ability to work in a preventative capacity to facilitate healthy family practices around eating and activity can help alter one of the key social contexts in which children develop. This article shares the results from a survey of parenting and family life educators that explored their current efforts and understanding regarding childhood overweight, willingness to increase future involvement with the issue, barriers to addressing the issue, and need for Extension support.

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The increasing prevalence of overweight among young children constitutes a serious health concern in the United States. The National Health and Nutrition Examination Surveys revealed that over 26% of 2-5-year-olds were considered overweight or at risk for overweight (Ogden, Carroll, Curtin, McDowell, Tabak, & Flegal, 2006). Among 6-11-year-olds the prevalence of overweight has tripled in the previous three decades (Raynor & Maier, 2006). Childhood obesity carries both physical and psychosocial risks, including the early onset of adult diseases such as type II diabetes and cardiovascular disease; asthma; sleep disturbance; joint and bone disorders; social rejection; and low self esteem (Dehghan, Akhtar-Danesh, & Merchant, 2005). Additionally, overweight children are at considerably higher risk of becoming overweight or obese adults (Ogden et al., 2006).

The National Institute of Health convened a panel of experts to identify modifiable determinants of childhood overweight and recommend paths for future research and intervention. Among the panel's many recommendations was to apply the principles of family research and treatment to the issue of childhood overweight and alter the obsegenic environment in which children develop (Johnson-Taylor & Everhart, 2006). Research indicates that family and parenting practices constitute one of the critical social contexts and environmental determinants of childhood. By altering obsegenic factors such as unhealthy eating, activity, or media consumption practices in a child's family context, the likelihood of that child becoming overweight may be reduced.

### Parenting Practices and Child Eating

Parenting practices that focus on the quality of the family food environment result in improved child-feeding practices and reduced overweight, whereas practices that focus on control of child consumption may have negative effects (Birch & Davidson, 2001). An authoritative food parenting approach where parents provide appropriate structure and boundaries that promote healthy eating and reinforce healthy practices increases the likelihood children will eat healthfully (Arredondo, Elder, Ayuala, Campbell, Baquero, & Duerksen, 2006), whereas an authoritarian food parenting

style is associated with reduced healthy food consumption, increased consumption of restricted foods, and greater overall food consumption by children (Arredondo et al., 2006; Birch & Fisher, 1998).

Two aspects of food control are restriction of access to food or types of food and pressure to eat particular foods or amounts of food. A review of 22 studies found that parent food restriction was more frequently associated with increased child eating and overweight (Faith, Scanlon, Birch, Francis, & Sherry, 2004). Moreover, pressure to clean the plate or the use of junk food as bribes for desired behavior results in poorer child eating regulation (Feeg, 2004; Fisher & Birch, 1999).

Family meals provide the opportunity for modeling food behavior, influencing nutrition beliefs, and controlling the family food environment by offering healthy foods (Neumark-Sztainer, Hannan, Story, Croll, & Perry, 2003; Johannsen & Johannsen, 2006). Project EAT found that middle and high school youth who participated in more frequent family meals ate more fruits, vegetables, grains, and calcium-rich foods and drank fewer soft drinks (Neumark-Sztainer et al., 2003). Story and Neumark-Sztainer (2005) recommend child obesity prevention focus on strategies to help families address the scheduling issues around family meals.

## **Parenting Practices and Child Activity Level**

Research indicates a relationship between parenting practices and child activity level. Parents can influence the indoor and outdoor environments in ways that promote activity, encourage active leisure choices, reduce sedentary activities, and model physically active lifestyles. Parental modeling, monitoring, and support of child physical activity all are positively associated with children's physical activity level (Arredondo et al., 2006; Irwin, He, Bouck, Tucker, & Pollett, 2005; Trost, Sallis, Pate, Freedson, Taylor, & Dowda, 2003).

Excessive screen time, defined as exposure that exceeds 2 hours per day, is associated with increased risk of childhood overweight (Lumeng, Rahnama, Appugliese, Kaciroti, & Bradley, 2006). The association between television viewing and child overweight risk has been attributed to several factors: greater time spent in sedentary activity, exposure to unhealthy food commercials, snacking while watching, and reduction in family meals (Gable, Chang, & Krull, 2007; Robinson, 1999). Obesity prevention and intervention strategies that help parents establish rules and boundaries related to screen time have proven effective (Robinson, 1999).

## **Parent and Family Life Educator Survey**

Parent and family life educators work in various settings to provide support services and instruction that strengthens or enriches individuals and families. These professionals are well poised to impact families in the areas of nutrition and activity. Yet the discipline has been largely silent. The Washington State University Extension Health Promotion and Obesity Prevention team, a multi-disciplinary group consisting of nutrition, early childhood, parenting, and family science professionals, collected survey information from parent educators to address the following questions:

R1: What factors do parent educators believe contribute to children's health and weight?

R2: What obesity prevention and health promotion priorities do parent educators identify within the scope of their work?

R3: How much time and resources do parent educators devote to health promotion?

R4: What are the barriers that prevent parent educators from addressing obesity prevention and health promotion with the families they serve?

R5: What are the programming and training needs of parent educators related to obesity prevention and health promotion?

### **Sample**

Participants of the NW Parenting and Family Education Conference in 2004-2006 were recruited to complete an online survey. Emails were sent to 536 past conference participants. The survey was completed by 108 individuals, yielding a response rate of 20.15%. The majority of respondents were female (95.37%) and Caucasian (95%). Over 80% of the respondents had worked 5 or more years in parenting education. The breakdown by education level was: 2% high school, 14% community college, 33% bachelor's, 45% masters, and 6% doctoral degree.

### **Procedure**

The online survey was conducted December 2006 through January 31, 2007. Two emails were sent at a 1-month interval asking participants to complete the survey.

### **Instrument**

The survey was developed by the Washington State University Extension Health Promotion and

Obesity Prevention team. The survey included 20 forced choice and four open ended questions regarding respondents' priorities, as well as their views about the contributors and barriers to promoting health and preventing childhood obesity through parenting education.

## Survey Results

### R1: Contributors to Health and Weight

Principal components analysis of participants' responses to 10 causes of child obesity yielded three factors: family, eating, and media contributors to child health and obesity. Analyses revealed only one significant effect of demographic variables on responses: parent educators who served infants and preschoolers were less likely ( $p < .05$ ) to recognize media influences in their responses ( $M = 1.38$ ,  $SD = .54$ ) than educators who served older children ( $M = 1.91$ ,  $SD = .85$ ) or served children of all ages ( $M = 1.81$ ,  $SD = .68$ ),  $F(2, 104) = 6.47$ ,  $p < .01$ .

### R2: Priorities

#### *Importance of the Issue*

Over 75% of survey respondents identified health promotion and childhood obesity prevention as a somewhat high to very high priority. Despite the high level of priority, only 8% of parent educators reported spending "a great deal of time" on these issues. The majority of respondents (61%) reported spending some time on health promotion and childhood obesity content, while 31% spent little or no time on these topics. Consistent with this discrepancy between priorities and time spent was the finding that the vast majority of respondents (79%) reported a willingness to spend more time on health promotion and obesity prevention.

Not surprisingly, respondents who placed a high priority on these issues spent more time on them,  $r(105) = .50$ ,  $p < .001$ , and also were more willing to spend more time in the future,  $r(105) = .30$ ,  $p < .01$ . Willingness and current time spent were not correlated with one another. Educational level showed a positive correlation with the priority that the respondents placed on health promotion and obesity prevention,  $r(106) = .19$ ,  $p = .05$ . Finally, parent educators who served children 6-18 years old spent more time ( $p < .05$ ) on health promotion and obesity issues ( $M = 2.67$ ,  $SD = .62$ ) than did educators who served younger children ( $M = 2.20$ ,  $SD = .62$ ) or who served children of all ages ( $M = 2.20$ ,  $SD = .63$ ),  $F(2,102) = 3.60$ ,  $p < .05$ .

#### *Topics Parent Educators Should Address*

The determinants of child obesity that most respondents believed parenting educators should address were: food choices, the amount of daily physical activity, and family meals (between 40 and 60% of respondents). Other common responses (involving about 25% of the respondents) were screen time, parenting style, portion sizes, and beverage choices. Items endorsed by less than 15% were daily routines and sleep, media influences, and promoting health lifestyles for all body types.

Both education and years working as a parent educator were negatively correlated with the attitude that parent educators should address eating issues:  $r(106) = -.23$ ,  $p < .05$  and  $r(106) = -.26$ ,  $p < .01$  respectively. Age of the audience also made a difference. Parenting educators who worked with children of all ages ( $M = 1.61$ ,  $SD = .81$ ), and educators who worked with children ages 6-18 ( $M = 1.53$ ,  $SD = .72$ ), placed a greater emphasis ( $p < .05$ ) on family causes of obesity than parenting educators who worked with infants and preschoolers ( $M = 1.22$ ,  $SD = .66$ ),  $F(2,104) = 3.43$ ,  $p < .05$ . In contrast, parenting educators who worked with infants and preschoolers ( $M = 1.37$ ,  $SD = .77$ ) were more likely than other educators to focus on the eating causes of obesity (all ages:  $M = .93$ ,  $SD = .79$ ; 6-12:  $M = .71$ ,  $SD = .69$ ),  $F(2,104) = 6.13$ ,  $p < .01$ .

Answers to an open-ended question on other contributors to childhood obesity yielded 140 responses in five thematic areas: parenting issues and family meals, basic information, affordable options, other obesity contributors, and cultural awareness.

Parenting practices ( $n=25$ ) and issues related to family meals ( $n=21$ ) were common. Topics included establishing rules, appropriate discipline, expectations, and establishing routines, as well as eliminating ineffective practices such as cleaning the plate, coercion, modeling poor eating, relying on fast food, leaving children unattended after school, using food as a reward, and excessive media use. The value of providing tools such as easy menus and shopping lists, and of educating parents about the research on the importance of family meals were also emphasized.

The majority of respondents said that basic information regarding obesity prevention should be addressed. Responses emphasized the need to adapt the information to different audiences: children ( $n=11$ ), parents only ( $n=36$ ), and families ( $n=32$ ). Parent educators sought to address affordable options for both nutrition ( $n=12$ ) and family activities ( $n=6$ ), as well as provide information to assist families with budgeting ( $n=8$ ). Other contributors that appeared amenable to parenting education included stress and emotional issues either around obesity or as contributors to obesity ( $n=14$ ). A variety of contributors were listed such as peer pressure, attachment, self-efficacy, genetics, community, and school policies.

The need to exercise cultural awareness when addressing obesity prevention/health promotion was a common theme. Respondents cited the need for education to be sensitive to cultural differences, the need for parent educator training regarding diverse views, and the importance of countering messages from mainstream American culture regarding eating, screen time, and activity.

### **R3: Current Efforts**

Answers to an open-ended question about educators' current efforts in health promotion and obesity prevention yielded 182 responses regarding areas of focus and educational approach.

#### ***Areas of Focus***

Nutrition education (n=73), parenting practices that support health (n=41), physical activity education (n=20), media education (n= 12), and parent issues such as stress or limited resources (n=8) were the areas of focus. The nutrition side of the obesity equation received much greater emphasis than physical activity or media education. Respondents were aware that helping parents establish routines and develop effective discipline provided useful tools to promote and support healthy choices.

#### ***Approaches***

Discussion (n=33) was most often used to promote healthy practices and prevent obesity. Many respondents (n=20) noted that healthy practices around food were modeled by their programs. Other approaches were providing written resources (n=15), integrating topic into role plays or examples (n=8), and screening (n=5). There was no mention of continuous, long-term support around these issues. Approaches appeared to be implemented on an occasional or as needed basis.

### **R4: Barriers**

Given the discrepancy between priorities and time spent, barriers to higher levels of involvement in the health promotion and obesity prevention areas were examined. Approximately half of the respondents endorsed the most frequently endorsed barrier - lack of time, other curriculum demands, and lack of materials and resources. About one third of the respondents cited client interest. Limited knowledge, limited skills, organization priorities, and professional priorities were only endorsed by small percentages of the participants.

Twenty-two respondents provided additional barriers in response to an open-ended question. Three of the themes identified paralleled the quantitative categories: not a priority, lack of skills, and limited resources. Other barriers included: obesity prevention was not part of job responsibilities; topic sensitivity; and worries about offending parents, damaging the client relationship, or being culturally insensitive. Two respondents indicated that clients' inability to secure healthy foods economically was a barrier that they faced, giving them little reason to educate parents about the healthy options that were not available.

### **R5: Nature of Assistance Requested**

Ninety-four percent indicated that WSU Extension would be most helpful in: "identifying evidence-based materials and resources" (52% very helpful, 34% helpful, and 8% somewhat helpful) and "providing curriculum and parent training materials and resources" (53% very helpful, 35% helpful, and 6% somewhat helpful). Less interest was expressed in receiving: "professional development and training" (37% very helpful, 40% helpful, and 14% somewhat helpful) and receiving help in "developing partnerships and collaborations" (36% very helpful, 37% helpful, and 18% somewhat helpful).

A unique theme that emerged in the qualitative responses was that WSU Extension should advocate and lead policy change at the local and state level. Suggested policy changes had to do with funding priorities, the need for agencies to make obesity prevention a priority, and the need for county or statewide campaigns.

Regarding how participants would like to receive information, there was a clear preference for written materials—84% indicated written materials, 49% indicated regional trainings, 31% indicated Web-based materials, 16% indicated professional meetings, and only 5% requested videoconferencing.

## **Discussion and Recommendations**

Results from the study reported here should be viewed with caution. The survey response rate of 20% raises the question of how non-responders feel about the issue. Does their failure to respond to the survey indicate that obesity prevention is not viewed as relevant to their work? Also, the sample is not representative because participants were recruited through a regional conference heavily attended by individuals living in the Northwest.

Despite the limitations, several interesting insights emerged. The priority parent educators and FLEs who participated in the survey placed on child obesity prevention did not align with the actual time spent on the issue. Seventy-nine percent of respondents expressed a willingness to do more if barriers such as a lack of time and resources, other curriculum demands, and the sensitivity of the topic could be overcome. Current time working on health/promotion obesity issues was not significantly correlated with willingness to spend more time in the future. This suggests that parent and family life educators represent an under-tapped and willing resource in childhood obesity prevention. These professionals possess the training in family principles, research, and parenting practices recommended by the NIH Childhood Obesity panel (Johnson-Taylor & Everhart, 2006).

The existing research related to parenting practices, child eating, and activity can serve as the basis for early prevention of weight gain strategies, which studies indicate are more effective than intervention after weight gain (Ritchie, Ivey, Masch, Lopez, Ikeda & Crawford, 2001). Programs such as the USDA-funded Expanded Food and Nutrition Education (EFNEP) and Food Stamp Nutrition Education (FSNE) programs, as well as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) focus on teaching parents nutrition information, but are less effective at teaching parents how to implement feeding strategies in the home (Ontai, Williams, Lamp, & Smith, 2007). Programs such as these offer an excellent opportunity to implement a multidisciplinary approach by adding a parenting or family life educator to the teaching team.

Survey responses reflected the national tendency to emphasize the eating side of the obesity equation rather than the activity side. This is not surprising because physical activity has only been emphasized in the U.S. Dietary Guidelines in recent years. Professional development, prevention strategies, and curriculum efforts should focus on parenting practices that support physical activity and reduce sedentary behaviors such as screen time as well as healthy eating.

Limited models for such efforts currently exist. Robinson (1999) noted the efficacy of obesity prevention and intervention strategies that help parents establish rules and boundaries related to screen time. National initiatives such as the VERB campaign use sophisticated media marketing strategies to encourage kids to have fun, get active, and stay active (Donato, 2006). The Hearts N'Parks program, which operates in 50 communities in 10 states, provides a venue for all family member to learn about heart healthy eating and engage in non-competitive physical activity (Donato, 2006).

A review of the literature found no parent education curriculum aimed at increasing healthy activity. However, several school and child care based programs that promote fitness and activity included a parent involvement component. Research-based curriculum that parent educators can use to facilitate healthy practices around family activity and fitness need to be developed.

The ages of children in families served influenced several aspects of obesity prevention work. Parent educators who served younger children spent less time on health promotion and obesity issues; were less likely to endorse media influences as an obesity contributor; and were more likely to focus on the eating causes of obesity. This is a concern because research indicates that eating and activity patterns are established during early childhood (Golan & Crow, 2004; Irwin et al., 2005). This group also was less likely to recognize the effect of media influences. The media environment of young children has been identified as a risk factor for overweight (Lumeng et al., 2006). Parent educators who serve families with young children might be a priority audience for professional development that raises awareness of the childhood obesity issue in young children and suggests ways educators can contribute to prevention efforts.

## Conclusion

Parents influence the food environment through food-related parenting practices, the physical and emotional setting in which eating occurs, and their own food behaviors (Golan & Crow, 2004). Parents influence the indoor and outdoor environments by promoting child activity, encouraging active leisure choices, reducing sedentary activities, and modeling physically active lifestyles (Arredondo et al., 2006). However, current initiatives tend to deconstruct obesity and target a narrow range of contributing factors. One reason for this tendency is discipline-specific specializations related to nutrition, parenting, or physical activity. A multi-disciplinary, integrated approach that addresses both sides of the obesity equation with parenting education that supports family's efforts to change and adopt healthier practices offers tremendous potential to alter the obesogenic environment in which children develop.

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