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Connie S. Lewis

University of Louisiana at Monroe, clewis@ulm.edu

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Childhood Obesity: Physiological and Psychological Implications and Ethical Responsibilities

Connie S. Lewis, PhD,
University of Louisiana at Monroe, USA

ABSTRACT

Childhood obesity continues to be a health concern in the United States with physiological and psychological consequences. Research conducted in schools may address the physiological effects and exacerbate negative psychological effects, including weight bias and stigmatization. In the home, children are dependent on parents/caregivers to provide a healthy diet and exhibit a healthy lifestyle. The ethical theory, Ethics of Care, emphasizes dependence and interdependence on others, and ethical and moral responsibilities in the parent/child relationship. The assurance of ethical considerations involving children in research and parental provision for healthy dietary provision is of utmost importance. Any action or inaction that results in harm for this vulnerable population, whether perpetrated by the parents or researchers, is concerning.

Key Words: Childhood obesity, United States, Ethical Theory, Ethics of Care, Harm

Connie Lewis
University of Louisiana at Monroe
Email: clewis@ulm.edu

Childhood Obesity: Physiological and Psychological Implications and Ethical Considerations

by

Connie S. Lewis, PhD

Obesity continues to be a cause for concern in the United States. The Centers for Disease Control and Prevention (CDC) reported findings for 2011-2012 showed no significant improvement in obesity prevalence in the previous ten years with 8.1% of infants and toddlers overweight, 16.9% of children and adolescents (2-19) obese, and 34.9% of adults obese (Ogden, Carroll, Kit, & Flegal, 2014). Childhood obesity is frequently in the news, the subject of research, and the topic and focus of interventions addressed in schools and homes. Numerous interventional studies have been developed and implemented with various measures of success and sustainability; however, research has been ineffective in reversing the high rates of childhood obesity. As the prevalence of childhood obesity continues to rise, investigators have added an additional line of inquiry: What are the moral and ethical responsibilities of parents and guardians associated with healthy weights of children? This is particularly relevant since parental action is manifested by recognizing and responding to the needs of the child. This paper will describe the importance of applying an ethical framework; specifically, the ethics of care, to future studies and discourse on childhood obesity.

Ethics of Care

The ethics of care, also known as care ethics, is a theory that addresses dependence of individuals on others and interdependence between individuals, specifically within a family (Ethics of Care, 2013). It was initially developed by psychologist Carol Gilligan during the 1960s. It has been widely applied in various professional fields such as nursing, health care, and education (Ethics of Care, 2013). The theory emphasizes the moral responsibility of parents to care for their children. The ethics of care considers family as an ontologically, epistemologically, and morally important sphere where virtues are cultivated and inherited (Ethics of Care, 2013). For example, children are dependent upon parents and other adults within their moral sphere.

Societal antecedents to the epidemic of childhood obesity

When conditions within the larger society change, the results can lead to unintended consequences (positive and negative). The timeline for the accelerated rates of childhood obesity coincides with increased numbers of both parents or single parents participating in the workforce. This workforce pattern led to more latch-key children; those returning home from school without a parent immediately present. Due to safety concerns, many of these children remained indoors until the parent or parents arrived home after work. Although there is no empirical link between the advent of latch-key children and childhood obesity, the parallel timelines are compelling.

Other factors have exacerbated the problem. Children, even the very young, are more sedentary, frequently spending many hours per day playing computer games or watching

television (Laurson et al., 2008). Furthermore, parents who work all day are less likely to prepare in-home meals and turn to relatively inexpensive fast-food, which is high in fat and calories. Since children tend to replicate, or model, their parents' behavior, this cycle repeats itself in future generations (Bandura, 1971).

This is not an indictment of parents who are working hard to support their families. It is quite the contrary. By reframing the discourse about childhood obesity using the ethics of care theory, we can begin to fully understand and appreciate: 1) How societal changes influence parental decisions that impacts his or her child and, 2) What are the best mechanisms to support parental decisions leading to healthier children. This is a more holistic approach than what commonly happens when nurses or doctors overtly or subtly chastise parents for a child's weight.

Current evidence with a narrow lens

There is an abundance of literature about childhood obesity and the influence that parents have on the weight of a child. However, much of the studies and subsequent guidelines and recommendations offer a linear approach to the problem. If parents do X, Y, and Z, then their child will not be obese. The following is a summary of the evidence and recommendations currently used by the majority of providers.

A healthy lifestyle should be modeled by parents during this vulnerable childhood period. Nutritional needs of children differ as they develop through the various stages of growth and development. The American Academy of Pediatrics offers age-specific considerations for nutritional needs of children (Kleinman, 2009). This information is often shared with parents by health care professionals and can provide guidance while children are in the home. Each stage can provide insight and direction for dietary needs and assist parents/caregivers in establishing and modeling healthy dietary habits and outcomes for their children.

Parents have a responsibility to teach healthy choices regarding diet and activity. Providing nourishment for their children is a central aspect of parenting. While most adults have the ability to make and implement conscious decisions regarding diet, young children are dependent on parents or caregivers for their basic necessities including nutritional needs. Parents are responsible for what food is brought into the home and available to their young children for mealtime and snack time. As a child enters the school-age and adolescent stage, they begin to make independent choices regarding what they eat. These choices can be influenced and reflective of prior dietary patterns, habits and behaviors regarding diet during earlier, formative years. Addressing this all-important health behavior early in life is important as obesity-related habits beginning in childhood and resulting in overweight and obesity in youth are correlated with obesity in adulthood and the associated adverse health outcomes (Barlow, 2007; Deshmukh-Taskar et al., 2006; Juonala et al., 2011; Thompson & Bentley, 2012).

Many of the interventions developed and implemented to address this childhood epidemic address the physiological aspects associated with, and resulting from, overweight and obesity in children. These include cardiovascular risk factors, elevated blood pressure, Type II diabetes, obstructive sleep apnea, asthma and orthopedic complications (Kelsey, Zaepfel, Bjornstad & Nadeau, 2013). Of equal importance are the psychological effects of childhood obesity. However, the insidious psychological aspects, such as low self-esteem, depression, bias, teasing, stigmatization, and the ethical considerations of overweight and obese children are often

overlooked. Washington (2011) defined weight bias as “the inclination to form unreasonable judgments based on a person’s weight” (p. 1). He further defined stigma as “the social sign that is carried by a person who is a victim of prejudice and weight bias” (p. 1). According to Merriam - Webster Online Dictionary, the definition of stigmatize is “to describe or regard something, (such as a characteristic or group of people) in a way that shows strong disapproval” (“Stigmatize,” n.d.). Weight stigma is usually the result of negative attitudes and beliefs and may be manifested by verbal teasing, bullying, and social exclusion by ignoring or avoiding (Puhl & Latner, 2007), and according to the authors, can be expressed in subtle or overt ways. Childhood obesity and the associated stigma is a sensitive topic necessitating the avoidance of discrimination against overweight children (Wickins-Drazilova & Williams, 2010). Although emotional and social consequences of childhood obesity are often less addressed and documented, any action that exacerbates these consequences is of ethical concern (Washington, 2011).

Childhood obesity research conducted in schools may lead to additional knowledge and proposed interventions; however, it may also present the stimulus to target overweight and obese children. Many of these children may already be dealing with negative issues regarding their weight. Focused childhood obesity research on a targeted sub-group of school-age children may potentiate additional stigmatizing actions. Many school-based interventions are of physiological focus, including body mass index percentile measurement and physical activity; and, while psychological results may result from the physiological interventions, that aspect is not usually included in the analysis as this is rarely the focus. Reducing body mass index is important; however, of equal importance is the reduction of weight bias and stigmatization since the consequences can be just as serious (Washington, 2011). Even in girls of normal weight, it is not uncommon for them to be dissatisfied with their size and desire to be thinner, possibly a result of the stigmatizing effect. Overweight and obese children are often teased by their classmates and overlooked when choosing friends or team members. Teachers may perceive overweight children as untidy and less likely to be successful in their school work when compared to thinner students. They may have lower expectations of overweight children. Parents of overweight children may also engage in weight-bias teasing and emphasize the importance of weight loss (Washington, 2011). Overweight and obese children may experience stigmatization, may feel set apart, and may feel as if something is wrong with them that needs to be fixed.

Schools offer a rich environment for conducting research related to childhood-related questions. With obesity-related interventions and research conducted in the school setting, the ethical aspects of research protocol, such as confidentiality and informed consent, should be ascertained, assuring parental knowledge of their child’s participation in research (Kersh, Stroup & Taylor, 2011). Body mass index (BMI) screening in schools can provide beneficial information for trending and influencing legislature. This could also lead to potential harm such as parents putting their children on diets, privacy issues leading to increased stigmatization of overweight children, lowered self-esteem, increased dissatisfaction with body size, and the increased occurrence of eating disorders (Ikeda, Crawford, & Woodward-Lopez, 2006). The goal of school intervention during these formative years should focus on the prevention of harm in all aspects of health,

The school setting is where children learn many social behaviors such as acceptable and unacceptable behavior, how to take turns, how to share, and how to make friends and be a friend. It is also the place where they learn to judge others based on clothes, body size and color. As children are forming their ideals of what is normal and what is abnormal, what is right and what

is wrong, what is considered pretty and what is considered ugly, they are developing positive and negative behaviors. In most instances, school is considered their social life and they are subjected to learning more than just subject material. This socialization contributes to their attitude toward others, not necessarily promoting negative behaviors, but allowing the manifestation of them. Evaluation of obesity prevention and health promotion measures are critical to ensure that the improvement of physiological health does not actually cause harm to psychological health. Participants in a recent study in the United States felt that parents are to blame and are responsible for childhood obesity; furthermore, study participants did not support obesity prevention policies and programs outside the school setting (Wolfson, Gollust, Niederdeppe & Barry, 2015). While there are laws in place related to abuse, neglect, and truancy, there are few safeguards in place to protect the child from the lack of the provision of a healthy diet and physical activity. The harm principle was developed by John Stuart Mill and includes the omissions and inactions of a person that could result in harm to others (Lacewing, n.d.). This suggests an association of parental responsibility with the harm principle as it applies to inaction or action that can result in harm to others, in this instance, dependent children. In addressing self-harm, overweight and obese children in the home are unable to make choices to effect change. Their diet consists of food and nourishment the parents have provided. Children continue the unhealthy dietary habits and lifestyle with no thought of the harm that may result. Parents have the ability and responsibility to identify harm(s) regarding their children and reduce those harms. Ethics of care emphasizes the importance of response to identified harms such as the lack of consistency of a healthy diet and physical activity in the home. Primary prevention of overweight and obesity can be started in the home by implementing and modeling healthy dietary and physical activity habits. Parents should follow the advice of healthcare professionals, set examples with diet and exercise, and become involved in local activities that support a healthy lifestyle. Any action or inaction that exacerbates the negative consequences of childhood obesity is of ethical concern. Children are vulnerable to choices made by parents and the associated outcomes. As these actions may be perpetrated in the home, by the parents or caregiver, clear ethical responsibility rests with parents. Parents have an all-important role in the effort to reduce bias, stigma, and other negative consequences associated with childhood obesity.

Conclusion

As one can see, this linear and paternalistic approach severely limits a deeper understanding of the complicated and multi-layered issue associated with childhood obesity. Until we accept that all of the facts, figures, and millions spent on research of this kind has yielded little, if any, transformative outcomes, we will never be able to move the needle on childhood obesity. It is not enough to tell parents what they are doing wrong. We must decide what role society plays and seek ways to improve conditions in support of parents and the children who are dependent upon them.

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