



**JUNIOR LEAGUE OF BOSTON**  
**NUTRITION AND WELLNESS TASK FORCE**  
**FINAL REPORT**

2011-2013

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## **EXECUTIVE SUMMARY**

2011-2013

In the spring of 2011, the Junior League of Boston commissioned a Nutrition and Wellness Task Force to explore the landscape of health-related issues in the Boston area and to determine where the League could have a greater impact.

Our mission was to:

- Identify top issues of health and wellness for girls in that geographic area
- Gain a better understanding of both the baseline status and the organizations addressing these issues in Boston
- Determine the types of questions we should be asking in the community
- Identify potential networking partners for Done In A Day (DIAD), JLB Events or future community projects
- Make recommendations on ways in which the League can address these issues within existing or future community projects, partnerships, and activities.

Throughout July and August 2011, our ten-member Task Force met to discuss where the Junior League of Boston should focus its efforts within the broad topic of health. Based upon our collective experience and research within the health and wellness arena, we determined that efforts would center on the following three areas:

- Nutrition (healthy eating habits, food choices, allergies and food intolerances)
- Physical activity
- Emotional health (social/behavioral issues, mental health)

## **NUTRITION**

### **Obesity/Healthy Eating/Eating Disorders**

Unhealthy eating can take many forms. In this report, we will address two: Eating as a contributor to being overweight or obese, and eating disorders, which may include anorexia, bulimia, or binge eating disorder.

There has been a dramatic increase in obesity in the United States from since 1990. Overweight and obese individuals are at an increased risk for many diseases and chronic health conditions, including heart disease (such as hypertension), osteoarthritis, Type II diabetes, stroke, respiratory problems, and some cancers (Ogden 2012). Since 1980, obesity prevalence among children and adolescents has almost tripled. Comparing data from 1976-1980 to 2007-2008 through the NHANES dataset the prevalence of overweight children and adolescents increased significantly (CDC). Research has also found that Boston female high school students are more likely to be overweight or obese (20.6%) than the national average (15.5%; Lopiano, Snyder, & Zurn, 2007).

The Public Health Service's Office in Women's Health reports that anorexia is the third most common chronic illness within our target demographic: adolescent girls (2000). Of those who have eating disorders: 95 percent are between the ages of 12 and 25; 50 percent of those between the ages of 11 and 13 see themselves as overweight; 80 percent of 13-year-olds have previously attempted to lose weight.

### **Food Intolerance**

Estimates of the prevalence of food intolerance— the inability to properly digest or fully process certain foods, leading to chronic symptoms and illness – vary widely from 2% to over 20% of the population. Few people understand the effects of food sensitivity and food intolerance. It is often confused with food allergy, and because many symptoms are chronic, they are often attributed to something else. Low awareness contributes to poor diagnosis and even a tendency to tag symptoms as 'incurable.'

## Task Force Recommendations

As our research highlighted three different areas of interest within nutrition – eating disorders (ED), obesity/healthy eating (HE), and food intolerances (FI) – we have specified under which area each recommendation falls.

### *Year 1*

- Require that all community projects working with girls serve healthy snacks/meals and use these mealtimes as teaching moments to introduce new foods and impart information about nutrition (HE)
- Incorporate nutritional learning moments into every single event as appropriate, such as healthy food options at the Ball and healthy snacks/meals at Junior League of Boston meetings (HE, ED)
- Begin developing a curriculum around a “How to make healthy choices within your environment” to later incorporate into existing girls’ projects or to become its own traveling program, similar to Kids in the Kitchen (HE, ED)
- Begin developing curricula around food allergies/intolerances (education & accommodation) to later incorporate into the existing health curricula of our girls’ programs or into KITK sessions (FI). For example, this curriculum could focus on identifying hazards or alternatives, i.e. what can you use instead of nuts or what foods may have a hidden nut component?
- Coordinate with the Communications Committee to include tips for members to support healthy eating at internal meetings and placement activities in the newsletter or as a resource on the JLB website.

### *Year 2*

- Incorporate a session around “How to make healthy choices within your environment” into all girls’ programs (HE)
- Incorporate food allergy/intolerance information into the health curricula of our girls’ programs (FI)
- Develop an approved snack list of healthy snacks (HE)
  - a Use nationally recognized nutritional guidelines for determining healthy choices

### *Year 3+*

- Create a program, similar in structure to KITK, around learning to read nutritional labels, making healthy choices at grocery stores and convenience stores, and preparing healthy snacks with limited ingredient options (HE)

- Develop parent workshops around (a) making healthy food choices and (b) food allergies and intolerances (HE and FI)
  - Parents will attend a workshop at a location, such as a Boys & Girls Club, where we provide ingredients and teach recipes for preparing healthy or allergen-free snacks. Parents will prepare a week's worth of snacks in class to take home.
  - Parents can attend a workshop hosted by local experts on food intolerances as well as people experienced in preparing meals for diners with food intolerance issues.

## **PHYSICAL ACTIVITY, PHYSICAL EDUCATION, & SPORT PARTICIPATION**

Our research on physical activity, physical education, and sports participation focused on three areas: the benefits of physical activity, current recommendations for physical activity and participation levels among girls in Boston, and barriers to participating in sports or other physical activities in Boston. Not surprisingly, researchers have identified an array of physical and mental health benefits resulting from regular participation in physical activity (PA) during childhood and adolescence. Evidence suggests that even short periods of physical activity can be beneficial. Both boys and girls who participated in team sports rated life satisfaction and quality of health more highly than non-participating peers.

The current evidence-based guidelines in the United States recommend 150 minutes per week of PE for elementary school students and 225 minutes per week of PE for middle school and high school students (Division of Adolescent and School Health, CDC, 2011), and the Massachusetts General Law for PE requires that it be taught in all grades for all students (The General Court of the Commonwealth of Massachusetts, 2013). However, the CDC data indicates that almost 45% of Massachusetts female high school students did not attend PE in a typical school week. Participation also declines with grade. While about 65% of 9th grade girls have PE at least once a week, only 37% of 12th grade girls do (CDC, 2011). A 2004 survey of Boston youth cited lack of interest, after school jobs, a parental desire to have the student home, lack of proximity to home, and poor neighborhood conditions as factors influencing the decision to not participate in after-school sports. The lowest levels of physical activity have been found among racial and ethnic minorities and those of lower socio-economic status.

## Task Force Recommendations

### *Year 1*

- Require the incorporation of physical activity into all community programs working with girls
  - Physical activity should be deliberately introduced into each program meeting, to an extent appropriate for the placement and location (e.g. “energy breaks” interspersed with other program activities)
  - Resources such as a PA “tip sheet” with ideas on fitting PA into your day can be developed by the JLB and handed out to girls
  - We can promote alternative ways of exercising (dance, going for a walk, hula hooping, stretching, taking the stairs, etc.)
- Incorporate hourly energy/stretch breaks into JLBoston meetings for members to create a stronger culture of physical activity
- Endeavor that all new Done in a Day, JLB Events, and development projects support our focus area of nutrition and wellness
- Develop a strategic plan to create a database of physical activity opportunities for girls in the Boston area (e.g., races, events, community classes, etc.)
- Update the design of JLB t-shirts to include a valuable fact about health and wellness on the back (will help to further align our brand with our mission)
- Begin an education campaign around health and wellness facts to educate our volunteers. Coordinate with the Communications Committee in order to include an informative fact in each weekly e-newsletter.
- Design a wellness competition to be used internally among our current girls’ projects.
  - Logs to track physical activity, healthy choices

### *Year 2*

- Begin compiling data for physical activity opportunity database.
- Continue education campaign
- Implement wellness competition among girls’ projects.

### *Year 3+*

- Create a new girls’ project with a specific focus on physical activity to reach a population that we are not currently serving
- Provide space in HQ for local organizations serving girls to use our facilities for physical activity (dance classes, yoga, etc.)
- Offer demonstrations of different activities (e.g. yoga, running, stretching and strength exercises) for girls within existing projects.

## **EMOTIONAL HEALTH**

We began our research on emotional health by identifying several key behavioral issues and mental health problems that affect teenagers, specifically adolescent girls: mood disorders (e.g., depression and anxiety), low self-esteem and poor body image, eating disorders (treated at length elsewhere in this report), and violence involving bullying, aggression, sexual harassment, relationship violence, and the real threat of living in neighborhoods where the majority of girls report that they do not feel safe.

In a research review conducted by the Women's Sports Foundation, the authors found support for a strong interdependence among adolescent girls between behavioral health/self-image issues and physical activity levels, such that in general, higher levels of activity were related to lower levels of emotional distress (Staurowsky et al., 2009). Although in early childhood the risk of depression is roughly equivalent among females and males, by adolescence, girls are twice as likely to experience depression as boys. (Cyranowski, Frank, Young, & Shear, 2000; Hyde, Shibley, Mezulis, & Abramson, 2008). Research has demonstrated that a positive evaluation of one's worth is a key indicator of overall psychological health. Multiple studies have shown that body dissatisfaction in American girls emerges by the age of six and is well-established by the age of nine.

### **Task Force Recommendations**

The Junior League of Boston is already providing mentoring, guidance, and role models for adolescent girls through our work with Germaine Lawrence and the Boys' and Girls' Clubs, although the total number of girls served is relatively small compared to the total adolescent population of Massachusetts. The Task Force believes that the JLB has the ability to expand our work to a larger clientele of underserved girls.

#### *Year 1*

- Develop more formalized trainings to educate all members working on direct service projects (or events where girls are present) to deliver a consistent message regarding respect for others, appropriate behavior, and conflict resolution.
- For all materials including images of women or girls used in Junior League events or communications, review to ensure an inclusive range of appearances are depicted. Review program, handout, and website

- language to ensure implicit assumptions or value judgments related to appearance are appropriately revised.
- Initiate support of community organizations providing outreach to adolescent girls. For example, the JLB can support Boston GLOW through a Done in a Day placement in support of their major annual fundraising event.
  - In reviewing placement curricula, identify opportunities to strategically introduce positive messaging around body image, interpersonal violence, and other issues relevant to emotional well-being.
  - Coordinate with Communications Committee to include information or tips related to supporting girls' emotional well-being in the newsletter or on the JLB website.

## *Year 2*

- Continue to seek potential partners for community projects.
- Develop a resource booklet that specifically addresses how to respond to girls in crisis.
- Provide training opportunities to members to better equip them to interact with girls who have emotional health issues or are dealing with violence; examples may include workshops on active listening or training on referring girls to community resources as needed
- Review research on mentorship to address violent youth behavior to explore the possibility of a new mentorship placement

## **BACKGROUND ON NUTRITION AND WELLNESS TASK FORCE** **COMMITTEE**

In the spring of 2011, the Junior League of Boston commissioned a Nutrition and Wellness Task Force to explore the landscape of health-related issues in the Boston area and to determine where the League could have a greater impact. Our mission was to:

- Identify top issues of health and wellness for girls in that geographic area
- Gain a better understanding of both the baseline status and the organizations addressing these issues in Boston
- Determine the types of questions we should be asking in the community
- Identify potential networking partners for Done In A Day (DIAD), JLB Events or future community projects
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Throughout July and August 2011, our ten-member Task Force met to discuss where the Junior League of Boston should focus its efforts within the broad topic of health. Based upon our collective experience within the health and wellness arena, we determined that efforts would center on the following three areas:

- 1 Nutrition (healthy eating habits, food choices, allergies and food intolerances)
- 2 Physical activity
- 3 Emotional health (social/behavioral issues, mental health)

The Task Force separated into two committees: a research committee and a writing committee. The research committee was responsible for researching background information on our three focus areas and establishing why these are important issues in the Greater Boston area. Both city- and state-specific data,

as well as national trends, were assessed. The writing committee was responsible for adapting the research into a final product to present to the Board of Directors.

We also met monthly as a Task Force, using our time to review the research, discuss its implications, and work collaboratively to develop our recommendations on ways the Junior League of Boston can have a positive influence in these areas. We determined that a tiered structure of recommendations would be most beneficial to the League, with suggestions broken down into a three-year action plan. The 2012-2013 Task Force members have worked to finalize the report and action plan, as well as begin implementing its recommendations in existing placements and activities as well as exploring future opportunities.

This report details the highlights of our research, broken down by focus area, with corresponding recommendations.

## NUTRITION

### BACKGROUND

In exploring nutrition, we began our research by looking into food allergies and intolerances, eating disorders (anorexia and bulimia), and obesity, with the intention of later narrowing our efforts to focus on one specific topic. However, our group discussions revealed a strong interest in pursuing all three issues, as they each offer the Junior League of Boston different opportunities for creating programs with positive community impact.

### OVERWEIGHT, OBESITY, AND EATING DISORDERS

Unhealthy eating can take many forms. In this report, we will address two: Eating as a contributor to being overweight or obese, and eating disorders, which may include anorexia, bulimia, or binge eating disorder.

Obesity is a growing source of concern across the United States. In a 2010 report on state obesity rates released by the Centers for Disease Control and Prevention, Massachusetts was reported to have an obesity rate of 23 percent (CDC, 2012). Mississippi had the highest rate at 34 percent, while Colorado had the lowest rate at 21 percent (CDC, 2010). While Massachusetts ranked in the ten lowest rates in the country (only Colorado, Connecticut, District of Columbia, Hawaii, Nevada, and Utah boasted lower rates), it is important to note that almost a quarter of our state's population is considered to be obese (CDC)

There has been a dramatic increase in obesity in the United States from since 1990. In 1990, 10 states had a prevalence of obesity less than 10% and no states had prevalence equal to or greater than 15%. By 2009, only one state had a prevalence of obesity less than 20%, Colorado (CDC). By 2011, 39 states had a prevalence equal to or greater than 25% and 12 of these states had a prevalence equal to or greater than 30% (CDC)

Overweight and obese individuals are at an increased risk for many diseases and chronic health conditions, including heart disease (such as hypertension), osteoarthritis, Type II diabetes, stroke, respiratory problems, and some cancers (Ogden 2012).

Since 1980, obesity prevalence among children and adolescents has almost tripled.

Comparing data from 1976-1980 to 2007-2008 through the NHANES dataset the prevalence of overweight children and adolescents increased significantly (CDC).

- Within the 2-5 age range the percentage increased from 5% to 10.4 %.
- Within the 6-11 age range, the percentage increased from 6.5% to 19.6%, and
- Within the 12-19 age range, the percentage increased from 5% to 18.1%.

These statistics show that the obesity epidemic continues to worsen over time, despite an increased understanding of the associated health risks.

In addition, obesity can influence and impact the social and emotional impact of youths. A recent article noted that overweight and obese youths are subject to more bullying, are often rejected by peers and are less chosen as friends as compared to healthy weight children. Weight-based teasing may increase one's susceptibility to depression (Puhl 2007).

The Massachusetts Health Care Forum released an issue brief in 2012 addressing the obesity epidemic in the Commonwealth. The goal of this brief was to encourage creation of policy that would create an environment "to make physical activity not just the *easy choice*, but the *desired choice*" (Sacheck & Glynn, 2012). The brief also noted racial and ethnic disparities in obesity prevalence, pointing out research that indicates Hispanic and Black students are less likely to report 60 daily minutes of physical activity (Massachusetts Department of Elementary and Secondary Education, 2011).

Research has also found that Boston female high school students are more likely to be overweight or obese (20.6%) than the national average (15.5%; Lopiano, Snyder, & Zurn, 2007).

With the aforementioned statistics in mind, early preventative action is key. We believe that the Junior League of Boston can be most effective by providing positive educational messages (rather than focusing on preventing eating disorders and obesity), and we therefore recommend that the League direct its efforts toward the promotion of healthy food and activity choices and positive self-image.

According to a nationally representative survey study conducted in the United States (Hudson, Hiripi, Pope, & Kessler, 2012), lifetime prevalence of eating disorders reaches:

- 0.6% for anorexia nervosa
- 1.0% for bulimia nervosa
- 3.9% for binge eating disorder
- 4.5% for any binge eating behaviors

With the exception of the binge eating behaviors, eating disorders among this sample were approximately three times more common for women than for men. The South Carolina Department of Mental Health estimates that nearly half of all Americans personally know someone with an eating disorder (<http://www.state.sc.us/dmh/anorexia/statistics.htm>, 2006). Binge eating disorder

is among the most common, with 9% of normal weight women and 21% of overweight women in one study reporting incidence of binge eating within the last six months (French, Jeffrey, Sherwood, & Newmark-Sztainer, 1999).

The Public Health Service's Office in Women's Health reports that anorexia is the third most common chronic illness within our target demographic: adolescent girls (2000). Of those who have eating disorders:

- 95 percent are between the ages of 12 and 25.
- 50 percent of those between the ages of 11 and 13 see themselves as overweight
- 80 percent of 13-year-olds have previously attempted to lose weight.

According to the South Carolina Department of Mental Health (SCDMH), only about 10% of people who have eating disorders receive formal treatment. And among those women with eating disorders who do receive inpatient treatment, only 20% get the medically recommend duration of care, with 80% being sent home early. One possible reason for this deviation from clinical recommendation could be the prohibitive costs of inpatient treatment and some health insurance plans' failure to cover them; the SCDMH estimates that the per-day cost of treatment in the United States ranges from \$500 to \$2,000, with an average cost per month of \$30,000. Outpatient treatment may ultimately cost in excess of \$100,000 per patient (SCDMH, 2006).

## FOOD INTOLERANCE

Estimates of the prevalence of food intolerance— the inability to properly digest or fully process certain foods, leading to chronic symptoms and illness – vary widely from 2% to over 20% of the population.

Food allergies - distinguished from food intolerance by their sudden onset and severe nature – are still relatively rare. It is estimated that between 2% and 4% of children between the ages of 0 and 3 have food allergies (Meyer, Schwarz, & Shah, 2012), while another study found an overall prevalence of food allergies in children under age 18 of approximately 8% (Gupta et al., 2011). One study found a prevalence of food allergies in adults of approximately 2.5% (Liu et al., 2010). The prevalence of food allergies and associated anaphylaxis appears to be on the rise. According to a study released in 2008 by the Centers for Disease Control and Prevention, the number of people with food allergies has increased by approximately 18% between 1997 and 2007 (Branum & Lukacs, 2008).

Few people understand the effects of food sensitivity and food intolerance. It is often confused with food allergy, and because many symptoms are chronic, they are often attributed to something else. Low awareness contributes to poor diagnosis and even a tendency to tag symptoms as 'incurable.' However, food tolerance can be corrected with a simple change in diet.

While there are many advocacy groups (such as FoodIntol) and resources (including *Without* magazine and AllergyEats website and mobile application) that provide information and assistance for those with food allergies and intolerances, the Task Force has identified a need for further information and assistance in the Greater Boston area. Given the percentage of people affected by food intolerance nationwide and the limited number of organizations that address the issue locally, food intolerance appears to be an area where the Junior League of Boston could have a major impact on the community.

## NETWORKING IDEAS IN BOSTON AREA

We have identified the following organizations within the Greater Boston area that focus on nutrition.

- Harvard School of Public Health Prevention Research Center - Planet Health; a complete middle school curriculum that focuses on nutrition and health

Volunteer/organization information: <http://www.planet-health.org/>

- The Greater Boston Food Bank – Kids’ Café; partnership with the Boys & Girls Clubs; feeds children and teaches them about smarter food choices and healthy eating

Volunteer information: <http://gbfb.org/our-mission/kids-cafe.php>

- The New Balance Foundation Center for Childhood Obesity Prevention, Clinical Research, and Care at the Boston Children’s Hospital – performs research on obesity and offers a variety of programs for overweight and obese children

Volunteer/organization information:  
<http://www.childrenshospital.org/clinicalservices/Site3080/mainpageS3080P0.html>

- AllergyEats - works to consolidate and make available menu data for people with allergies and intolerances.

Volunteer/organization information: <http://www.allergyeats.com/>

- City Sprouts - an organization promoting community gardens and using the produce from those gardens as part of healthy eating

Volunteer/organization information: <http://www.citysprouts.org/get-involved/>

- Community Servings - a food and nutrition program serving families in the greater Boston area affected by chronic illness

Volunteer/organization information:  
<http://www.servings.org/volunteer/index.cfm>

- KidsCOOK Productions - produces media content to teach children and adolescents about good nutrition, through their channel KickinKitchen

Volunteer/organization information: <http://kickinkitchen.tv/>

- Project Bread - Their major fundraiser is the Walk for Hunger; they also operate a food hotline

Volunteer/organization information:  
[http://www.projectbread.org/site/PageServer?pagename=getinvolved\\_main](http://www.projectbread.org/site/PageServer?pagename=getinvolved_main)

- ReVision Farms - grows vegetables to help feed families residing at ReVision Family Home and to aid in nutritious eating for residents in Dorchester

Volunteer/organization information: <http://www.vpi.org/revision/careers-volunteers/>

- The Food Project - works with teens to farm produce for distribution to needy families and sale through CSAs

Volunteer/organization information: <http://thefoodproject.org/volunteer>

## TASK FORCE RECOMMENDATIONS

Nutrition is an area where the Junior League of Boston already has an active placement through the Kids in the Kitchen (KITK) program. However, to date, our efforts impact only a small group of girls who participate in one of our programs. The Task Force believes that the League can do more for our current clientele and that our efforts can be expanded to have a larger impact on the community as a whole. We can do this by infusing principles of healthy eating into most of our external placements, by reaching out to parents and other caregivers, and by socializing healthy eating within our own organization.

As our research highlighted three different areas of interest within nutrition – eating disorders (ED), obesity/healthy eating (HE), and food intolerances (FI) – we have specified under which area each recommendation falls.

Year 1

- 1 Require that all community projects working with girls serve healthy snacks/meals and use these mealtimes as teaching moments to introduce new foods and impart information about nutrition (HE)
- 2 Incorporate nutritional learning moments into every single event as appropriate, such as healthy food options at the Ball and healthy snacks/meals at Junior League of Boston meetings (HE, ED)
- 3 Begin developing a curriculum around a “How to make healthy choices within your environment” to later incorporate into existing girls’ projects or to become its own traveling program, similar to Kids in the Kitchen (HE, ED)
- 4 Begin developing curricula around food allergies/intolerances (education & accommodation) to later incorporate into the existing health curricula of our girls’ programs or into KITK sessions (FI). For example, this curriculum could focus on identifying hazards or alternatives, i.e. what can you use instead of nuts or what foods may have a hidden nut component?
- 5 Coordinate with the Communications Committee to include tips for members to support healthy eating at internal meetings and placement activities in the newsletter or as a resource on the JLB website.

#### Year 2

- 1 Incorporate a session around “How to make healthy choices within your environment” into all girls’ programs (HE)
- 2 Incorporate food allergy/intolerance information into the health curricula of our girls’ programs (FI)
- 3 Develop an approved snack list of healthy snacks (HE)
  - b Use nationally recognized nutritional guidelines for determining healthy choices

#### Year 3+

- 2 Create a program, similar in structure to KITK, around learning to read nutritional labels, making healthy choices at grocery stores and convenience stores, and preparing healthy snacks with limited ingredient options (HE)
- 3 Develop parent workshops around (a) making healthy food choices and (b) food allergies and intolerances (HE and FI)
  - a Parents will attend a workshop at a location, such as a Boys & Girls Club, where we provide ingredients and teach recipes for preparing healthy or allergen-free snacks. Parents will prepare a week’s worth of snacks in class to take home.
  - b Parents can attend a workshop hosted by local experts on food intolerances as well as people experienced in preparing meals for diners with food intolerance issues

## PHYSICAL ACTIVITY, PHYSICAL EDUCATION, & SPORT PARTICIPATION RESEARCH

### BACKGROUND

Our research on physical activity, physical education, and sports participation focused on three areas: the benefits of physical activity, current recommendations for physical activity and participation levels among girls in Boston, and barriers to participating in sports or other physical activities in Boston. The Task Force noted a significant overlap with our nutrition research around the issue of obesity.

### BENEFITS OF PHYSICAL ACTIVITY

Not surprisingly, researchers have identified an array of physical and mental health benefits resulting from regular participation in physical activity (PA) during childhood and adolescence including:

- positive body image (Kirkcaldy, Shephard, & Siefen, 2002)
- higher confidence and self-esteem (Kirkcaldy, Shephard, & Siefen, 2002)
- lower risk for diseases such as diabetes, heart disease, osteoporosis, some cancers, and depression (see Hallal, Victoria, Azevedo, & Wells, 2006, and Strong et al., 2005, for a review)
- lower risk of teen pregnancy, related to greater likelihood of delaying sex (Sabo, Miller, Farrell, Melnick, & Barnes, 1999)
- reduced likelihood of cigarette smoking (Pate, Heath, Dowda, & Trost, 1996)
- lower risk of drug use (Korhonen, Kujala, Rose, & Kaprio, 2009)

Evidence suggests that even short periods of physical activity can be beneficial. One study showed that cognitive function was improved for nearly an hour following a single 30-minute episode of exercise (Joyce, Graydon, McMorris, & Davranche, 2009). Others have shown more sustained improvements in memory with exercise programs ranging from two to ten weeks in duration (Masley, Roetzheim, & Gualtieri, 2009; Small et al., 2006). Finally, more sustained exercise programs (months) are related to longer-term improvements in cognitive function relative to those who are physically inactive (Aberg et al., 2009). While this research was primarily conducted with adults rather than adolescents, it does suggest that even occasional physical activity might be associated with improvements in academic performance.

One study that was conducted with middle school students (7th and 8th grade) showed that both boys and girls who participated in team sports rated life satisfaction and quality of health more highly than non-participating peers. However, the girls in the sample also rated their life satisfaction and quality of health as higher if they participated in non-team-based physical activity (Zullig & White, 2011). This provides further evidence that physical activity, whether team-based or individual, may be associated with benefits for young girls.

### RECOMMENDED LEVELS OF PHYSICAL ACTIVITY: HOW DOES BOSTON MEASURE UP?

The Task Force found that physical activity levels, particularly among girls in Boston, fall short of meeting recommended guidelines. According to the Centers for Disease Control guidelines, children need at least 60 minutes of physical activity each day (CDC.gov, 2011). Most of this time should be spent in moderate to vigorous aerobic activity such as running, biking or swimming. A portion of the time should be spent doing muscle- and bone-strengthening activities such as gymnastics, pushups, and jumping rope. These types of activities should be included three times per week. Children should be encouraged to participate in activities that are age-appropriate and fun. Unfortunately, many children and teens in Massachusetts are not meeting these minimum recommendations (CDC, 2011).

One study estimates that only 8 percent of youth aged 12-15 participate in enough PA to meet public health recommendations. (Cradock, Melly, Allen, Morris, & Gortmaker, 2009). A Boston Foundation report stated that in 2005, only 68.7 percent of high school students nationwide engaged in 3 or more days of vigorous physical activity. In Massachusetts, the percentage was only 62.9 percent, and in Boston, the percentage was even lower: 50.1 percent. In 2011, the Boston Foundation's Healthy People/Healthy Economy report noted that "Massachusetts has the worst score in the country for physical activity among high school students – and state policy needs to create minimum standards for all youth physical activity." Clearly, many youths in Boston are less active than they should be.

Two studies support the conclusion that girls in Boston spend too little time engaged in physical activity of any kind. Lopiano et al. (2007) found that only 51 percent of high school girls in Boston participated in sufficient PA compared to a national average of 61.5 percent, with Black, non-Hispanic and Hispanic females in Boston less likely to meet recommended standards than their Caucasian counterparts. The authors also found participation to be low in both physical education and high school sports teams. Only 36.1 percent of girls in Boston participated on sports teams compared to 57.6 percent for boys in Boston and 50.2 percent for girls nationally. Black and Hispanic girls were found to be significantly less likely than White girls to play on at least one sports team in high school.

The CDC's High School Youth Risk Behavior survey indicates similarly discouraging numbers regarding participation in physical education (PE) in 2011. The current evidence-based guidelines in the United States recommend 150 minutes per week of PE for elementary school students and 225 minutes per week of PE for middle school and high school students (Division of Adolescent and School Health, CDC, 2011), and the Massachusetts General Law for PE requires that it be taught in all grades for all students (The General Court of the Commonwealth of Massachusetts, 2013). However, the CDC data indicate that almost 45% of Massachusetts female high school students did not attend PE in a typical school week. Participation also declines with grade. While about 65% of 9th grade girls have PE at least once a week, only 37% of 12th grade girls do (CDC, 2011).

### BARRIERS TO PARTICIPATION IN SPORTS AND PE

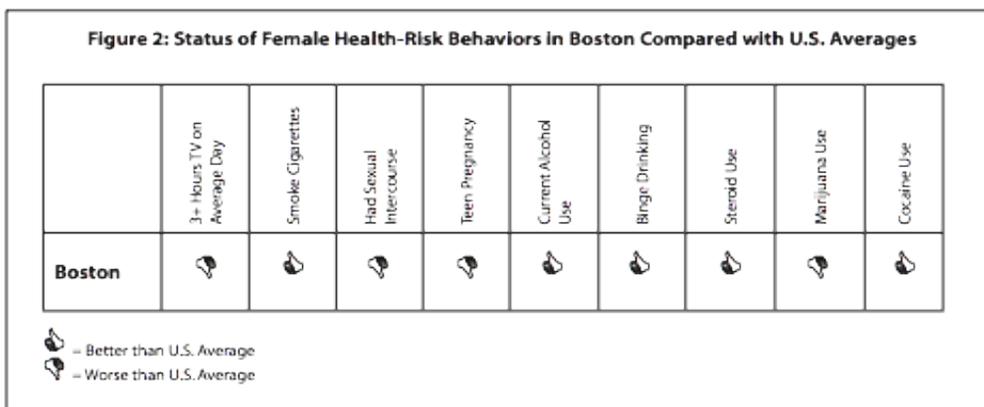
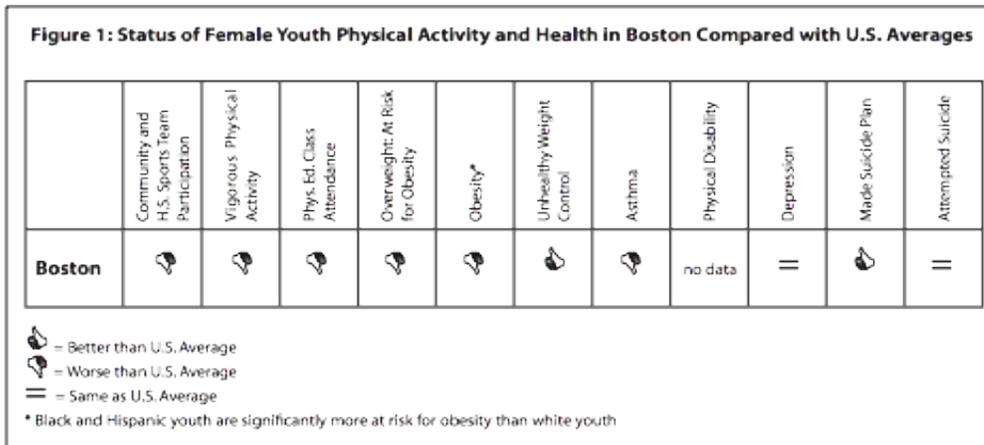
The Task Force has identified several factors that might contribute to the lack of sufficient PA among girls in Boston. Schools, perhaps because the Massachusetts law regarding PE specifies neither how much nor what kind of activity should be offered, are not involving many girls in PE. Sports facilities that are available to all boys and girls are limited. Adults may also be less knowledgeable about the benefits of physical activity for girls, which may contribute to lower participation rates (Lopiano, Snyder, & Zurn, 2007). A 2004 survey of Boston youth cited lack of interest, after school jobs, a parental desire to have the student home, lack of proximity to home, and poor neighborhood conditions as factors influencing the decision to not participate in after-school sports. The lowest levels of physical activity have been found among racial and ethnic minorities and those of lower socio-economic status.

The Task Force identified safety concerns as a major barrier to Boston girls participating in sports. When girls do not feel that they have safe and effective access to sports programs, they are less likely to take part. Although Boston has many parks, green spaces, and recreational facilities for PA, these are also locations where violent crimes occur frequently (Bennett, 2007).

Other factors that decreased physical activity included television viewing, playing video or computer games, and obesity. In 2010, the Boston Public Health Commission (2010) reported that 45 percent of Boston Public High School students watch three or more hours of TV on an average school day and that 72 percent of those students do not engage in regular PA. The Commission also reported that 33 percent of Boston Public High School students reported playing three or more hours of video or computer games and that 73% of those students do not engage in regular PA. Interestingly, being overweight or obese is identified as both a barrier to physical activity and a result of lack of activity.

Figures 1 and 2, shown below, summarize how girls in Boston compare to U.S. averages on measures of physical activity and health-risk behaviors. Clearly,

there is an opportunity to improve the profile of Boston’s girls in the area of physical activity.



(Lopiano, Snyder, & Zurn, 2007, p. 4)

Fortunately, some interventions have been found that help interest girls in physical education in school. For example, the Leadership Education for Activity Program (LEAP) significantly increased PE participation rates in high school girls in one study (Pate et al. 2005). In the next section, we review opportunities for the Junior League of Boston to support physical activity initiatives for the girls in our community.

## NETWORKING IDEAS IN BOSTON AREA

The Task Force has identified several organizations within the greater Boston area that are working to get girls up off the couch and involved in physical activities. They include:

- **GoGirlGo! Boston** - This is an award winning curriculum and sports education program that works to improve the health of sedentary girls and to keep girls involved in physical activity by supporting programs and organizations that work with girls.

Volunteer information:

<http://66.40.5.5/Content/Articles/GoGirlGo/Boston/V/Volunteer-Flyer.aspx>  
<http://www.womenssportsfoundation.org/sitecore/content/home/programs/gogirlgo/communities/gogirlgo-boston.aspx>

- Dream Big! - Boston  
Founded in 2010, Dream Big! is a 501(c)(3) Boston based non-profit organization. Dream Big!'s mission is to help low-income and homeless girls achieve their dreams by providing the basic items necessary to enable them to participate in sports and physical activities, helping to lay the foundation for healthy, active lifestyles and quality learning experiences. Dream Big! will partner with social service organizations, schools and community health centers to identify and fulfill the basic needs of low-income and homeless girls in elementary, junior high, and high school in order to help them engage in sports, recreation and physical activities.

Volunteer Information: <http://www.dream-big.org/content/how-you-can-get-involved>

- G-ROW Boston  
Launched in 1998 under the vision of Olympic gold medalist Holly Metcalf, G-Row is based on two fundamental beliefs:
  - Adolescent girls need to form healthy relationships and a sense of belonging in order to truly express themselves and be themselves;
  - Rowing for girls promotes self-confidence, determination, strength and personal growth in a tangible and powerful way.

Volunteer Information: <http://www.growboston.org/volunteer.htm>

- Girls on the Run of Suffolk County  
Girls on the Run® is a life-changing, experiential learning program for girls age eight to thirteen years old. The program combines training for a 3.1 mile running event with self-esteem enhancing, uplifting workouts. The goals of the programs are to encourage positive emotional, social, mental, spiritual and physical development.

Volunteer Information: <http://www.gotrbboston.org/contribute>

- Taking Healthy Steps, Boston Ballet and Roxbury Community College  
Taking Healthy Steps reaches nearly 200 young girls each year, introducing them to movement as a means of expression and encouraging

and inspiring them to take an active role in their physical, emotional and social well-being.

Volunteer Information: <http://www.bostonballet.org/community/taking-steps.html>

- East Boston Task Force  
The East Boston Task Force is an alliance of community organizations that supports the empowerment, education, and development of East Boston youth in order to promote healthier lifestyle choices, safety, and a more inclusive neighborhood. They are committed to increasing the availability of youth opportunities to all youth in East Boston by increasing and enhancing communication among schools, families and the community, and streamlining these processes to ensure that information and opportunities are easily accessible to all.

Volunteer Information: <https://eastbostonyouth.org/about>

- Tenacity Boston  
Founded in 1999, Tenacity has served over 20,000 Boston students who otherwise would lack a safe, productive, and healthy after-school and summer environment. Their high-quality literacy and tennis programming not only builds academic skills and improves fitness, they also foster the development of strong bonds between their students and caring staff, which instills the resilience needed to succeed in school and life.

Volunteer Information: <http://www.tenacity.org/>

- FitGirls  
FitGirls is a fitness program for girls in 4th and 5th grade that uniquely combines training for a 5k race with reading and community outreach.

Volunteer Information: <http://www.fitgirls.org/>

## TASK FORCE RECOMMENDATIONS

Physical activity advocacy would complement the Junior League of Boston's current work in the area of nutrition. Programs that focus on physical activity would also address the issue of obesity discussed in the nutrition section of this report. The Task Force believes that the JLB can address the issue of insufficient physical activity by either encouraging positive behaviors, such as increasing access to organized activities, safe facilities, or information about local opportunities to engage in physical activity, or by discouraging negative

behaviors, such as opting out of physical activity, watching excessive amounts of television, and negative body labeling.

#### Year 1

- 1 Require the incorporation of physical activity into all community programs working with girls
  - a Physical activity should be deliberately introduced into each program meeting, to an extent appropriate for the placement and location (e.g. “energy breaks” interspersed with other program activities)
  - b Resources such as a PA “tip sheet” with ideas on fitting PA into your day can be developed by the JLB and handed out to girls
  - c We can promote alternative ways of exercising (dance, going for a walk, hula hooping, stretching, taking the stairs, etc.)
- 2 Incorporate hourly energy/stretch breaks into JLBoston meetings for members to create a stronger culture of physical activity
- 3 Endeavor that all new Done in a Day, JLB Events, and development projects support our focus area of nutrition and wellness
- 4 Develop a strategic plan to create a database of physical activity opportunities for girls in the Boston area (e.g., races, events, community classes, etc.)
- 5 Update the design of JLB t-shirts to include a valuable fact about health and wellness on the back (will help to further align our brand with our focus on nutrition and wellness)
- 6 Begin an education campaign around health and wellness facts to educate our volunteers. Coordinate with the Communications Committee in order to include an informative fact in each weekly e-newsletter.
- 7 Design a wellness competition to be used internally among our current girls’ projects.
  - a Logs to track physical activity, healthy choices

#### Year 2

- 1 Begin compiling data for physical activity opportunity database.
- 2 Continue education campaign
- 3 Implement wellness competition among girls’ projects.

#### Year 3+

- 1 Create a new girls’ project with a specific focus on physical activity to reach a population that we are not currently serving
- 2 Provide space in HQ for local organizations serving girls to use our facilities for physical activity (dance classes, yoga, etc.)
- 3 Offer demonstrations of different activities (e.g. yoga, running, stretching and strength exercises) for girls within existing projects.

## EMOTIONAL HEALTH

### BACKGROUND

We began our research on emotional health by identifying several key behavioral issues and mental health problems that affect teenagers, specifically adolescent girls: mood disorders (e.g., depression and anxiety), low self-esteem and poor body image, eating disorders (treated at length elsewhere in this report), and violence involving bullying, aggression, sexual harassment, relationship violence, and the real threat of living in neighborhoods where the majority of girls report that they do not feel safe.

In a research review conducted by the Women's Sports Foundation, the authors found support for a strong interdependence among adolescent girls between behavioral health/self-image issues and physical activity levels, such that in general, higher levels of activity were related to lower levels of emotional distress (Staurowsky et al., 2009). Additionally, it is unknown whether low self-esteem leads some girls to be vulnerable to sexual harassment or controlling/violent relationship partners, or whether low self-esteem is the result of shame for being harassed and abused. Yet research has definitively shown that early intervention and mentoring by adult women increases the odds that girls will develop healthy attitudes and behaviors (Slater, Guthrie, & Boyd, 2001).

### MOOD DISORDERS

While typical sadness or anxiety passes within a couple of days, true depression, if untreated, can become chronic and interfere with one's day-to-day activities. Factors such as family history, stressful events, chronic medical problems, early exposure to toxins, substance abuse, lack of social support, and discrimination have been associated with an increased risk of developing mental disorders such as depression. Depression in adolescence frequently is accompanied by other disorders such as anxiety, post-traumatic stress disorder, disruptive behavior, eating disorders, risky behavior involving alcohol and drugs, criminal activity, and promiscuity. Suicide is the third leading cause of death among American teenagers and young adults ages 15-24.

Depression can be influenced by genetics as well as environmental factors, and has no single cause. Living in extremely stressful surroundings where poverty is the norm and life experiences involving family trauma or street violence both affect individual risk for depression.

Although in early childhood the risk of depression is roughly equivalent among females and males, by adolescence, girls are twice as likely to experience depression as boys. (Cyranski, Frank, Young, & Shear, 2000; Hyde, Shibley, Mezulis, & Abramson, 2008). One study, for example, found that while depression rates for 13-year old boys and girls were equivalent at around 2%, by

age 18 the gap had widened such that 23.2% of girls reported depression compared to 10.8% of boys (Hankin et al., 1998). Researchers cite the hormonal changes of puberty as contributors to an increase in rates of depression among teenage girls, as well as unrealistic standards of beauty and femininity, dysfunctional family dynamics, and new social pressures that emerge when children reach adolescence. In addition, research has suggested that girls are more likely than boys to continue feeling bad after experiencing difficult situations or events. Another study found that girls report more self-doubt, particularly with respect to their own problem-solving abilities and the solvability of their problems, than boys do. At the same time, girls base their feelings of security on approval from others to a greater degree than boys (Calvete & Cardinosa, 2005). The sex differences in emotional well-being may be exacerbated by the fact that girls report a higher incidence of poverty, sexual abuse, or other trauma than boys; in one study, over 70% of girls who had experienced a depressive episode reported a prior hardship, compared to 14% of boys (Cyranowski, Frank, Young, & Shear, 2000).

An additional factor related to depression for some girls is the social isolation of living in areas with widespread street violence. Forty percent of Boston girls report that they rarely or never feel safe in many of the places that they frequent. Ironically, the intimacy of Boston's neighborhoods can make girls feel unsafe or uncomfortable because they regularly see people who have made sexual advances or have abused them in the past. Many girls also report that their parents will not allow them to be alone in their neighborhoods, contributing to feelings of loneliness and hopelessness. On the weekends, many girls report that they are afraid to go outside for fear of violence. Instead, they usually stay indoors and spend time on the computer, watching TV, doing homework and sleeping. Girls are often reluctant to share their depression or anxieties with adults, typically because the adults are so burdened themselves or because they do not envision any possible improvement in their situation. Early intervention and mentoring are critical in helping girls unburden themselves and providing a forum for exploring their feelings.

Interventions with physical activity components may also help address some emotional health symptoms. As previously discussed in the Physical Activity section of this report, the positive effects of moderate exercise are well-known and apply to all age groups. For both biochemical and psychological reasons, exercise elevates mood and creates a sense of happiness and well-being.

### SELF-ESTEEM AND BODY IMAGE

Research has demonstrated that a positive evaluation of one's worth is a key indicator of overall psychological health. Self-esteem is a product of two factors: a sense of competence or self-efficacy based on one's performance or accomplishments, and an awareness of how others perceive one's self.

For many girls, low self-esteem is linked to negative perceptions of weight and appearance. Multiple studies have shown that body dissatisfaction in American girls emerges by the age of six and is well-established by the age of nine. In fact, 81 percent of ten-year-olds are afraid of being fat. Body image dissatisfaction is prevalent among youth, with 30% of boys and 60% of girls reporting that they wish to change their body shape (Ricciardelli & McCabe, 2001; Stice & Whitenton, 2002).

Negative body image may have many sources, including cultural prejudices and popular media imagery emphasizing a vision of female physical perfection that is unrealistically thin. One study found that physical comparisons and body conversations among friends may lead to body dissatisfaction, particularly among girls (Lawler & Nixon, 2010). In U.S. culture, a bias against obese people is manifested in children by the age of five; and among both teen and preteen girls, weight concern is a powerful motivator for tobacco use. Poor body image is also associated with abuse of appetite-suppressing substances, such as cocaine and amphetamines. Parents' attitudes about weight, appearance, and diet can also strongly influence their daughters' perceptions.

A study by the Kaiser Family Foundation found that media consumption among 8 to 18 year olds is on the rise, with an average daily media use time of 7.38 hours in 2009 (compared to 6.21 hours in 2004). While consumption of digital media such as television, video games, and websites has increased from 2004 to 2009, consumption of print media has decreased (Rideout, Foehr, & Roberts, 2010). Studies have shown that reading "teen magazines" and frequent exposure to thin models is associated with lower self-esteem, body dissatisfaction, decreased confidence and eating disorder symptoms. Girls today are faced not only with media ideals of how a woman should look, but if they are already at risk for depression due to stressful life circumstances, they are twice as likely to overeat or binge on food. This can set up a circular dynamic where guilt and shame may lead to depression and more binge eating. Self-esteem can be especially at risk during changes such as moving to a new school or starting a new job, since even healthy adolescents are concerned about acceptance by a new peer group.

In addition to formulating unrealistic physical standards, girls are also subjected to both blatant and subtle sexualization, whereby a person's value derives solely from his or her sexual appeal or behavior. Research links sexualization with three of the most common health problems of girls and women: eating disorders, low self-esteem, and depression. While the male body has been judged traditionally on its ability to accomplish goals, the female body has been judged traditionally on its sexual attractiveness to men. An additional component of sexualization is when a person is held to a narrowly-defined standard that equates physical attractiveness with being sexy. Furthermore, sexualization makes a person into an object for others' sexual use rather than being seen as a person with the capacity for independent action and decision making. Girls receive subtle messages from television programs, in that 41 percent of male TV characters are shown "on the job" compared to only 28 percent of female

characters. One study revealed that when men are shown in the background of a video, they are most often fully clothed. When women are shown in the background, approximately half the time they are dressed provocatively (ChildrenNow, Boys to Men: Media Messages About Masculinity, 1999).

When girls ask their parents for sexy clothes or style their identities after celebrities they think are sexy, they are effectively sexualizing themselves. Gradually, they learn to think of and treat their own bodies as objects of others' desires and evaluate themselves according to the responses they receive from peers. Sexualization is related to impaired functioning in a variety of domains, including cognitive functioning, physical and mental health, and how attitudes and beliefs are internalized. The effect on cognition is important because it could detract from the ability to concentrate and focus one's attention, perhaps leading to impaired performance on mental activities needed for academic success (Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998; Gapinski, Brownell, & LaFrance, 2003; Hebl, King, & Lin, 2004).

## VIOLENCE

### Bullying and Aggression

Bullying is characterized by an imbalance of power between individuals or groups. People who bully use their power to control or harm others, and the victims may have a hard time defending themselves. Bullying also involves a deliberate intent to harm and is usually repeated on the same victim continuously by the same person or group. After increasing for several years, the arrest rate of juvenile girls for violent crimes began to drop in 2009 (Puzzanchera & Adams, 2011). The increase in the years prior may suggest that girls were becoming more violent during that time period. However, at least one study finds that the frequency of violent assaults perpetrated by girls has not been rising; rather, schools and other institutions have been more likely to punish girls, which inflates the recorded number of violent acts committed by girls (Zahn et al., 2008).

While there is academic disagreement about the cause of violent behavior among young girls, potential contributing factors include social media, a "girl power" subculture (originally meant to empower young girls to be self-reliant, ambitious, and assertive), and increased access to technology make it easier for girls to engage in direct or indirect bullying. Indirect bullying, such as cyber-bullying, includes relational aggression (RA), seeking to damage relationships or social status within a group, rather than the direct use of actual or threatened physical or verbal violence. While girls are more likely than boys to display indirect bullying behavior, there are many incidents of girls resorting to actual physical violence. According to the CDC's Youth Risk Behavior Surveillance System (YRBS), in 2011 almost 5% of female high school students in Massachusetts reported participating in a physical fight on school grounds, with almost 18% reporting participating in a physical fight in the past 12 months (CDC, 2011).

According to one report, girls who directly bully others often have one or more underlying risk factors such as mental illness (e.g. depression, conduct disorder), substance abuse, or a lack of positive role models (National Center for Mental Health Promotion and Youth Violence Prevention, 2011). Exposure to psychologically abusive parental figures or delinquent peers is also associated with increased likelihood of violent behavior (Ferguson, San Miguel, & Hartley, 2009). Girls who act violently toward others are also more likely to have delays in their cognitive, moral and social development, which can lead to less social success and lower academic achievement (Artz & Nicholson, 2002). Higher levels of girls' violence are also associated with lower socioeconomic status.

Many girls who exhibit violent behavior have observed this type of behavior at home or in the community and may have come to regard violence as an acceptable form of behavior. According to a study conducted by the U.S. Office of Juvenile Justice and Delinquency Prevention, girls ages nine to 15 are almost two and a half times more likely to engage in violence if they have previously been maltreated or assaulted or were the victims of physical or sexual violence (Zahn et al., 2010).

Moreover, the sanctions currently in place in most school systems are not effective at reducing violent behavior in the school setting. Evidence suggests that common methods of punishing violent or aggressive behavior in school, such as detention, may actually encourage further violence (Mayer, 2002) and are not likely to reduce its incidence (Sprague et al., 2001). However, Vreeman and Carroll (2007) found reduction in bullying behavior for students in a mentoring program--a finding which is promising for the Junior League's efforts, but may be resource-intensive to implement within a school setting. Adolescent victims of violence may also flounder in the school setting: One study found that adolescents' willingness to seek help from school authorities when they are victims of bullying is directly related to their perception of the authorities' helpfulness, while their willingness to retaliate is negatively related to authorities' helpfulness (Aceves, Hinshaw, Mendoza-Denton, & Page-Gould, 2010). This suggests that relationships with teachers and other school staff influence violent behavior at school.

Fighting can improve a girl's social status among peers because she exudes confidence and seems to be able to protect others (Jones, 2004). Girls fight for attention from boys, to defend their reputation, or in self-defense against sexual harassment (Zahn, et. al, 2008). Girls may be encouraged to fight by peers, especially by boys. Without meaningful input from adults and safe forums to discuss the impact of violence, girls do not recognize that such behavior is intolerable and dangerous.

Despite the incidence of female aggression and violence, the victimization of girls must not be lost in the process. A 2005 study found that violent victimization is a significant precursor to aggressive behavior in girls, and that girls are more likely

to act violently if they live in severely violent or impoverished communities (Molnar, Browne, Cerda, & Buka, 2005). We must pay attention to both perpetrators and targets to effectively address violent behaviors.

### Sexual Harassment and Relationship Violence

Victimization through sexual harassment is unfortunately not uncommon for young girls.

The Voices on Violence 2010 report by Girls' LEAP Boston stated that 83% of middle and high school girls reported experiencing sexual harassment in school. Over one-third of the girls in Girls' LEAP Standard Programs during 2008-2009 said that girls receive unwanted comments and/or touching by boys "very often." Most girls do not realize that they are being victimized by this behavior or that it can be dangerous to their health. Girls are much more likely than boys to report psychological consequences of sexual harassment, including loss of confidence, loss of appetite, and disengagement from school work. However, some girls receive what they view as reassurance about their appearance and desirability (sexualization), and still others dismiss sexual harassment as acceptable flirting.

Women and girls may become the victims of controlling and abusive relationship behavior (emotional, physical, and sexual). Non-consensual sexual activity or attention, including verbal, visual, or physical contact, is considered sexual assault or abuse. The CDC's National Intimate Partner and Sexual Violence survey suggests that a woman in Massachusetts has a 15% lifetime chance of being the victim of sexual violence, and about a 25% chance of experiencing any type of physical or sexual violence from an intimate partner (Black et al., 2011). Results from the 1997 and 1999 Youth Risk Behavior Survey indicate that about one in five teen girls in Massachusetts has experienced some form of violence in a dating relationship (Silverman, Raj, Mucci, & Hathaway, 2001).

Unfortunately, over time exposure to violence can have sustained detrimental effects. For example, one research review found that a girl's risk of being a victim of relationship violence increases if she has been exposed to violence in the home, or if she suffers from depressive symptoms or substance abuse (Vézina & Hébert, 2007). Another study found that exposure to violence leads adolescents to normalize violence (Guerra, Huesmann, & Spindler, 2003).

These effects of early exposure to violence may also include an increased propensity toward violence oneself. One study found that inner-city youth exposed to violence on a regular basis eventually normalize violent behavior, which both protects them from some of the adverse psychological consequences of exposure and makes them more likely to behave violently themselves (Ng-Mak, Sueve, Salzinger, & Feldman, 2002). Boys in another study were more likely to accept interpersonal violence in a romantic relationship and to believe relationship violence was normal in their peer group if they had experienced violence in their home (Kinsfogel & Grych, 2004). The increased tendency toward aggressive behavior following exposure to violence is evident as early as first

grade (Guerra et al., 2003). Another study found that people who feel themselves to be in a low-status position are more likely to behave violently (Henry, 2009), perhaps in an attempt to elevate their status. This evidence suggests that people who act aggressively or violently toward their romantic partners are likely to have been victims of or witnesses to violence themselves.

Considering all the forms of violent behavior discussed in this report, virtually every study examining girls' responses to victimization found that adolescent girls rarely formally report incidents of being bullied, assaulted by others, sexually harassed, or abused by a boyfriend. Some girls accuse adults in their lives of normalizing harassing behavior, such as downplaying or ignoring harassing behavior that they witness. These adult reactions do not motivate girls to ask adults for help. Instead, most girls prefer to handle these situations themselves, sometimes resorting to physical aggression in an attempt to stop the offensive behavior. Many are unaware that these behaviors are abusive, unacceptable and dangerous.

In addition to the immediate consequences of victimization, girls incur problems that may persist throughout their adult years, damaging their self-esteem and contributing to long-term behavioral and mental health issues. The following are well-documented outcomes of long-term victimization: difficulty focusing on tasks, isolation and loneliness, decreased confidence, suicidal or homicidal thoughts, declining academic performance, anxiety, and eating disorders (O'Neill, 2008, p. 17).

Research has demonstrated links among many of these issues, making it all the more critical to provide early intervention, such as girl-specific programs where open discussion and mentoring can enable girls to see a way out of the cycle of victimization and violence, and improve their physical and mental health.

### NETWORKING IDEAS IN BOSTON AREA

- Girls' LEAP (Lifetime Empowerment & Awareness Program) creates awareness of violence and sexual assault and teaches girls self-defense skills, builds confidence, and encourages girls' well-being.

Volunteer information:

[http://leapmail.wix.com/girlsleap#!get\\_involved/c8k2](http://leapmail.wix.com/girlsleap#!get_involved/c8k2)

- Center on Media and Child Health at Children's Hospital Boston is a research center focused on understanding the effects of media on children's physical, mental, and social well-being.

Volunteer information: <http://cmch.tv/>

- Boston GLOW (Girls' Leadership, Organized Women) provides leadership training and service learning opportunities to girls and women to work toward the vision of empowered women as community leaders.

Volunteer information: <http://www.bostonglow.org/>

- Catching Joy promotes volunteerism from an early age by organizing projects suitable for children and adolescents to contribute to others. Volunteer information: <http://catchingjoy.org/>
- East Boston Task Force works with a cohort of high school students identified as being at high risk of dropping out, and maintains daily contact and support with these students during their ninth grade year. Task force members also coordinate outreach with other programs and services.

Volunteer information: <http://www.eastbostonyouth.org/>

- Girls Rock Campaign Boston provides support and mentorship to young girls, with an emphasis on empowerment, through musical education and performance.

Volunteer information: <http://girlsrockboston.org/get-involved/volunteer>

- Massachusetts Society for the Prevention of Cruelty to Children supports the rights of children and families through mental health interventions, adoption services, and child abuse and intervention programs.

Volunteer information: <http://www.mspcc.org/page.aspx?pid=351>

- Roof Over Head Collaborative works with landlords to provide below-market rent to families in need of housing assistance.

Volunteer information: [http://www.roofoverhead.org/how\\_to\\_help](http://www.roofoverhead.org/how_to_help)

## TASK FORCE RECOMMENDATIONS

The Junior League of Boston is already providing mentoring, guidance, and role models for adolescent girls through our work with Germaine Lawrence and the Boys & Girls Clubs, although the total number of girls served is relatively small compared to the total adolescent population of Massachusetts. The Task Force believes that the JLB has the ability to expand our work to a larger clientele of underserved girls.

### Year 1

- 1 Develop more formalized trainings to educate all members working on direct service projects (or events where girls are present) to deliver a

consistent message regarding respect for others, appropriate behavior, and conflict resolution.

- 2 For all materials including images of women or girls used in Junior League events or communications, review to ensure an inclusive range of appearances are depicted. Review program, handout, and website language to ensure implicit assumptions or value judgments related to appearance are appropriately revised.
- 3 Initiate support of community organizations providing outreach to adolescent girls. For example, the JLB can support Boston GLOW through a Done in a Day placement in support of their major annual fundraising event.
- 4 In reviewing placement curricula, identify opportunities to strategically introduce positive messaging around body image, interpersonal violence, and other issues relevant to emotional well-being.
- 5 Coordinate with Communications Committee to include information or tips related to supporting girls' emotional well-being in the newsletter or on the JLB website.

#### Year 2

- 1 Continue to seek potential partners for community projects.
- 2 Develop a resource booklet that specifically addresses how to respond to girls in crisis.
- 3 Provide training opportunities to members to better equip them to interact with girls who have emotional health issues or are dealing with violence; examples may include workshops on active listening or training on referring girls to community resources as needed
- 4 Review research on mentorship to address violent youth behavior to explore the possibility of a new mentorship placement

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