

# Parental Perceptions of Family and Pediatrician Roles in Childhood Weight Management

Jenna L. Lupi, MPH<sup>1</sup>, Maryam B. Haddad, MSN, MPH<sup>2,3</sup>, Julie A. Gazmararian, PhD, MPH<sup>3</sup>, and Kimberly J. Rask, MD, PhD<sup>4</sup>

**Objective** To characterize parental perceptions of the respective roles of families and the pediatrician in childhood weight management.

**Study design** Structured in-person interviews (n = 69) were conducted with parents of children ages 3-12 years visiting a pediatric clinic. Interview topics included perceptions of weight and associated problems, child weight status and concerns, and the pediatrician's role in weight management. Interviews were coded qualitatively and analyzed thematically.

**Results** Nine major themes were developed from the findings. Parents were clear about the health consequences of excess weight but were not clear about the concept of body mass index, often relying on visual cues or symptoms to identify excess weight. Parents relied on pediatricians to identify weight problems and suggest diet and exercise plans, but few recognized them as a link to additional weight-management resources. Parents were divided on the role of the pediatrician in managing child weight and were most interested in receiving tailored nutrition information. Parents preferred family behavioral change strategies over singling out an overweight child. Although parents did not always define their child as overweight, many parents of overweight children did express concerns about their child's weight.

**Conclusions** Parents believe that pediatricians have a central role in identifying childhood weight problems by completing screening tests such as body mass index assessments, interpreting the health implications, and communicating those implications to parents. Ensuring that parents understand the health implications of excess weight is critical given gaps in parental knowledge and confidence with healthy lifestyle changes as well as parental ambivalence toward child-directed interventions. (*J Pediatr* 2014;165:99-103).

It is recommended that pediatric care providers assess body mass index (BMI) as a regular screening for obesity treatment and prevention in patients annually starting at age 3 years.<sup>1,2</sup> For those children >85th percentile for weight, The American Academy of Pediatrics, the Endocrine Society, and the US Preventive Services Task force recommend evaluation of obesity-associated issues and the engagement of parents and families to collaboratively set lifestyle change goals.

Although many parents fail to recognize their child's weight status, pediatrician comment has been identified by parents as appropriate and important in recognizing weight problems.<sup>3</sup> Parents and pediatricians have both reported mixed opinions regarding the ideal setting for weight management, with some in each group favoring the pediatrician's office and others favoring providers such as registered dietitians (RDs).<sup>4</sup> Both providers and parents agreed that parents should be involved in determining the weight management strategy,<sup>5</sup> but communication between providers and parents has not met expert recommendations.<sup>6,7</sup>

A better understanding of parental perceptions of the role of health care providers in pediatric weight management is needed to develop effective interventions that can increase communication between providers and parents about childhood weight management. The study focused on 3 questions: (1) How do parents perceive their role in their child's weight management?; (2) How do parents perceive the role of their pediatrician in their child's weight management?; finally, (3) how does a child's weight affect the perceptions of parents in regard to both their role and the role of the pediatrician in their child's care?

## Methods

A structured interview guide was developed for one-on-one interviews with parents to assess their perceptions of the definition of overweight and the respective roles of parents and the pediatrician in childhood weight management. Participants were selected through nonprobability convenience sampling from a private pediatric primary care practice in Atlanta, Georgia. The clinic is staffed by 8 pediatricians and 1 nurse practitioner, and providers see approximately 120 children a day with both public and private health insurance coverage. This study was reviewed and approved by Emory University's Institutional Review Board.

From the <sup>1</sup>Department of Behavioral Sciences and Health Education, <sup>2</sup>Laney Graduate School, and Departments of <sup>3</sup>Epidemiology and <sup>4</sup>Health Policy and Management, Emory University, Atlanta, GA

Supported by the Alliance for a Healthier Generation. The authors declare no conflicts of interest.

0022-3476/\$ - see front matter. Copyright © 2014 Elsevier Inc.

All rights reserved.

<http://dx.doi.org/10.1016/j.jpeds.2014.02.064>

BMI Body mass index  
RD Registered Dietitian

The study population included parents or guardians of children ages 3-12 years attending the clinic for a sick-child visit. In this clinic, the standard of care is for staff to enter BMI into the electronic record system and for pediatricians to provide nutritional and weight counseling during all well-visits. Well-child visits were excluded from the study population to avoid undue influence of same-visit discussions about child weight and nutrition. Potentially eligible families at the clinic for a sick child visit were seen initially by a nurse in individual examination rooms. Once the child's initial assessment was complete, nurses introduced the study by using a script provided to them by the research team. Families were recruited without regard to the child's weight. If the parent agreed to participate, the interviewer reviewed the confidentiality agreement with participants and obtained written consent for participation. Interviewers also asked for permission to record the interviews. In addition to the recordings, interviewers took notes as they moved through the questions. The child remained in the examination room while the interview took place. Interviews took approximately 20 minutes to complete, and participants received a \$10 gift card.

The majority of interview questions were designed deductively before the interviews began and were based on the literature, and additional probing questions were added inductively by the interviewers when appropriate. Deductive questions were asked of all the participants and inductive probes were asked in response to participant comments to better understand individual experiences. Following demographic questions, the interview guide was divided into topic areas. The topics and associated questions are displayed in **Table I** (available at [www.jpeds.com](http://www.jpeds.com)). The initial interview guide was pilot tested with 4 participants. The responses were not included in the study sample but provided an opportunity to revise the interview questions.

The goal of data analysis was to identify similarities and differences between responses, both broadly and based on child weight, to develop themes. Interviewer notes were compared with the audio-recording and additional notes were added as necessary. All data were anonymous to protect the identity of the interviewed families.

All the interviews were transcribed into an Excel spreadsheet (Microsoft Corp, Redmond, Washington), and codes were developed across interviews for each question. Coding was first assessed using a deductive approach based on the interview questions, followed by an inductive approach within each question assessing repetition of words or phrases and underlying concepts across interviews. For example, sample codes for the question "How would you define overweight" include fat, weight, BMI, visual, and affecting life/health. Coding began when about one-half of the interviews were completed and continued until all interviews were completed. Minor changes to the interview process were made based on continuous data analysis. The main change was to alter a skip pattern to include more opinions regarding RDs. These changes did not have any major influence on data consistency.

Common patterns, similarities, and differences among participants were identified by comparing codes from different

questions. After multiple reviews were completed, the codes were categorized based on similarities into 9 main themes. The codes and themes were initially developed by one of the interviewers and were then reviewed several times by 2 additional interviewers. This process was done to help conceptualize the data as a whole. Key themes were summarized, and similarities and differences between responses are presented.

## Results

A total of 69 interviews were completed before thematic saturation was reached. The sample was racially diverse and predominantly college-educated. Participant demographic characteristics are shown in **Table II**. Nine major themes were developed based on participant responses. They are discussed below and summarized in **Table III** (available at [www.jpeds.com](http://www.jpeds.com)).

Participants provided diverse definitions for overweight and obesity, demonstrating that the clinical distinction between the 2 terms was not clear to this well-educated sample of the general public. BMI, although often mentioned, was likewise poorly understood. When asked what the term obese meant, one participant replied "[it] has to do with BMI and percent body fat, but I'm not sure exactly what." Although the term BMI was recognized, it was clear that this was a newer concept for parents, with reactions like "understanding BMI is such a push right now" and "I've always wondered what BMI is exactly." Another participant asked, "Can they do BMI here?" Confusion was expressed by parents of both normal weight and overweight children.

**Table II.** Characteristics of parents and children in the pilot study (n = 69)

Characteristics	Number of participants/median	Percentage/range
Parent age, median	40	20-50
Parent education, no.		
Some high school	2	3%
High school graduate or equivalent	10	14%
Some college	14	20%
College graduate	24	35%
Postgraduate work	19	28%
Parent race, no.		
White	41	60%
Black/African American	22	32%
Hispanic/Latino	3	4%
Asian	1	1%
Other	2	3%
Insurance type, no.		
Private	49	71%
Public	19	28%
None/uninsured	1	1%
Child age, median	6	3-12
Child sex, no.		
Male	37	54%
Female	32	46%
Child BMI, no.		
Below 85th percentile for BMI	47	68%
Above 85th percentile for BMI	22	32%

Download English Version:

<https://daneshyari.com/en/article/4164874>

Download Persian Version:

<https://daneshyari.com/article/4164874>

[Daneshyari.com](https://daneshyari.com)