

Parent Readiness to Change Differs for Overweight Child Dietary and Physical Activity Behaviors



Kyung E. Rhee, MD, MSc, MA; Rebecca McEachern, MD; Elissa Jelalian, PhD

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ABSTRACT

Parent involvement is important to help overweight children lose weight. However, parent readiness to make changes around child eating and physical activity (PA) behaviors can differ across domains. Using a cross-sectional design, our aim was to examine which factors were associated with parents being in the Action/Maintenance stage of change in each domain. From November 2008 to August 2009, parents of overweight/obese children (n=202) attending a tertiary care obesity clinic in Providence, RI, answered questions assessing their stage of change, beliefs about child health and weight, and provider behaviors. Separate multivariate logistic regression models were created to determine which factors were associated with parent readiness to make changes for child dietary and PA behaviors. Almost 62% of parents were in the Action stage of change for child dietary behaviors, but only 41% were in the Action stage of change for PA behaviors. Parents who believed their own weight was a health problem were less likely to be ready to make changes to their child's dietary behaviors. Physician discussion of strategies was related to readiness to make changes for child dietary behaviors, but not PA behaviors. In the PA domain, parents of younger children were more likely to be ready to make changes. Training health care providers to address PA readiness and be aware of factors influencing dietary and PA readiness may result in more effective conversations with parents and improve behavior change efforts for pediatric weight loss.

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PARENTS PLAY AN IMPORTANT ROLE IN HELPING children develop healthy eating and physical activity (PA) behaviors.¹ They are also critical in helping overweight and obese children successfully lose weight.²⁻⁴ However, before weight loss can occur, parents need to be ready to make eating and PA changes to assist and support their children. In the Transtheoretical Model, there are five stages of change: Precontemplation, Contemplation, Preparation, Action, and Maintenance.⁵ Behavior change occurs when one recognizes the importance of change, has the confidence to change, and is ready to change—that is, in the Action stage of change. Being in this stage has also been associated with increased engagement in healthy lifestyle behaviors.⁶⁻⁸ A previous study showed that parent confidence to change child dietary and PA behaviors was related to treatment adherence and child weight loss.⁹ By virtue of enrolling in this program, parents presumably recognized the importance of making changes. Therefore, without both confidence and belief in its importance, parents may not be ready to help children develop healthier habits and lose weight.

Several studies have examined factors related to parent readiness to make changes for overweight children.^{10,11} One study found that parents who had older children and perceived child weight to be a health problem were more likely to help children lose weight.¹⁰ Another study found

that physician assessment of parent confidence appeared to influence readiness level.¹¹ Discussing parent confidence and readiness is often used in motivational interviewing and can help parents move along the stage of change continuum.¹² However, weight loss is a complex behavior that involves making changes to both eating and PA habits. Often, parents may find making changes in one domain easier than another. Yet assessment of weight-loss readiness typically combines these behaviors and assumes that readiness to make changes in one domain applies to the other, affecting weight loss equally.^{10,11,13} A recent study among adults found that low confidence to make changes in PA behaviors was the best predictor of weight-loss treatment failure.¹⁴ Identifying domain-specific factors that influence parents' readiness to assist their children in making changes in the area of eating and PA may lead to more tailored messages for parents. These messages might affect parents' decisional balance (the value of making behavioral changes vs the value of not making any changes) and the likelihood of treatment success for children.

The aim of this study was to identify parents who were actively making eating and PA changes for their overweight child and determine what factors were associated with readiness in each domain. To our knowledge, only one other study examined readiness in these domains separately.¹⁵ They found that parent's perception of elevated child

weight was associated with readiness to decrease portion sizes and dietary fats in the child's diet, but not increase PA or decrease sedentary behaviors. The impact of other factors like parent health, weight, and physician behaviors was not assessed. Given previous reports on the importance of the health care provider,^{10,11} we hypothesized that physicians' discussions would be associated with parent readiness to change in both domains. We also hypothesized that more parents would be ready to make changes around their child's eating behaviors than their child's physical activity behaviors.

METHODS

Study Design

In this cross-sectional study, a convenience sample of parents or guardians (herein identified as "parents") of children attending a tertiary care pediatric obesity clinic at Hasbro Children's Hospital (the Pediatric Division of Rhode Island Hospital, Providence) were given a survey to assess their readiness to make behavior changes around child dietary and PA habits. They also provided information on demographics, child eating and PA behaviors, their child's and their own weight and health, and physician behaviors. Children were typically referred to this clinic by their primary care provider (PCP) if they were overweight (body mass index [BMI] ≥ 85 th and < 95 th percentile) or obese (BMI ≥ 95 th percentile) and had metabolic complications of obesity, such as insulin resistance, abnormal glucose tolerance, type 2 diabetes, hyperlipidemia, or hypertension. Families attending the clinic between November 2008 and August 2009 were given the surveys when they arrived at the clinic as part of their initial paperwork. All surveys were completed via paper and pencil by the parent and were available in English and Spanish. One of the authors (R.M.) was available to clarify questions regarding survey items and collected the surveys on completion. Parents who brought their children for follow-up visits were not given the surveys to complete again because the investigators were interested in assessing initial readiness to change levels. During this time, 227 families had an initial visit. Of these, 209 parents (92%) of children between the ages of 5 and 20 years old completed the survey. Eighteen families refused to participate. Seven children were not overweight or obese and were excluded. The final sample included 202 parent-child dyads. The study was approved by the Rhode Island Hospital Institutional Review Board and all parents provided written informed consent.

MEASURES

Dependent Variables

The primary outcome of interest was parent readiness to change in two different domains: helping children eat a healthy diet and helping children engage in PA. Eating a healthy diet was defined as having five or more servings of fruits and vegetables per day and consuming foods high in fiber and low in fats as per the 2007 Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity.¹⁶ PA was defined as having at least 60 minutes of active movement per day, including running, playing outside, walking to school, or playing a sport. The questions were modeled from previously used questions¹⁰ and designed to categorize respondents into the five stages of change:

Precontemplation, Contemplation, Preparation, Action, and Maintenance.⁵ These stages are typically operationalized around intent or actual behavior change that has occurred during 1 to 6 months.¹⁷ For example, people in the Precontemplation stage of change do not intend to make any changes within the next 6 months, although people in the Contemplation stage of change are thinking about making changes, typically within the next 6 months. People in the Preparation stage of change are typically ready to make changes in the next 30 days and have begun to take small steps toward engaging in these new behaviors. People in the Action stage of change have been engaging in the new behaviors for 1 to 6 months, and people in the Maintenance stage of change have been engaging in these behaviors for longer than 6 months.

Based on this model, the survey included three questions for each of the two domains: Do you intend to find ways to improve (the way your child eats/your child's PA level)? In the past month, how often did you do things to help your child (eat healthier foods/be more physically active)? How long have you been doing things to help your child (eat healthier foods/be more physically active)? Parents who indicated that they were not making behavior changes for their child, not intending to make changes within the next 6 months, or were making sporadic changes less than once a month were categorized into the Precontemplation/Contemplation stage of change. Parents who indicated that they were already making behavior changes for their child or intending to in the next month, but were only making changes one to three times per month or had only been making more frequent behavior changes for 1 month or less, were categorized into the Preparation stage of change. Parents who indicated that they were already helping their child eat healthier/be more physically active, implementing these changes more than once a week, and engaging in these behaviors for more than 1 month, were categorized into the Action/Maintenance stage of change.

To examine the validity of these stage of change categories, parents were asked to report on child eating and activity habits, such as drinking sugar-sweetened beverages and watching television (see [Figure 1](#) for survey items). Diet soda was included as a sugar-sweetened beverage because it is classified as a "red food" in the Traffic Light diet,¹⁸ and children are discouraged from consuming it. Child behaviors served as a proxy for parent behaviors because children are not likely to make behavior changes without their parent's involvement and this allowed the investigators to determine what children were actually consuming and doing. Items used to assess dietary behaviors were similar to those used in previously validated brief dietary assessment tools.^{19,20} Dietary behaviors were assessed around sugar-sweetened beverages, snacks, and fast food rather than a full assessment of fat and fiber intake because these foods are often more easily defined and understood by participants than identifying those foods that are high in fat and low in fiber. A briefer assessment of dietary behaviors was also conducted to ease participant burden. PA and television-viewing behaviors were measured according to guidelines set by the 2007 Expert Committee Recommendations.¹⁶ PA and leisure time behaviors for the weekday and weekend were assessed separately. All responses to food and PA items were dichotomized to reflect previously reported minimal levels or suggested requirements.^{16,21,22} Cut points for breakfast and

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