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Do parents or siblings engage in more negative weight-based talk with children and what does it sound like? A mixed-methods study☆

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ABSTRACT

The current mixed-methods study examined the prevalence of negative weight-based talk across multiple family members (i.e., mother, father, older/younger brother, older/younger sister) and analyzed qualitative data to identify what negative weight-based talk sounds like in the home environment. Children ($n = 60$; ages 9–12) and their families from low income and minority households participated in the study. Children reported the highest prevalence of negative weight-based talk from siblings. Among specific family members, children reported a higher prevalence of negative weight-based talk from mothers and older brothers. In households with younger brothers, children reported less negative weight-based talk compared to other household compositions. Both quantitative and qualitative results indicated that mothers' negative weight-based talk focused on concerns about child health, whereas fathers' and siblings' negative weight-based talk focused on child appearance and included teasing. Results suggest that interventions targeting familial negative weight-based talk may need to be tailored to specific family members.

Introduction

Familial negative weight-based talk, which includes weight teasing, negative comments about appearance, critical comments about one's body shape or size, and conversations about dieting, is common among youth (Berge et al., 2013; Berge, MacLehose, et al., 2014; Berge, Rowley, et al., 2014; Neumark-Sztainer et al., 2002). Such weight talk, also referred to as "fat talk" (MacDonald, Dimitropoulos, Royal, Polanco, & Dionne, 2015), has been found to be associated with multiple negative health outcomes such as low self-esteem, depressive symptoms (Eisenberg, Neumark-Sztainer, Haines, & Wall, 2006), thinking about or attempting suicide (Eisenberg, Neumark-Sztainer, & Story, 2003), loneliness, poor self-perception of one's physical appearance, a preference for sedentary activities (Hayden-Wade et al., 2005), overweight and obesity (Berge, MacLehose, et al., 2014; Berge, Rowley, et al., 2014), unhealthy weight control behaviors (Libbey, Story, Neumark-Sztainer, & Boutelle, 2008) and disordered eating behaviors (Berge et al., 2013; Eisenberg, Berge, Fulkerson, & Neumark-Sztainer, 2012). Given the harmful outcomes associated with familial negative weight-based talk, it is important to understand more about familial sources of negative weight-based talk. For example, do parents or siblings engage in more negative weight-based talk, do older or younger brothers engage in more negative weight-based talk, and what does negative weight-based talk sound like in the home environment? Identifying which family members are engaging in more negative weight-based talk will allow for tailoring interventions to these family members in order to reduce the prevalence of familial negative weight-based talk.

Prior studies have indicated that approximately 25–60% of youth who are overweight report negative weight-based teasing from parents and/or family members (Keery, Boutelle, van den Berg, & Thompson, 2005; MacDonald et al., 2015; McCormack et al., 2011; Neumark-Sztainer et al., 2002, 2010). Additionally, studies have shown that negative weight-based talk by family members is associated with child and adolescent body dissatisfaction, unhealthy weight control behaviors, and depression (Eisenberg et al., 2012; Greer, Campione-Barr, & Lindell, 2015; Keery et al., 2005; MacDonald et al., 2015), regardless of whether the child is overweight or normal weight.

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While the potentially deleterious effects of negative weight-based talk are known, the knowledge about specific sources of negative weight-based talk is limited, as well as what negative weight-based talk sounds like in the home environment. Most studies that have investigated negative weight-based talk focus on peer or family teasing. A few studies have included both parent and sibling variables (Greer et al., 2015; Schaefer & Salafia, 2014; Taylor et al., 2006), but to the best of our knowledge, only one study has examined family, parents, and siblings separately (Keery et al., 2005). In addition, the limited studies that have included siblings have been conducted mostly with Caucasian, mid- to higher-income participants.

Furthermore, qualitative research on weight talk/teasing in the home environment is limited. A previous qualitative study conducted by the authors of the current study found that families of children ages 6–12 engaged in: weight talk contradictions (i.e., said they didn't talk about weight with their children, but then gave examples of when they did use weight talk/teasing), overt and covert weight talk/teasing, and reciprocal teasing (Berge, Trofholz, Fong, Blue, & Neumark-Sztainer, 2015); however, this previous study did not examine which specific family members were engaging in weight talk/teasing.

The current mixed-methods study addresses limitations in previous research in two ways. First, it examines the prevalence of negative weight-based talk across mothers, fathers, older/younger brothers, and older/younger sisters and examines the likelihood of engaging in negative weight-based talk by family member. Second, it analyzes qualitative data to provide a more in-depth picture of what negative weight-based talk sounds like in the home environment. Furthermore, the study sample includes children from minority and low-income populations, who are underrepresented in studies examining familial negative weight-based talk.

Family systems theory (Bateson, 1972; Doherty & McDaniel, 2010; von Bertalanffy, 1968) guided the study design, research questions, and data analysis of the current study. Family systems theory purports that the family is the most proximal level of influence on a child's behavior and can either exacerbate or decrease the likelihood of any given behavior being expressed. Family systems theory also focuses on relational connections between family members and how these interconnections can influence individual behavior, as well as family-level behavior. For example, a child may experience negative weight-based talk from a family member. This in turn may increase the child's negative emotional response, triggering the child to emotionally eat. This increase in unnecessary calories could result in the child gaining weight, thus increasing the likelihood of experiencing more negative weight-based talk. Overweight and obesity therefore becomes a familial-sustained problem.

The current study addresses the following research questions: (a) Who are the main sources of negative weight-based talk among family members (mother, father, older/younger brother, older/younger sister)?; (b) Which family members are most likely to engage in negative weight-based talk?; and (c) What does familial negative weight-based talk sound like in the home environment? Understanding familial sources of negative weight-based talk and examples of what negative weight-based talk sounds like in the home environment may be useful in informing the development of family-based obesity prevention interventions to reduce the mental and medical health risks associated with familial negative weight-based talk in children (Berge et al., 2013; Berge, MacLehose, et al., 2014; Berge, Rowley, et al., 2014; Eisenberg et al., 2003, 2012; Hayden-Wade et al., 2005; Libbey et al., 2008). Additionally, this study will set the stage for future work examining familial negative weight-based talk with larger racially/ethnically diverse samples.

Method

Sample and Study Design

Family Meals, LIVE! is a mixed methods, cross-sectional study conducted in Minneapolis/St. Paul, Minnesota. The main aim of the study is to identify key risk and protective factors for childhood obesity in the home environment (Berge, Rowley, et al., 2014). Children ($n = 120$) and their families from four primary care clinics serving racially/ethnically and socio-economically diverse families participated in the study. A recruitment letter from the child's primary care doctor was sent to the primary caregiver/parent inviting the child and their family to participate in the Family Meals, LIVE! study. Eligibility criteria included: (a) children had to be between the ages of 6 and 12 years old; and (b) all family members had to speak and read English.

Of the 120 children participating in the study, 54% were boys and 46% were girls, with an average age of 9 ($SD = 2$, range 6–12). The majority (91%) of parents/guardians were mothers or other female guardians (e.g., grandparents, aunts) and were approximately 35 years old ($SD = 7$, range 25–65). The racial/ethnic backgrounds of the participating children were as follows: 64% African American, 13% Caucasian, 3% American Indian, 4% Asian, and 16% mixed or other race/ethnicity; parents were similarly diverse. The majority of parents had finished high school but had not attended college, and about 50% of parents were working full or part time. Over 70% of the children were from very low socioeconomic status households (<$35,000 annual household income).

Procedures

Children and their families participated in two home visits, two weeks apart (Berge, Rowley, et al., 2014). The first home visit included training parents/families on how to collect direct observational data on their family meals. Results from the direct observational components of the study are described elsewhere (see Berge, Rowley, et al., 2014). In the second home visit, a quantitative survey was administered to the child and primary caregiver/parent and a qualitative interview was conducted with the primary caregiver/parent. Parents were interviewed by research staff who had been trained in conducting qualitative individual interviews (Crabtree & Miller, 1992). The interview questions (described below) allowed for an in-depth exploration of key issues surrounding weight talk and teasing in the home environment. The quantitative surveys and qualitative interviews conducted with parents were utilized for analysis in the current study. All participating family members provided consent or were assented into the study on the first home visit. All study protocols were approved by the University of Minnesota's Institutional Review Board.

Research team. Research team members who conducted the qualitative interviews ($n = 6$) included full-time research staff and research assistants who were graduate students in the department of family social science or the school of public health at the University of Minnesota. Team members were between the ages of 25–40 years and represent a combination of Caucasian, African American, and Hispanic racial/ethnic groups. Before conducting any home visits or analyses, presentations on cultural aspects of research and potential biases when conducting research with racially/ethnically and socioeconomically diverse participants were delivered. Research staff and research assistants conducted all in-home visits in dyads.

Measures

Negative weight-based talk. Negative weight-based talk was assessed using survey questions adapted from the Inventory of Peer