

Childhood Obesity Prevention: Fathers' Reflections with Healthcare Providers

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Abstract

Background: To prevent childhood obesity, parents and their children's healthcare providers need to engage in effective dialogue. We know much about mothers' experiences, but very little about fathers' experiences.

Methods: We explored African-American, Caucasian, and Latino fathers' perceptions and experiences communicating with their children's provider during clinic visits regarding weight, diet, and physical activity. Focus groups ($n=3$), grouped by race/ethnicity, including a total of 24 fathers, were conducted. The men were asked open-ended questions; responses were recorded and transcribed, and analyzed using ATLAS.ti.

Results: Findings revealed that these fathers were involved in their children's healthcare and found providers to be helpful partners in keeping their children healthy, yet they generally felt "left out" during clinic appointments. The quality of the relationship with their children's provider influenced how receptive fathers were to discussing their children's weight, diet, and physical activity behaviors. Fathers made suggestions to help improve communication between providers and fathers, such as personalizing the discussion.

Conclusions: These fathers expressed strong feelings about the provider–parent relationship when discussing weight, diet, and physical activity.

Introduction

Both parents and providers have a role in preventing childhood obesity as well as its future consequences.^{1–5} Among 2 to 5 year olds and 6 to 11 year olds, 27% and 33%, respectively, are either overweight or obese.⁶ Parents influence younger children's eating and physical activity behaviors.^{7–9}

The clinical encounter can serve as a catalyst to encourage parents to foster a healthy diet and physical activity because providers are a resource for parents in keeping their children healthy.^{10,11} Unfortunately, providers and parents have reported negative experiences when discussing weight,

diet, and physical activity behaviors in clinical settings.^{10,12–16} Providers may be less inclined to discuss obesity prevention and management because they feel parents are not motivated to make changes and are afraid that they will offend parents of children by discussing weight.^{12–15} Parents may not be motivated to make changes because they do not feel their children are overweight or obese.^{16,17} Meanwhile parents have said that they felt they were being criticized or blamed for their children's weight issues by doctors.¹⁰

Although fathers' presence in the household influences children's development, much of the literature has been limited to mothers' perspectives regarding their experiences with providers.^{11,18–20} The purpose of the larger

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study was to explore African-American, Caucasian, and Latino fathers' experiences and perceptions of their interactions with their children's healthcare provider. Specifically, we wanted to explore: (1) Whether fathers were involved in their children's healthcare; (2) fathers' receptivity to discussing diet, physical activity, and weight with their children's healthcare provider; and (3) fathers' feelings on how providers can improve the provider-parent interaction. Berry et al. presented the findings from the Latino male and female focus group participants in a previous article.²¹ This article explored the cultural implications on Latino caregivers' definition of obesity and feelings about the provider-parent interaction when discussing weight, diet and physical activity.

Methods

Procedure

Participants were recruited by posting flyers throughout the community. All participants had to be a male parent/caregiver and have a child who was 12 years or younger. The parent's or child's weight statuses were not an inclusion or exclusion criteria. Research staff with substantial experience leading focus groups with racial/ethnic minorities conducted three focus groups with 24 fathers living near the central region of North Carolina. On the basis of the researchers' previous experience working with racial/ethnic minorities in the South, the research team decided that separating the groups would foster a more open discussion. In North Carolina, there has been a history of either forced or chosen segregation, and to this day, there are many groups or organizations, such as churches, that represent one racial or ethnic group. The focus groups lasted approximately 90 minutes, were audio-recorded, and took place at the university research center and two community centers. A note taker wrote down observations on verbal and nonverbal interactions during the groups. All focus groups were conducted following the same protocol; however, Latino focus groups were conducted in Spanish with bilingual facilitators and note takers. Participants gave written consent prior to the discussion and received free child care and \$20 for their time. This study was approved by the University of North Carolina at Chapel Hill institutional review board (05-NUTRI-648).

Instruments

We developed the discussion guide from reviewing the literature and gathering expert opinions from parents, pediatricians, nutritionists, nurses, and researchers. All experts had extensive experience working with low-income and ethnic minority populations in public health and clinical settings, ensuring that the questions were culturally relevant. The discussion guide questions are presented in Table 1. Following the focus group discussions, participants filled out a brief multiple choice survey covering four areas: (1) Demographics; (2) children's diet and physical activity; (3) perceptions of their children's weight; and (4)

comfort level with their children's providers. The survey was administered after the focus groups, allowing late-comers to fully participate.

Data Analysis

We transcribed the English focus group discussions verbatim and checked for completeness. Professional staff transcribed and then back-translated the Latino focus group discussion. Researchers developed a codebook based upon an initial read of the transcripts (open-coding and memos), focus group notes, and the discussion guide.^{22,23} An example is presented below where the theme is provider-parent interaction, code is barrier, and subcode is verbal.

Codes: [Provider-Parent Interaction] [Barrier] [Verbal]

I think [...]it sounds like you know the men in this room would be receptive to any ideas, thoughts, or opinions from a doctor telling us how to be or to enrich our children's lives whether it's through monitoring television or video games or foods to eat. But the major barrier, because we're African-American men, typically doctors don't address men, they are addressing the wives.

Memos:

Feel that doctors are not addressing the fathers. Instead they just address the wives.

Using the codebook, two researchers coded the transcripts and met to reconcile any discrepancies. A qualitative software program, Atlas.ti (Atlas.ti Scientific Software GmbH, Berlin, Germany), was used to help organize the data.

Results

Participants

The 24 fathers self-identified as African American (33%), Caucasian (17%), or Latino (50%). All of the Caucasian participants graduated from college, which differed from the African-American (37%) and Latino (0%) fathers (Table 2). On average [mean ± standard deviation (SD)], the fathers had 3.4 ± 2.9 children between the ages of 1 month to 12 years (4.9 ± 3.7 years). Table 2 shows the survey results regarding these fathers' attitudes, beliefs, and experiences with childhood obesity-related topics.

Summary of Focus Group Findings

Overall, these fathers were very involved in their children's healthcare; viewed providers as a source of information on their children's weight, diet, and physical activity; and had very strong feelings about the provider-parent relationship when discussing their children's weight, diet, and physical activity.

Theme 1: Fathers are involved. These fathers were very involved in their children's lives and were involved in making decisions about their children's diet and physical

Table 1. Discussion Guide

Question	Prompt
If you wanted to get information on how to help your child be healthy (and by “healthy” we mean eating well and being active) who would you most likely go to?	Family Friends Books Pastor/Priest Physician/Doctors/Nurses
How do you feel about your doctor or nurse talking about:	
Your child’s weight? The amount of time your child spends in front of the TV, computer, or videogames? Amount of time your child spends in outdoor play time? Your child’s activity level or eating habits if your child is NOT overweight? What foods you eat or how you cook?	
How can your doctor or nurse be most helpful to you in keeping your child at a healthy weight?	Have doctor write down instructions Weight prescription Have your doctor spend time giving you tips Listening to a tape Follow-up phone call Through a handout, paper after the doctor appointment Something in the mail (postcard, newsletters) Person contact via nurse, case manager, etc
What, if anything, should your doctor or nurse avoid doing?	
What would be less helpful to you?	

activity. They were involved because they loved their children and felt they had a responsibility to ensure their children’s health. For some, their personal experiences with their partner or fathers made a strong impact in their decisions to be more involved: “I promised myself that I’m not going to be like my daddy.” Some of the fathers worked from home or were stay-at-home fathers, and, as a result, they were primarily responsible for the children’s diet, physical activity, and healthcare. They also reported attending health visits either with the mother or alone. At these health visits, they noted that it was rare to see other men, which they believed was normal.

Theme 2: Receptivity to health care providers’ advice/information about their children’s weight, diet, and physical activity. Overall these fathers were receptive to receiving advice from their children’s provider about diet and physical activity. Having an established relationship increased the receptivity of these fathers. Although they were generally open to discussing their children’s weight, diet, and physical activity, fathers noted that diet or physical activity was not frequently discussed during health visits. Thus, they viewed discussing these topics, such as diet, as not a normal “doctor thing.”

“You would think that the best approach would be to kind of get some ideas from your doctor, but I can’t think of too many times when I’ve discussed diet um, with my children’s doctor.”

For the most part, fathers felt they were more likely to seek advice from doctors if they were “concerned” because providers are there to “fix problems.” In addition, the information had to fit with their concept of “healthy,” and if it was appropriate for their children. For example, these fathers were less open to discussing television viewing because they felt that television could be used as an educational tool.

The fathers outlined additional barriers to discussing diet and physical activity. If the provider asked about diet and physical activity, they reported that it would make them feel “guilty” because they “missed” something. Also, discussing these topics was seen as largely irrelevant because it was not “health-related” and they usually had specific reasons for taking their children to the provider. Furthermore, providers were not viewed as being the “expert” on diet and physical activity.

“It almost makes you sound like a bad parent if they start to talk about something along those lines. Something about it’s a judgment now versus a health issue. And then I think I might start to be upset. Barriers would go up and I would not be interested in discussing that with them because I would not perceive them as an expert.”

Theme 3: Suggestions to improve provider–parent interactions when discussing children’s weight, diet, and physical activity. Fathers reported that not only was the content

Table 2. Respondent Demographic Characteristics (N = 24)

	African American n=8 n (%)	Caucasian n=4 n (%)	Latino n=12 n (%)	Total n=24 n (%)
Marital status				
Married/living with a partner	8 (100)	4 (100)	12 (100)	24 (100)
Education				
<High school	0 (0)	0 (0)	3 (25)	3 (12)
Some high school	0 (0)	0 (0)	3 (25)	3 (12)
High school graduate	1 (12)	0 (0)	5 (42)	6 (25)
Some college/technical School	4 (50)	0 (0)	1 (8)	5 (21)
College graduate	3 (37)	4 (100)	0 (0)	7 (29)
How important is the issue of overweight children to you?				
Important	6 (75)	3 (75)	12 (100)	21 (87)
Not important	1 (12)	0 (0)	0 (0)	1 (4)
Don't know/not sure	1 (12)	1 (25)	0 (0)	2 (8)
How would you describe your child's weight?				
Overweight	1 (12)	0 (0)	1 (8)	2 (8)
Underweight	1 (12)	1 (25)	1 (8)	3 (12)
Normal	6 (75)	3 (75)	10 (84)	19 (79)
Do you have a concern about your child's weight?				
Yes	2 (25)	2 (50)	10 (84)	14 (58)
No	6 (75)	2 (50)	2 (16)	10 (42)
Don't know/not sure	0 (0)	0 (0)	0 (0)	0 (0)
Has your doctor or nurse ever said they were concerned about your child's weight?				
Yes	0 (0)	0 (0)	4 (33)	4 (17)
No	8 (100)	4 (100)	8 (67)	20 (83)
How comfortable do you feel talking to your doctor about your child's health?				
Comfortable	8 (100)	4 (100)	12 (100)	24 (100)
Not comfortable	0 (0)	0 (0)	0 (0)	0 (0)
Don't know/not sure	0 (0)	0 (0)	0 (0)	0 (0)
How comfortable do you feel talking to your doctor about your child's weight?				
Comfortable	8 (100)	4 (100)	12 (100)	24 (100)
Not comfortable	0 (0)	0 (0)	0 (0)	0 (0)
Don't know/not sure	0 (0)	0 (0)	0 (0)	0 (0)
How comfortable do you feel talking to your doctor about what your child eats?				
Comfortable	8 (100)	4 (100)	11 (92)	23 (96)
Not comfortable	0 (0)	0 (0)	1 (8)	1 (4)
Don't know/not sure	0 (0)	0 (0)	0 (0)	0 (0)

important, the context and tone of the discussion were essential to facilitate positive interactions. Fathers highlighted several ways they felt providers could make the interaction more positive. These included talking about obesity prevention from the first interaction, personalizing the discussion, offering ideas on how to change behaviors, following up, and handing out relevant educational materials. Furthermore, they wanted to be addressed when they were in attendance.

Fathers indicated that it would be helpful if their children's providers spent time discussing how to change a behavior instead of pointing out what they are doing wrong. They expressed wanting concrete examples on how to make those changes. Fathers wanted to know "why" it was important to make changes as well as more detail about how much and what to avoid. They shared wanting the provider to give a sense of "urgency" to the matter and emphasize how important it was to have a healthy lifestyle. In addition, fathers wanted to discuss educational materials, and they wanted them to be relevant to the topic. For example, they reported frustration that they "go to the doctor for one thing and get a newsletter for something else." They also wanted the providers to follow up, give feedback on any changes, and to write down information.

Not only what was said was important, but establishing respect and trust was also essential. Fathers expressed the sentiment that they did not feel respected at the visits because providers did not address them directly in conversation. This was especially true when both parents were present at a visit. Therefore, they reported that they would be less receptive to receiving information from their children's provider about diet, physical activity, and weight.

Fathers felt that they were often not addressed because the providers were used to seeing the mothers. In addition, they felt that the doctors might have perceived their attendance at clinical visits negatively. Not only did these fathers state they wanted to feel respected, they wanted to be able to trust their children's provider. If trust was not established at the very start, fathers stated that they would not go back.

"You got one time, and if I don't trust you, I ain't never going to do business with you again. To me, that's the most important thing to me with a doctor."

Fathers shared that providers could earn their trust by showing concern for their children. As one father said, "At least act like you care." They also discussed how they wanted the provider to speak in a manner that was easy to understand. One father said: "Don't come and use these big words. And don't try to sound dumb yourself."

Discussion

This study explored fathers' attitudes, beliefs, and experiences regarding communicating with their children's

providers about weight, diet, and physical activity. Our study had three key findings: (1) These fathers were involved in their children's healthcare; (2) these fathers were generally receptive to receiving advice from healthcare providers about their children's weight, diet, and physical activity; and (3) these fathers shared strategies to improve the provider-parent interaction when discussing their children's weight, diet, and physical activity that is consistent with patient-centered care.

The fathers in this study were involved in their children's healthcare, but they noted that when they attended appointments, they felt left out because conversations and counseling were usually directed toward the mother. This finding highlights how research has traditionally focused on the female caregiver or mothers' perspective regarding their children's health or healthcare. However, there has been an increase in the number of studies exploring fathers' involvement in their children's health and healthcare.²⁴⁻²⁸ Given these findings, healthcare providers may want to reexamine their efforts to engage fathers when addressing weight, diet, and physical activity. This is consistent with a clinical report issued by the American Academy of Pediatrics' Committee on Psychosocial Aspects of Child and Family Health, which encouraged practices to become more "father-friendly" by actively engaging fathers, thereby, emphasizing the importance of providers establishing a relationship with fathers as well as mothers.²⁹ They recognized that fathers are active participants in their children's healthcare, which can positively influence children's development.^{24,30}

Although providers were viewed as a potential source to receive advice about their children's weight, diet, and physical activity, these topics were rarely discussed. Other studies have also found that providers do not always counsel families about weight, diet, and physical activity.³¹⁻³³ These clinic visits could be viewed as missed opportunities where providers can clarify any misconceptions. For example, some fathers in our group felt that placing a limit on the amount of educational TV/video would have limited their children's development. Additionally, fathers in our sample felt that providers were not "experts" on diet and physical activity, indicating that these fathers may not have seen obesity as a "medical" issue. This disconnect between what providers view as a health risk versus parents has been reported by other studies. For example, Burnet et al. showed that parents defined "obesity" in terms of functionality, whether a person can easily walk up a flight of stairs.³⁴ Other studies have found that parents value their children's quality of life over weight, even among parents seeking help for their obese children.^{8,35} Healthcare providers may need to help parents make the connection between their children's obesity and current and future health risks. However, providers may have more success if they focus on the aspects of self-esteem and quality of life for children who are overweight or obese.³⁵

Generally, these fathers were receptive to receiving information from their children's healthcare provider about

weight, diet, and physical activity, which is similar to other studies.^{10,24} However, our findings suggest that the content, context, and tone of the discussion influenced their receptivity to the provider's advice, similar to other studies with predominantly mothers.^{8,10,34,35} Our participants shared several strategies that would make them more amenable to discussing their children's diet, activity, and weight: Discussing these topics from the very first visit, asking questions, offering concrete examples on how to make changes, and making recommendations specific to their family helped to minimize any judgment. The desire to be listened to and respected was found in other studies that were conducted, but these studies had mostly mothers as participants.^{10,19} Also, a study of low-income fathers found that trust was essential for effective parent-provider dialogue.²⁴ Both Crawford et al. and Ariza et al. found that parents expressed a preference for providers to tell them "how" to make changes and to tailor their advice for their family.^{18,36} Thus, the one size fits all approach may not be suitable when working with families regarding obesity prevention and management.

Findings from our study as well as others demonstrate that the traditional "anticipatory guidance style," characterized by providers counseling parents regarding general health behaviors, may not be the best communication strategy when discussing preventive health behaviors.³⁷ Instead, a more patient-centered approach may be more effective.^{37,38} This approach is characterized by asking questions, assessing parental readiness, and working with parents to make changes. Using this patient-centered approach may help decrease the feeling of blame and make the discussion seem more relevant to the individual child, thereby, increasing the likelihood that behavior change may occur.

Although this study provided an in-depth exploration with fathers from diverse backgrounds regarding their attitudes, beliefs, and experiences with their children's provider, there were several limitations. The sample size was small but consistent with traditional qualitative studies and purposive samples to obtain rich information rather than to test hypotheses.³⁹ In addition, this study represented a community sample versus a clinic sample, which may have allowed the participants to be more open about their experiences with providers. The potential for social desirability bias was present because participants may have wanted to respond in a favorable manner in the focus group discussions. However, the study protocol took steps to ensure that participants felt comfortable, and no providers were present to conduct the focus groups. Our findings may not be generalizable, because all of the fathers were married or living with a partner. Furthermore, these fathers were actively involved with their children, which may be unique to this sample. Although their educational backgrounds were diverse, the participants expressed very similar sentiments regarding the parent-provider relationship. We did not directly assess these fathers' attendance at sick or well child clinical visits, general frequency of attending pediatric visits, when in the child's life cycle that attendance began (or ended), or

whether their children were overweight or not, all of which could have an influence on their level of participation, engagement with the topic, and comments. However, our findings suggest that these fathers are active participants in their children's healthcare and, perhaps related to that, our findings echo previous research regarding parents', consisting of mainly mothers, experiences with healthcare providers about their children's weight, diet, and physical activity.^{10,19,35} Although this was a small study, we believe it offers an important exploration of fathers' experiences regarding their interactions with their children's provider about obesity prevention.

Conclusion

The clinical encounter can serve as a great way for parents and providers to communicate about how they can address weight, diet, and physical activity. This study, as well as others of parental perceptions, demonstrates how parents may have different definitions of "good care" than healthcare organizations/providers. Unlike healthcare organizations/providers, parents may not put as much emphasis on weight and other health risks associated with obesity. Instead they may value psychosocial outcomes such as self-esteem and overall quality of life and their connection with their healthcare provider.³⁵

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