Latino Parents’ Perceptions of Their Ability to Prevent Obesity in Their Children

Melissa E. Glassman, MD, MPH; Marilyn Figueroa, EdD, CD/N; Matilde Irigoyen, MD

The obesity epidemic in Latino children has reached staggering proportions. This study explored Latino parents’ perceptions of their ability to prevent obesity in children. Three focus groups were conducted with 26 Latino parents of preschoolers at a New York City Head Start program. Parents perceived high levels of ability to prevent obesity primarily via dietary influence. Four factors negatively impacted parents’ ability: family history, intergenerational and interparental issues, adolescence, and societal pressures. Culturally effective, family-based obesity interventions among Latinos should build upon parental perceptions of ability to prevent obesity, while simultaneously helping parents address the factors they perceive challenge this ability. **Key words:** childhood obesity, focus group, Latino, parental perceptions, preschool child

The obesity epidemic has reached staggering proportions among children of all ages. Particularly troubling is the increase in obesity rates among our nation’s youngest members: rates of overweight and obesity among 2- to 5-year-olds have reached 26%. Although this epidemic affects children of all backgrounds, Latinos suffer disproportionately higher rates than other ethnicities. In New York City, the rate of overweight and obesity among 3- to 5-year-old children enrolled in Head Start programs is greater than 40%, with Latinos having increased risk compared with other ethnicities. This trend continues with age and by elementary school; 43% of children in New York City public schools are overweight or obese, again with the highest risk found among Latinos. The societal implications of this are profound given that Latinos are the fastest growing ethnic group in the United States, projected to increase from approximately 12% to almost a quarter of the total population by the year 2045.

The development of obesity is influenced by multiple factors, including genetics and environment. Yet the family unit and parents in particular are among the earliest, strongest, and most direct influences on a young child’s weight. Family-centered obesity prevention programs that include at least 1 parent have shown the potential to limit obesity in young children. Understanding how parents view their ability to prevent obesity in their children is critical to the development of these programs. Parents have identified challenges to their ability to manage their children’s weight, including a lack of time to develop healthy eating habits, feelings of inadequacy as role models, and lack of support from their children’s pediatrician and other family members. However, these...
studies have not focused specifically on Latino parents.

Culture influences perceptions of ideal body size, diet and food choice, and exercise. Studies have revealed that Latinos tend to associate larger body sizes in their children with greater health and find overweight is a problem only if severe enough to prevent their children from keeping up physically and emotionally with their peers. In terms of food choice, Latino diets tend to be higher in carbohydrates than white or African American diets. An important cultural consideration among Latinos is the importance of family and interestingly, in several studies, self-reported active play time for children included sedentary activities at home with the whole family. Furthermore, sociocultural beliefs in traditional gender roles, where sports and physical activity are considered to be male oriented, may be an additional sociocultural barrier to physical activity for girls.

Despite these important cultural influences on ideal body size, diet, and exercise, little is known about how Latino parents view their ability to prevent obesity in their children. With the highest rates of obesity found among Latinos, more research is needed that addresses Latino parents’ experiences in particular. This information will further inform efforts to develop culturally effective, family-centered obesity prevention programs for young Latino children. This present qualitative study explored Latino parental perceptions of their ability to prevent obesity in their children.

METHODS

Study setting and sample

Our study took place at a Head Start program located in Northern Manhattan, one of the most disadvantaged communities in New York City. The majority of residents are Latino and foreign-born, and one-third live in poverty. The community is marked by high rates (>50%) of childhood overweight and obesity. The Head Start program enrolls 66 three-to-five-years-olds. Spanish is the primary language of almost all the families, with the majority coming from Mexico and the Dominican Republic. In 2006, at least 26% of enrolled children had weight-for-height percentiles greater than the 90th percentile (personal communication with Dr Figueroa, nutritionist at the study’s Head Start program, October 2006). All of the enrolled children have a primary-care provider in the community. In addition, they all meet Federal Poverty guidelines, as defined by the US Department of Health and Human Services. Based on these guideline in 2009, the poverty level for a family of 4 was defined as a gross annual income of less than $22,050.

Study design

Focus groups were held at the Head Start program site. Any parent or guardian of an enrolled child was eligible to participate in our study. All parents of preschoolers enrolled in this Head Start program take part in parenting groups that occur while their child participates in the Head Start classroom. A convenience sample was recruited from these pre-existing parenting groups. Signed informed consent was obtained from all participants prior to the focus group sessions. Each session took approximately 90 minutes and participants were provided with a snack and a 4-dollar subway voucher.

Participants

We recruited 26 participants for our study (Table 1).
Between October and November 2006, 3 focus groups were held with 7, 8 (only group that included males), and 11 participants, respectively. Our sample, comprised predominantly of parents, included 1 grandmother. Participants were 19 to 54 years old (mean age = 32 years) and 25 were immigrants. In addition to having a preschool-aged child enrolled in the program, 2 to 5 parents per group also had older children, ranging in age from 6 to 19 years. All the participants self-identified as Latino and all met Federal Poverty guidelines. Demographic information (including number and ages of children, parent's country of birth, and number of years living in New York City) was obtained via a self-administered anonymous survey filled out individually by each participant.

The focus groups were facilitated by an experienced, bilingual, Latino moderator who used a semistructured topic guide and was assisted by a member of the research team, who observed and took notes during the discussions. Two members of the research team, a pediatrician who worked in the local community and the nutritionist at the Head Start program, developed the semistructured topic guide (Table 2). The researchers included questions in the topic guide that had particular relevance to this Head Start community, based on their longstanding professional experiences with families in both the Head Start program and community at large. The moderator facilitated the discussion by asking the open-ended questions included in the topic guide. These questions initiated lively, rich discussions among participants in all 3 groups. The moderator moved to the next question on the topic guide when no further discussion ensued on a particular topic. Probes were also used occasionally when needed by the moderator to help facilitate the discussion (italics in Table 2).

At the beginning of the focus group, each parent was also provided with a 7-figure scale of line drawings of children's bodies. This scale had been successfully used in another study to investigate mothers' preferences for ideal body size for their children.14 The drawings of varying body sizes were randomly ordered on the page and comprised a spectrum ranging from very thin to very heavy. One of the topic guide questions asked parents to individually identify and circle on the scale their ideal body size for preschool-aged girls and boys. A follow-up question then asked parents to share with the group which body number they chose as their ideal body size for girls and boys and why.

Focus groups were conducted in Spanish, audiotaped, and transcribed by a professional transcriptionist. Spanish transcripts were read and compared back with the audiotapes for accuracy by a member of the research team. Transcripts were then translated into English and imported into ATLAS.ti qualitative data analysis software (version 5.2, 1993-2008, ATLAS.ti Scientific Software Development, Berlin, Germany) for in-depth analysis. This study was approved by the institutional review board of Columbia University Medical Center.

Data analysis

The analytic framework of this study was based on social cognitive theory, a central
Table 2. Semistructured Topic Guide Questions

<table>
<thead>
<tr>
<th>Introduction:</th>
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| 1. What is obesity?  
*Probe: How do you know if a child is obese?* |
| 2. If your friend asked you to tell her the difference between obesity and overweight, what would you tell her?  
*Probe: fat, big boned...* |
| 3. We’ve all heard lots of different names for obese children, like chubby or fatso. If a child is obese, what might you call him or her? |
| 4. If a child is overweight, what might you call him or her? |

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<tr>
<th>Parental attitudes regarding ideal body size:</th>
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<tbody>
<tr>
<td>5. Parents have different ideas about what an “ideal” body looks like, the body they prefer their children to have. Some people have told me that the ideal body size for their child is chubby. Others prefer thinner children. (<em>Give each parent a handout with line drawings of various body sizes</em>). Here are some pictures of children of different body sizes. Which do you think is the ideal body size for a child?</td>
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<td>6. (<em>Once parents identify an ideal body size on their handouts</em>) Why? In your opinion, what makes this the ideal body size for a child?</td>
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<tr>
<td>7. Now I want you to think about how this might change as a child gets older. What is the ideal body size for boys when they become teenagers? What is the ideal body size for girls when they become teenagers?</td>
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<tr>
<td>8. How much of a problem is childhood obesity in our community?</td>
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<th>Obesity-related morbidities</th>
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| 9. In your opinion, what types of problems does obesity cause in children?  
*Probe: health problems, physical/functional problems, emotional problems...* |
| 10. Who do you think has more problems: an obese girl or an obese boy? Why? |
| 11. In your opinion, how does this change as a child gets older? By this I mean, does obesity or overweight cause more problems in teenagers compared to younger children? |
| 12. You mentioned that overweight or obesity can cause a variety of problems in children, such as ________. Does obesity or overweight cause different types of problems or more serious problems in teenagers compared with younger children? In what way? |
| 13. In your opinion, who is obesity worse for, an obese teenage girl or boy? |

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<th>Obesity intervention:</th>
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| 14. We’ve been talking a lot about some of the problems that obesity causes for children and for teenagers. You mentioned ________ for children and ________ for teenagers. How do you know when it’s time to intervene or do something about a child’s weight?  
*Probe: How do you decide that a child’s weight is causing enough problems that it’s time to do something about it? May mention: physical signs, decreased mobility, can’t keep up, social/people making fun of my child, my child’s doctor tells us there is a problem.* |
| 15. In your opinion, what is the age that you think a child has to be before you would consider intervening and doing something about an overweight or obese child’s weight? |
| 16. What can be done, if anything, to help a preschool child have a healthy weight? |
| 17. Let’s talk about who should help children have a healthy weight. In your opinion, whose responsibility is it to help a child have a healthy weight? |
| 18. How about as the child gets older, say, as a teenager. Whose responsibility is it to help a teenager have a healthy weight? |

*(Continues)*
Table 2. Semistructured Topic Guide Questions (Continued)

<table>
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<tr>
<th>exercise:</th>
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<tr>
<td>19. What kind of exercise do you LIKE to do?</td>
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</table>
|20. You just mentioned a lot of exercises that you like to do. Do you actually do them?  
  Probe: How often in a week do you do them? |
|21. How about your children: what kind of exercises does your child do? |

Food choice and limit setting: |

|22. Now I’d like to talk a little about decision making when it comes to eating and food choices.  
  How do you know when your child is hungry? |
|23. Who decides how much food your child will eat?  
  Probe: how do you know when your child is full? |
|24. What do you do if your child refuses to eat? |
|25. What do you do if your child wants to eat or drink something you don’t want him or her to eat? |
|26. What types of foods, if any, do you think contribute (or cause) children to be obese? |

Conclusion: |

|27. Today in our discussion group, we talked a lot about what it means to be obese, problems that it might cause for children, and ways you think parents and community members can help children have a healthy weight. We want to end with one final question about how we think about an obese or overweight child. Compared with this country, in your country, where you were born, what do people think about an obese or overweight child? |
|28. How is it different than how we think about an obese or overweight child in this country? |

component of which is a person’s perceived self-efficacy at changing behavior. For our analysis, we specifically looked at the perceptions of parents’ ability to prevent obesity in their children. English transcripts were independently read by 2 researchers and analyzed via content analysis, a systematic process in which categories or themes are identified through the coding of text. The researchers then met to discuss the major themes identified.

RESULTS

A dominant, overarching theme of parental perceptions of ability to prevent obesity emerged repeatedly in the transcripts on preliminary analysis. Higher-level analysis consisted of coding the transcripts for any text that was relevant to this broad theme. Codes that directly related to parental ability to prevent obesity were selected and categorized into 2 broad categories: those that described parental perceptions of having this ability and those that demonstrated a negative impact on parental ability to prevent obesity. Further analysis revealed several predominant themes within each category (Tables 3 and 4).

Parental perceptions

Obesity in the community

Parents in all 3 groups were unanimous that obesity was a major problem in the community and cited many of the major obesity-associated morbidities, such as high cholesterol and diabetes. Social and emotional morbidities, such as low self-esteem, were mentioned as well.

Ability to prevent obesity

Parental ability to prevent obesity was defined by parental influence over diet and over exercise. Parents placed a higher value on their influence over diet compared to exercise as a means to prevent obesity.
Table 3. Domains of Parents' Ability to Prevent Obesity in Their Children

**Theme 1 summary:** Parental ability to influence child’s weight status was mediated primarily via dietary influence.

1.1 “My daughter was two pounds overweight... the problem was with the juice that my daughter drank two or three times a day, so I took the juice away. She drank regular milk so I reduced it to two percent. We returned to the pediatrician and the difference was noticeable... and it was because of only two things that I reduced and that helped a lot. Two pounds I don’t think was a lot, but I was able to prevent that she become fat in the future.”

1.2 “[The parents] are the ones that spend the majority of the time with [their children]. So, they can pay attention to the quantities and quality of the foods they offer the children.”

1.3 “[Parents can] reduce [milk] to two percent, the juices... so many things that... the sugarless cereals so that the child avoids getting fat... I don’t think there is an age for that. One can begin controlling [their diet] ever since they are little.”

1.4 “I serve her a dish of soup and she eats and sometimes... after that she tells me, ‘Mommy, do you have soda?’ ‘No, I don’t have soda.’ And if she sees a soda in the fridge she has to finish the soup.”

1.5 “What I do is to manipulate [her to encourage her to eat], for example with the juice. Or [I tell her] that when she is done eating we are going to do this activity.”

1.6 “I talk to him and tell him, like sometimes I only have [one particular] food ready and he wants something else. I tell him, ‘If you eat this first, I’ll give you that later.’ Then he says: ‘Okay.’”

1.7 “When she wants a snack, an orange, she says, ‘Mami, Papi,’ and she gets some sort of fruit. She is given it and when she wants something she also asks. She always asks, she is never just given it, ‘Look, eat this.’ She asks on her own.”

1.8 “I’ve learned here and all that, that when she says she doesn’t want anymore it’s because her stomach doesn’t need it anymore. For the little stomach, it is enough with two, three spoons of food that she eats, and she can eat again after two, three hours.”

1.9 “There are favorite meals for children, right? They don’t have any measurement on that. It is there where maybe we should be cautious, and implement portions or ounces; ‘You are going to drink this much of that.’ And there also are meals that are nutritious that are not a child’s favorite. So, the same way, I say, ‘take this plate of soup’ and I determine the quantity. She takes it this way, because if I let her [freely eat her favorite meal] she is going to take those 12 ounces and she goes without end.”

1.10 “I know from controlling him with his food because next to my house... I used to babysit a boy since [he was a baby] and now he is six. And he started to get fatter and fatter. And the mother set a ribbon... she tied it to the fridge... and if he asks for more she doesn’t give him more.”

1.11 “Us as parents, we are going to talk to them, to try to eat healthy food, because sometimes they start going to go to middle school and such, they are going to start eating things, sometimes they eat pizzas or something like that. But if one, since they are little, talks to them and starts instilling in them that they have to eat their vegetables, healthy things, [then] they are going to eat [healthily], because they eat [that way] at home.”

**Theme 2 summary:** Although parents influenced exercise, boys were considered inherently more physically active than girls.

2.1 “Males... always maintain themselves active. I don’t know why the male has that energy, that we, [females], I don’t think have so much like [males]. They go here, they go there, they carry things and lift heavy things. The woman is more, like, you know, vain, a little.”

2.2 “Children, male and female, have a different weight because he eats a lot but he is like more active, is like more, I don’t know. And he doesn’t gain weight.”
Table 4. Factors That Negatively Impacted Parents’ Ability to Prevent Obesity in Their Children

**Theme 3 summary:** Family history of obesity: a family history of obesity predisposed some children to obesity but did not absolve parents of responsibility of managing their child’s weight.

3.1 “My girl is chubby but she eats a lot of vegetables. I almost never give her candy; let’s say one lollipop a week, maybe. And she rarely eats things that are fattening, but she is robust.”

3.2 “…The other day in the mall I saw a mother in line at JCPenney’s. She had three kids and they were three teenagers, and all three, two girls, around thirteen and sixteen, and the guy around eighteen, all three were fat, fat like her. Very fat. So I think, that mother has a problem. …It can be from [genetic and medical reasons and] it can equally be from eating habits. So, in that way, the mother has dragged them in this…”

3.3 “My child, he has a classmate with him that is really chubby. And he says: ‘Mommy, the chubby one can’t climb stairs, he gets tired.’ And I explain to him that it is because he is fat. And I say: ‘And, why don’t you tell his mommy to feed him more nutritious food, not fast food, not to take him anymore to McDonalds?’”

**Theme 4 summary:** Intergenerational and interparental issues: pressure from other generations/caregivers eroded parental influence over diet.

4.1 “You might control your child, but then, if you take them to grandma’s house, their auntie’s house, they are gonna allow them something else, you know, they are gonna contradict you when you are not there.”

4.2 “My problem, is that I live with my mother. So the problem is, that she gives something to [my daughter] and I give her other things, so when she wants a candy or something, she goes with the grandmother, because she knows that the grandmother, there she does give it to her… and on top of that, and to top it off, the great grandmother comes…”

4.3 “They say ‘Ay, ay, ay… she is very thin. Look how small. She is not fine. She is malnourished. They don’t, they don’t take care of her.’”

4.4 “[My son] was very thin and went to Miami with his father, and it seems that he works on the mornings very early, and he says he took him a lot to Burger King, he always had a Burger King for breakfast because there wasn’t enough time. He came back chubbier, he came back with a belly and all that.”

4.5 “I try not to have juice at home. The bread that he takes is wheat bread, but if the father by any chance brings white bread, he wants to eat it.”

**Theme 5 summary:** Adolescence: as a child enters adolescence, parents lose direct influence over child’s diet.

5.1 “I believe that ever since my daughter is little, I am going to be trying to teach her what obesity is and all that, and excess weight. I believe that when she is in the adolescent stage, I am also going to be taking care of her and she is also going to be conscious of all those words, meanings and risks that come with obesity and excess weight. I think by then it would be her responsibility and also mine.”

5.2 “[Parents give adolescents] the option and they decide, because with an adolescent it is not like with a child anymore that you say, ‘this, don’t eat this.’”

5.3 “In adolescence they are swayed a lot by friends, even if they have the basics at home. …When they finally reach adolescence I tell you that it is very different because they have a world here at home, and they have another world on the street. When they are there, when they have access to the friends, the friends influence a lot. You have to create that, a strong bond of dialogue so that your child doesn’t go away, because the power that the friends have is very strong.”

(Continues)
Table 4. Factors That Negatively Impacted Parents’ Ability to Prevent Obesity in Their Children (Continued)

**Theme 6 summary:** societal pressures: pressures from society, particularly parents’ work schedules, eroded parental influence over diet.

6.1 “I believe that the problem is there within the community, because the majority of us came to this country, we came to work, for a better future, and we forget of, maybe, about food, because many people dedicate more time to their work than to their diet. . . . I know a person that. . . . leaves cereal to her kids, instant soups and all those things. And she gets home late, and when she gets tired of home, from work to the house, then a McDonalds. . . . On the weekends, that it is her day off work, then she doesn’t cook. . . . I think that for me that is the main thing, in order to dedicate more time to work you don’t take care of, of the diet, of everything, of family.”

6.2 “I’ve seen that in other houses the majority of people will, it is easier to go buy a soda than to buy fruit, a pineapple, blend it and make your natural juice. I say it is a lack of time makes us eat whatever we can.”

**Diet and food intake**

Parents unanimously perceived that they were responsible for providing healthy foods, limiting fast food and junk food, and making changes in the child’s diet in response to a child becoming overweight (comments 1.1-1.2). Moreover, parents felt that they had significant influence over their child’s eating behaviors through various, somewhat opposing, mechanisms. These included forcing their child to eat healthily (restrictive or controlling feeding behaviors) (comments 1.3-1.4); manipulating through bribery to get their child to eat what the parent wanted (comments 1.5-1.6); and allowing their child to choose what they wanted to eat (permissive feeding behavior) (comments 1.7-1.8). Parents also perceived that it was important to control the amount of food taken in by their children if the child was not eating what the parents felt was an appropriate amount of a particular food (comment 1.9) or to limit the amount of food if the child was obese (comment 1.10).

Parents also perceived high levels of influence over their child’s diet and feeding behaviors in a more indirect way, via modeling (child models his feeding behaviors on what he sees his parents eat) and via education (comment 1.11). Parents perceived that they had both the ability and responsibility to provide education to their child about healthy eating behaviors, including knowing about healthy foods and the appropriate timing of eating (eg, not having a big meal before bed). This was particularly important as the child entered adolescence, at which point their diet would no longer be under the direct influence of the parent.

**Exercise**

Parents discussed the importance of exercise at limiting obesity and perceived that they had influence over how much and where their child exercised in a formal setting. Parents felt they could influence their child’s weight by enrolling them in organized activities such as swimming and gym classes specifically designed for young children.

A subtheme emerged related to the inherent quality of physical activity in children, particularly among boys. Parents perceived that boys possessed an inherent inclination to engage in physical activity and to be active. They were perceived to be more active and, thus, at lower risk than girls of becoming overweight. This natural inclination was viewed as independent of parental influence over exercise (comments 2.1-2.2).
Factors that negatively impacted parental ability to prevent obesity in their children

Parents perceived several opposing and competing forces working against their efforts to prevent obesity. Four main factors negatively impacted parental ability to prevent obesity: family history of obesity, intergenerational and interparental issues, adolescence, and societal pressures. These factors were independent forces that parents actively had to work against to maintain their positive influence on weight status and obesity prevention. All 4 factors were mentioned by parents in the 3 groups except for societal pressures, which was only mentioned in group 3.

Family history of obesity

Parents identified family history of obesity as a challenge to their ability to prevent obesity in their children. A subtheme of diet/weight disconnect emerged in all 3 groups: that is, the child ate healthy foods yet remained overweight (comments 3.1). Family history was offered as a possible explanation for this disconnect.

Although the development of obesity was thought to be inevitable in some cases due to a strong family history of obesity, parents did not view this relationship neutrally. Parents thought that a strong family history of obesity was not an excuse to give up and not work hard to prevent obesity in children. Rather, a subtheme of blame emerged whereby parents expressed their disapproval of other parents who they thought succumbed to "family history" and did not try to prevent obesity from developing in their children. Even obese parents were considered to be responsible for positively influencing their child's weight status via diet and exercise (comments 3.2-3.3).

Intergenerational and interparental issues

Among participants, family units and households often consisted of extended family and multiple generations. Grandparents often were the primary caregivers while parents were at work. Parents described how they were unable to have full influence over their child's diet due to interference by relatives from an older generation (comments 4.1-4.2) who had different opinions about ideal weight and healthy eating. Parents also experienced an indirect loss of influence over diet when they were made to feel guilty about their parenting skills based on a child's perceived thinness, and, thus, felt coerced to feed their child more (comment 4.3).

A theme of interparental conflict also emerged as a challenge to the primary caregiver parent's influence over their child's diet. This conflict arose when children spent time in a secondary caregiver's household, usually that of the father. In situations such as this, influence over the child's healthy diet and feeding behaviors was lost when the child visited with the other parent (comments 4.4-4.5) who might not share the same approach to feeding behaviors or healthy food choices.

Adolescence

A common perception was that parents lose their influence over their child's diet and feeding behaviors when the child enters adolescence. Adolescents' food choices and eating behaviors were thought to be influenced by outside forces, such as friends and the local environment where pressure to eat unhealthily was compounded by the availability of fast food. Two different subthemes emerged: (1) the important role of indirect parental influence over their adolescent's diet based on past teaching and modeling; and (2) the transfer of food choice and diet selection from parent to adolescent. Although there was a perception that parents could continue to shape their adolescent child's food choices based on present and past food experiences at home and via parental education (comment 5.1), they also conceded that ultimately the adolescent makes food choices (comment 5.2-5.3). Parents cited pressures from peer groups as the main challenge to parental influence over diet.
Societal pressures

In 1 of the 3 groups, a theme of societal pressures emerged as a challenge to parental influence over their child’s diet and eating behaviors. Although parents knew what their child should eat to maintain a healthy diet, they cited work pressures resulting in a lack of time as a major limit to their influence over their child’s diet (comments 6.1-6.2). Because of this lack of time, parents repeatedly mentioned that fast food took the place of healthy, home cooked meals. The time factor also limited parent’s own ability to exercise and to engage their child in exercise.

Ideal body size

The majority of parents in our sample selected body sizes toward the thin end of the spectrum on our 7-figure scale. During the discussion about why parents preferred the particular ideal body size that they had selected, parents in all 3 groups stated that their preference just “looked right” to them. They repeatedly said that the body size they selected looked “right in the middle,” “not too thin and not too big.”

DISCUSSION

This study among low-income Latino parents on their perceptions of ability to prevent obesity in their children illustrates several novel and important themes. First, parents perceived that they were able to prevent obesity by providing their children with healthy diets and, to a lesser extent, encouraging physical activity. Second, parents defined 4 factors that negatively impacted their ability to prevent obesity, including family history of obesity, intergenerational and interparental issues, adolescence, and societal issues. Third, despite high levels of childhood obesity in the community, parents selected ideal body sizes for boys and girls toward the thin end of the spectrum represented by our line-drawing scale.

Parents viewed their influence over their child’s diet as a primary means to prevent obesity. They mentioned several ways that they influenced their child’s diet, such as via modeling healthy behaviors, dietary education, and different types of feeding practices. These practices included permissive and restrictive or controlling feeding practices. This finding that parents equated ability to prevent obesity with restrictive or controlling feeding practices may actually have a paradoxical effect on their children’s weight. Studies have shown that restrictive or controlling child-feeding practices that force children to consume a particular food increases children’s dislike for that food whereas restricting “bad” but palatable food from a child’s diet can enhance its likeability and increase its intake.28,29

Because young children are remarkably adept at regulating their energy intake,28 a fundamental principle of feeding young children is that they should be allowed to dictate the quantity of what they eat. The issue of control over intake amount arose several times in the discussions, particularly if a food deemed nutritious by parents was not being consumed. Parents also felt the need to restrict the amount of food consumed by children who were already obese. However, these efforts may in fact negatively affect the extent to which children are responsive to the energy density of the diet and their long-term ability to self-regulate their food intake.28

Parents in this study were aware of the importance of exercise and perceived they had influence over it in their children. However, parental influence over exercise was limited to enrolling their children in formal gym classes. There was no mention of the quality, duration, or level of activity that constituted appropriate exercise. Moreover, parents perceived that being physically active was a natural inclination and ability for children, particularly for boys, independent of parental influence. A similar gender differential was also noted in a study involving parents of obese Latino preschoolers: parents with female children were 4 times less likely to report having a safe place to play than parents with male children.21 This needs to be further investigated to better understand how gender affects a parent’s beliefs about
appropriate physical activity and to coach parents in ways to engage children of both genders in daily, informal play and exercise.

Although parents perceived they had the ability to prevent obesity in their children, parents mentioned 4 factors that negatively affected this ability: family history of obesity, intergenerational and interparental issues, adolescence, and societal pressures. Similarly, other studies have shown that parents perceive that a family history of obesity or genetic predisposition over-rides their ability to prevent obesity. Several studies have suggested that mothers believe their child’s overweight was primarily determined by genetics rather than poor diet or feeding behaviors or lack of physical activity, and thus inevitable.12,13,30 Although the parents in our study also perceived that family history negatively impacted their ability to prevent obesity, they maintained that obesity development could still be modified through appropriate, healthy eating and exercise. Health messages should capitalize on this point: despite a strong family history of obesity, parents can still focus on modifiable factors such as diet and exercise to limit obesity development in their children.

Studies have also revealed that parents perceive a loss of control over obesity development due to intergenerational factors.10,12 These studies suggest that when children are cared for by extended family, particularly those of an older generation, conflicts arise between the parents and the older care givers. In our study, this intergenerational conflict in part may stem from a traditional Latino preference for heavier body type and from a concern that thinness is associated with poor health.13,14,17,22,31 Thinness is especially worrisome to immigrant Latinos who consider malnutrition and intestinal infections a greater threat to a child’s health than overweight.13

Adolescence was also identified in this study as a limit on parental ability to prevent obesity in their children. It is noteworthy that parents recognized and stressed the importance of providing a strong foundation in healthy living via modeling behaviors and education to maximize the chances that their adolescent would be able to resist the negative influences of their peers. This concept could be incorporated into prevention programs and discussed when counseling parents about healthy lifestyles for the entire family.

The final challenge to parental ability to prevent obesity in their children that emerged in this study was a broad one, encompassing societal issues. Although mentioned by parents in only 1 of the 3 groups, several parents in that group discussed that demanding work schedules resulted in a lack of time and, thus, in meals of fast food instead of home-cooked meals. Although findings from our study may not be generalizable to other populations, this particular theme has been mentioned in several other studies among white and African American parents,10,32 and is not specific to Latino populations. This perception of lack of time, coupled with other challenges such as tentering economic resources and poor food choice availability which disproportionately affect low-income families,17 may have an additive effect on obesity rates in our inner-cities. These factors must be addressed to affect any meaningful shift in obesity rates in our communities.

Interestingly, the parents in this study did not prefer in the line-drawings children’s body sizes toward the heavier end of the spectrum. Despite high levels of overweight and obesity in the community, parents uniformly selected thinner body sizes as the ideal. Previous studies among low-income mothers revealed a preference for heavier body sizes due to many reasons, including showing better health and being aesthetically more pleasing.13,14,17 and acting as proof of “good mothering.”17 Parents in our sample demonstrated a high level of understanding about obesity issues and morbidities and it is possible that their heightened level of awareness has shaped their preferences for body size in some way.

Our study has several limitations. It is possible that the parents who volunteered to participate in the focus groups were highly motivated and knowledgeable, and not necessarily representative of all Head Start parents at our site or of parents in the...
surrounding community. Perhaps the same personal characteristics that led these parents to volunteer for this study also resulted in their perceptions of being able to positively influence their children’s diet, exercise, and ultimately, their weight status.

We had intended to calculate the body mass indexes of participants’ children based on self-reported weights and heights provided on the anonymous screeners. However, parents uniformly were unable to recall their child’s heights and did not fill in that section of the screener. On the basis of this, we were unable to calculate body mass indexes for any of the participants’ children. Although unlikely given our high overweight and obesity rates in the community, it is possible that we sampled parents of normal weight children only. This could potentially have affected parental perceptions of obesity issues.

In conclusion, despite the high levels of overweight and obesity in the community, the findings from our study are encouraging and provide us with areas for future work. Future research should focus on parental perceptions of exercise, particularly in light of a possible gender differential. In addition, a quantitative study could build upon these key concepts, to survey a larger population and provide more generalizable data. Given the importance of the family on weight management for young children, and the promising results of childhood obesity prevention programs that include parents, future public health efforts among Latinos should capitalize on perceptions of influence over diet, widen perceptions of influence over informal exercise, and address potential challenges to parental influence that were illustrated in this study.

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