The Continuum of Influences on Caregivers: A Social Marketing Study of Childhood Obesity

Julie Norton, University of the Sunshine Coast, jln004@student.usc.edu.au
Maria Raciti, University of the Sunshine Coast, mraciti@usc.edu.au

Abstract

This paper presents the continuum of influences that primary caregivers (namely parents) experience and the subsequent impact of these on the feeding of their young children. These influences on caregivers may commence from their own childhoods, through their life experiences to the birth and early infancy of their children. The paper highlights caregivers' concerns and dilemmas in feeding young children, particularly in the face of conflict between nutritional recommendations and socially acceptable behaviours and attitudes.

Keywords: social marketing, obesity, child obesity

The Continuum of Influences on Caregivers: A Social Marketing Study of Childhood Obesity

Introduction

Wide-spread awareness of the increasing prevalence and consequences of obesity and overweight for individuals and society at large over the last decade has been driven by international bodies, such as the World Health Organisation and the International Obesity Task Force (Aranceta *et al.,* 2009). As a result, social marketing campaigns that focus upon healthier eating have become commonplace the world over (Cairns and Stead, 2009). The challenge of deconstructing the complex aetiology and treatment of obesity has been recognised (Brownell and Wadden, 1992). Particularly in light of the increasing prevalence and earlier onset of childhood obesity (Children's Nutrition and Physical Activity Survey, 2007; Vaska and Volkmer, 2004), this study supports the strategy of preventing adult obesity by focusing more attention on the development of obesity in children.

Eating habits develop in childhood and persist into adulthood (Boulton, Margery and Cockington, 1995; Kelder, *et al.*, 1994; Singer *et al.,* 1995). A review of 66 studies assessing the association between combinations of parenting, child eating and child weight variables concluded that there is substantial evidence that parenting affects child eating and that there are many modifiable risk factors for childhood obesity that reside in young children's family environments (Ventura and Birch, 2008).

Qualitative studies aiming to elicit child and/or parent views regarding influencing factors on children's food choices have been conducted on parents of 5-6 year olds (Campbell, Crawford and Hesketh, 2006) and older children and their parents (Hesketh *et al.*, 2005). Themes of influence included food marketing, modelling and feeding strategies. Food availability or exposure to foods was a commonly noted influence but this was complicated by the fact that children's food preferences determine the food made available to them (Campbell, Crawford and Hesketh, 2006). Other work indicates that parents of children under 11 years consider healthy lifestyles to be too challenging in the face of social norms, perceived constraints of time and the jeopardising of children's "happiness", particularly in instances of low socio-economic status (Medical Research Council, 2007). Despite the interest in childhood obesity, there remains a dearth of studies focussing on attitudes and behaviours of parents of very young children such as infants and toddlers. This gap was the impetus for this study.

This two phase qualitative research project explores attitudes and behaviours of primary caregivers surrounding the quantity of food eaten by young children and the nature of foods that are made available to young children. This paper presents limited findings from interviews with 24 caregivers of children aged between 1 year and 2½ years of age. The research is novel in many ways, and specifically for this paper the contribution is in the development of a timeline of salient influences on parents that subsequently impact upon their young children's diets. It is intended that this research will provide insights into parental attitudes and motivations and so assist in the development of more effective social marketing campaigns or interventions addressing childhood obesity.

Method

This study is part of a wider research program. Twenty four Sunshine Coast residents were recruited predominantly in response to flyers displayed at child care and play group centres. Primary caregivers of children as young as practically possible were sought as dietary influence of parents is greatest when children are young and risk of obesity commences at a very early age (Reilly *et al.*, 2005; Vogels *et al.*, 2006). Diversity was sought regarding socio-economic status (Barros *et al.*, 2006); working status of caregiver (Brown, Scragg and Quigley, 2008) and family configuration (Anderson, Winett and Wojcik, 2000) as these factors have been proposed to be associated with obesity. Demographics of the 24 participants were: 23 female, average age 33 years, 11 living in a high socio-economic region, eight were not in paid employment, 12 working part-time away from home and four working part-time from home. There were three single mothers and the average age of caregiver's child was 20 months. The gender of the caregivers' children was reasonably equal (female = 13; male = 11) and many had older siblings (n = 13).

The interviewer was an accredited and practicing dietetic professional with over 20 years experience. The interviews addressed topics including the child's eating history, the caregiver's childhood experiences and influences, objectives as a parent, foods suitable or not for a child and the caregiver's own eating habits. The interview encounters lasted a minimum of an hour, incorporated projective techniques and observation and were conducted usually in the homes of the participants. One interview protocol was used to facilitate cross-case analysis and confirm or disconfirm elements of prior theory whilst still allowing introduction of new concepts (Perry, 1998). Interviews were recorded and transcribed verbatim. Analysis of data utilised theory building strategies (Eisenhardt, 1989; Strauss and Corbin, 1990) and was complemented by use of NVIVO 8.

Findings

The findings, from a sub-set of the interview data, are presented in a chronological manner commencing with influences on caregivers from a) pre-parenthood and during their children's age periods of b) birth to 1 year of age and c) 1 year to 2 ½ years of age.

Phase 1: Pre-Parenthood

Factors influencing caregivers' child-feeding practices include their own childhood experiences. For 13 of the caregivers some aspect of their childhood experiences with food was carried into their own practice as a parent. Other caregivers reported to want a better diet for their children than they had as children themselves or that their childhood experiences caused them to react against their parents' behaviour.

In contrast some caregivers considered major influences to be improvements in their own diets following personal health experiences; an increase in knowledge from nutrition related training; and other personal experiences such as observing others' children. For two caregivers, the expectation of how children should eat, which was gained from either their own childhood experiences or observations of other children, contributed to their anxiety as parents when their own children did not meet these expectations.

Phase 2: Influences from Birth to One Year of Age

According to current Queensland Health recommendations (Queensland Health, 2005), caregivers are advised to introduce solids at around 6 months, then slowly develop the texture over the next six months until the infant is eating "a wide range of family foods" by 12 months. Most caregivers reported no difficulties with the introduction of solids. For these children solids were introduced over a wide age range starting at three months through to nine months, with the majority introducing solids when the child was between four to five months of age. During the discussion of the child's feeding history three caregivers reported that the child became "fussy" at around 12 months of age; similarly two others noted a change in food preference at this age. Yet more descriptions of children becoming "fussy eaters" were reported as being triggered by illness or were regarding older siblings of the case child. One caregiver believed that her first child and his liberal and regular exposure to foods high in fat sugar and salt (HFSS foods) contributed to his "fussy eating". Three caregivers, with hindsight, reported that their first child was not ready for solids and that the early introduction may have contributed to their "fussy eating".

> *And I actually waited with him. 'Cause I fed her at four months, I put her on solids at four months. And I thought that's why she's a fussy picky eater...*

Combined with an extreme focus on making sure the child eats, caregivers concluded that "something is better than nothing". Alternatively, where caregivers were reluctant to force feed they experienced a dilemma regarding the child's intake.

Phase 3: Twelve Months to 2 ½ Years of Age

The findings revealed two categories for salient themes for this phase – firstly, influences from inside the home and secondly, social influences from outside the home. *Influences from inside the home*, comprise of strategies to facilitate eating, other behaviours of caregivers, spouse and siblings and parental attitudes for allowing HFSS foods. The recognition of the concept of "repeated introduction of foods" was quite high (n = 11) among participants. The concept of having a routine around eating was valued by some though equally there were unstructured meal and snack times. Encouraging child involvement was a strategy to encourage healthy eating. Although several reported that they considered it acceptable to use food as a bribe or reward for behavioural issues not related to eating, and others equally (n = 6) disagreed with the use of food as a bribe or reward under any circumstance, it was apparent that food or dessert was used to encourage children to eat more in some households.

Despite a unanimous awareness of themselves as role models, and more than half of the participants reported being happy with their own eating habits, only about one-third of the participants were considered to have a diet limited in HFSS foods, in contrast to a diet liberal in such foods. Sharing HFSS foods with their child was a commonly reported behaviour. Despite reporting that children's food should be the same as that of adults, there was evidence to the contrary. In fact, four caregivers altered their own diets to fit in with foods that were accepted by their children and most of these caregivers were considered to have a diet liberal in HFSS foods. Most caregivers with children in the 12 month to 18 month age group (seven of eight) had introduced or were regularly providing cakes, muffins, chips, chocolate, lollies or soft drinks to their child. The other in this group reported allowing lollies at parties.

References to partners pertained to them being supportive or either being more strict or less strict than the caregiver, or being poor role models. The strong influence from fathers was also evident during discussions regarding childhood memories. Making eating a "fun"

experience was more the role of fathers. For single mothers, the stresses of managing a young child alone were evident and although there was a comment of the child's father's absence being advantageous, more commonly there was difficulty in establishing what they considered a social environment for eating. The presence of siblings due to modelling and access also contributed to young children eating HFSS foods within the household. The motivation for one caregiver to improve the diet of her family did not come until her 15 year old child became overweight.

Several participants referred to time being an opposing force regarding the food that is provided to their child. The need for organisation was recognised; less food may be offered when constrained by time, but more commonly convenience was sought, particularly when favoured by the child.

> *No, just, um, if I'm rushing out somewhere, or if we're at gymnastics, and I've forgotten to pack something for her to eat, I'll buy her a cheese and cracker thing there, but she wants chips 'cos the other kids are eating chips, so…*

Food refusal emerges also as a factor ultimately resulting in caregivers providing foods that are known to be preferred, as is concern about waste. Previously identified and reiterated in this study is the caregivers' desire for a "happy home".

The second category of themes that emerged for this phase was *social influences from outside the home*. Several caregivers expressed their awareness of the risks of obesity. The caregivers' awareness of recommended child food intake is of a high level as indicated by responses from questions regarding everyday foods suitable for a child and typical daily intake. Awareness of, or pressure to breastfeed was also expressed, and to a lesser extent, the risk of allergies. The inclusion of HFSS foods seemed to be interpreted to fit in with the recommendation for a varied diet:

> *What are foods that you think shouldn't be allowed on an everyday basis?* (JN)
>
> *Um, oh, I suppose I don't agree with nothing, like, I think you need to have a varied diet. I think you can be exposed to everything...like Coca Cola and your soft drinks, and chocolate and yeah, highly refined processed foods I suppose, and chips...*

All caregivers agreed that HFSS foods should be allowed for various reasons; that it is a parental right; that such foods are enjoyable and that consumption of such foods is part of our society and that children need to learn how to manage them. For some, what was permitted for children to eat, even socially would lead parents to socialise with like minded others. Caregivers experienced pressure to provide their children HFSS foods from various people such as associates, other mothers but most particularly grandparents. This attitude is so ubiquitous that four caregivers interviewed expressed either their own concern about being too strict or criticised others for being too strict. Caregivers also reported situations where other mothers criticised their efforts for providing variety in everyday foods or for home cooking.

In accord with these lenient attitudes is that caregivers do not want to deprive their children, and the practice of using bribes and rewards to control a child's behaviour is socially tolerated. Other than provision of food and modelling, participants reported that parents have influence on their children's eating via the media but all claimed that they limit their own children's

exposure to advertising. Two caregivers commented that their children react to advertisements for take-away foods. Both children were in the 24 month to 30 month age group and were exposed to the products by the parents prior to the recognition of and request for the product. More commonly caregivers reported that they were not experiencing any difficulties "yet" regarding controlling their child's behaviour around food however there was the expectation that it would become more difficult with time.

There were comments regarding the great responsibility felt in caring for their young and growing child and guilt was discussed in relation to women's competence as mothers. This apparent lack of confidence is expressed also by caregivers having an attitude of being "lucky" that their child is a good eater with only partial recognition that they may have had an influence in this outcome. Confidence and a greater level of relaxation (both in caregivers' anxiety and usually the child's diet), seem to have resulted after experiencing the first child.

Conclusions and Implications

In conclusion, this paper highlights the various influences experienced over time which impact on caregivers feeding their young children. This continuum of influences is particularly insightful for the education and motivation components of social marketing campaigns as identified by Maibach, Rothschild and Novelli (2002) and Donovan and Henley (2003). In particular, these findings highlight the strong impact of personal experience (both pre- and during parenthood) and the implications in terms of their child's diet. Literature readily available to caregivers, describes one year to be an age where a child acquires more individual preferences however the attitude of caregivers is more commonly that the child becomes "fussy". As breastfeeding offers caregivers comfort that the child is receiving adequate nutrition (Norton, Harker and Harker, 2010), and twelve months is the time "recommended" that formula feeding or breastfeeding can be ceased, it is understandably of concern to caregivers if a child does not meet expectations of intake. Although there is an awareness of the risks of obesity, the greater motivation of caregivers of young children seems to be ensuring that the child should be eating certain quantities of foods. One risk of such a reaction is the introduction and frequent provision of HFSS foods and the development of the child's preference for those foods; as found in an earlier phase of this study. The other major issue highlighted in this paper is the general lack of confidence expressed by caregivers. This lack of confidence seems to arise from a combination of the responsibility of caring for a young child and conflict between nutritional recommendations (or their interpretation) and socially acceptable attitudes and behaviours surrounding food provision to young children. A social marketing education campaign that enlightens the general public on its role towards supporting parents' efforts in raising healthy children would be complimentary and contribute to addressing the obesity issue.

Limitations and Future Research

As with all research, there were a range of limitations associated with this study that impact on the generalisability of the findings. Limitations associated with this qualitative study in terms of the cross-sectional design, self-selecting sample and despite all efforts the under-representation of very low socio-economic status families is acknowledged. Future research pertaining to the educating of first time mothers regarding child development and expectations associated with child feeding is encouraged. A longitudinal study with a quantitative component across Australia and with international comparisons is also suggested.

References

Anderson, E., Winett, R., Wojcik, J., 2000. Social-cognitive determinants of nutrition behaviour among supermarket food shoppers: A structural equation. Analysis Health Psychology 19 (5), 479-486.

Aranceta, J., Moreno, B., Moya, M., Anadon, A., 2009. Prevention of overweight and obesity from a public health perspective. Nutrition Reviews 17 (1), 83-88.

Barros, A., Victoria, C., Horta, B., Goncalves, H., Lima, R.C., Lynch, J., 2006. Effects of socioeconomic change from birth to early adulthood on height and overweight. International Journal of Epidemiology 35 (5), 1233.

Boulton, T.J.C., Magarey, A.M., Cockington, R.A., 1995. Tracking of serum lipids and dietary energy, fat and calcium intake from 1 to 15 years. Acta Paediatricia 84, 1050-5.

Brown, R., Scragg, R., Quigley, R., 2008. Does the family environment contribute to food habits or behaviours and physical activity in children? Report by the Scientific Committee of the Agencies for Nutrition Action.

Brownell, K.D., Wadden, T.A., 1992. Etiology and treatment of obesity: Understanding a serious, prevalent and refractory disorder, Journal of Consulting and Clinical Psychology 60 (4), 505-512.

Cairns, G., Stead, M., 2009. Obesity and social marketing: works in progress. Proceedings of the Nutrition Society 68, 11-16.

Campbell, K.J., Crawford, D.A., Hesketh, D., 2006. Australian parents' views on their 5–6-year-old children's food choices. Health Promotion International 22 (1).

Children's Nutrition and Physical Activity Survey 2007. Available from http://www.health.gov.au/internet/main/publishing.nsf/Content/66596E8FC68FD1A3CA2574D50027DB86/$File/childrens-nut-phys-survey.pdf. Assessed June 2009.

Donovan, R., Henley, N., 2003. Social Marketing: Principles and Practice. Melbourne, IP Communications.

Eisenhardt, K.M., 1989. Building theories from case study research. The Academy of Management Review 14 (4), 532-550.

Hesketh, K., Waters, E., Green, J., Salmon, L. Williams, J., 2005. Healthy eating, activity and obesity prevention: a qualitative study of parent and child perceptions in Australia. Health Promotion International 20 (1),19-26.

Kelder, S.H., Perry, C.L., Klepp, K., Lytle, L.L., 1994. Longitudinal tracking of adolescent smoking, physical activity and food choice behaviours. American Journal of Public Health 84, 1121-1126.

Maibach, E., Rothschild, M., Novelli, W., 2002. Social Marketing. In Glanz, K., Rimer, B.K., Lewis F. (Eds.), Health Behaviour And Health Education: Theory, Research, And Practice.

3rd Edition, Jossey-Bass, San Francisco, 431-461.

Medical Research Council, 2007. The 'Healthy Living' Social marketing initiative: A review of the evidence. Available from www.dh.gov.uk Accessed October 2009.

Norton, J., Harker, M., and Harker, D., 2010. Changing times and expectations impact on childhood obesity. In Russell-Bennett, R. (Ed.). Proceedings of the 2010 International Not for Profit and Social Marketing Conference (INSM) Queensland University of Technology and Griffith University

Perry, C., 1998. Processes of a case study methodology for postgraduate research in marketing. University of Southern Queensland, Australia.

Queensland Health, 2005 Available from http://www.health.qld.gov.au/child-youth/factsheets Accessed June, 2010

Reilly, J.J., Armstrong, J., Dorosty, A.R., Emmett, P.M., Ness, A., Rogers, I., Steer, I., Sherriff, A., 2005. Early life risk factors for obesity in childhood: cohort study. British Medical Journal 357:1357–62.

Singer, M.R., Moore, L.I., Garrahie, E.J., Ellison, R.C., 1995. The tracking of nutrient intake in young children: the Framingham children's study. American Journal of Public Health 85, 1673-7.

Strauss, A., Corbin, J., 1990. Basics of qualitative research: Grounded theory procedures and techniques, Sage, Newbury Park, CA.

Vaska, V.L., Volkmer, R., 2004. Increasing prevalence of obesity in South Australian 4-year-olds: 1995 and 2002. Journal of Paediatrics and Child Health 40 (7), 353-5.

Ventura, A.K., Birch, L.L., 2008. Does parenting affect children's eating and weight status? International Journal of Behavioral Nutrition and Physical Activity, 5, 15.

Vogels, N., Posthumus, D., Mariman, E., Bouwman, F., Kester, A., Rump, P., Hornstra, G., Westerterp-Plantenga, M., 2006. Determinants of overweight in a cohort of Dutch children. American Journal of Clinical Nutrition 84 (4), 717-724.