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Qualitative perspectives on a family group intervention program for improving physical wellness

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ABSTRACT

Healthy Balance is an obesity-prevention group intervention program that promotes physical wellness for family systems by motivating them to make healthy lifestyle changes to their eating and activity levels together as a unit. The researchers conducted 19 qualitative interviews with caregiver intervention participants and healthcare providers to explore perspectives on the program, health, and lifestyle change processes. Themes emerged around improving physical wellness for young families, health change processes, and experiences with the family-based group intervention. Caregivers reported that they believed interventions focusing on improving the health literacy and behavioral change for the whole family to be more beneficial. Family systems theoretical concepts were supported through participants’ perspectives that detailed how intervening with the whole family can not only lead to physical health behavior changes, but also enhance family connection and quality time.

KEYWORDS

Family-based prevention; physical wellness intervention

Introduction

Obesity affects children and adults in epidemic proportions (Sahoo, Sahoo, Choudhury, Sofi, & Bhadoria, 2015) and has far-reaching consequences that affect a child’s physical and psychosocial health throughout the lifecycle. Given that obesity becomes increasingly difficult to treat the longer a person has been at an elevated weight (Daniels, 2006) and because childhood obesity rates have more than doubled over the last couple of decades (Ogden, Carroll, et al., 2015), it is important that prevention programs target this health issue early in life. Furthermore, evidence suggests that Type 2 Diabetes and Coronary Heart Disease, both of which have been linked to elevated weight, begin in childhood (Bhave, Bavdekar, & Otiv, 2004). In addition to medical consequences, childhood obesity is linked with socio-emotional consequences such as increased risk of discrimination and
bullying. According to studies, children who are obese are four times more likely to have problems at school than their healthy weight peers (Schwimmer, Burwinkle, & Varni, 2003). For all these reasons, it is no surprise that the United States (US) Department of Health and Human Services’ Healthy People 2020 initiative identified early childhood obesity as a top 10 public health priority; the goal is to improve child health outcomes and prevent multiple conditions across the lifespan by effectively reducing pediatric obesity (Office of Disease Prevention and Health Promotion, as cited in Messiah et al., 2016).

Despite the vital need for effective obesity-prevention interventions, few programs have produced significant obesity-prevention effects over multi-year follow-up (Fitzgibbon et al., 2005; Stice, Marti, Spoor, et al., 2008). Recent systematic reviews confirm this trend (e.g. Monasta et al., 2011; Waters et al., 2011). Yet, obesity treatment researchers have been able to clearly demonstrate that when people improve their nutrition habits and increase their physical activity, they can improve unhealthy weight gain trajectories and other obesity-related outcomes (Epstein, Valoski, Wing, & McCurley, 1990; Robinson, 1999). Childhood obesity-prevention programs often fail to fully capitalize on family system influences on child health habits and have fallen short in motivating families to make lasting lifestyle changes together as a unit (Berge et al., 2016; Luckner et al., 2012; Oude Luttikhuis et al., 2009). Maternal weight and family structure, however, have been found to significantly predict child body mass index (BMI) longitudinally, which lends support to the idea that salient family factors may impact caregivers’ support for increasing physical activity and healthy eating for their children (Gibson et al., 2016). Furthermore, Kitzmann and Beech (2006) found that child obesity treatment involving families was significantly more effective than for children in the control treatment condition. Epstein et al. (1990) found that family-based obesity-prevention interventions that targeted both parent and child behaviors led to better weight loss retention at 5- and 10-year follow-up.

These research findings make sense because when caregivers are included in interventions they can model health behaviors, make changes together as a family system, shape the home food environment, and create opportunities for connection through physical activity. Although there is compelling evidence for the effectiveness of family-based treatments at least in the short term (Kitzmann & Beech, 2006; Kitzmann et al., 2010) few obesity-prevention interventions seek to create family-level change that could lead to longer-term effects. In summary, there is evidence that excluding parents and caregivers as essential targets for child obesity-prevention programs misses a valuable opportunity for the role modeling of healthy behaviors in the home environment (Murtagh & Ludwig, 2011; West, Sanders, Cleghorn, & Davies, 2010). Based on this evidence, researchers recommend
interventions that engage parents and caregivers in addressing pediatric weight issues and obesity (Shrewsbury, Steinbeck, Torvaldsen, & Baur, 2011).

By using family systems theory (FST) as a framework for obesity-prevention programs for children, researchers can develop interventions that consider how change can occur for families as a whole versus just the individual members. One of the key relevant FST concepts is that individual behaviors cannot be fully separated from the overall system functioning. As such, there is evidence that parenting styles, level of warmth, and supportive family interactions can affect youth health behaviors as well as overall family functioning (Kremers, Brug, de Vries, & Engels, 2003; Rhee, 2008). In short, child health is strongly linked to family health (Schor, 1995). Thus, an FST approach could potentially impact child health behavior change more significantly as well as provide additional change opportunities at the level of the child’s home and family environment. For instance, it could increase familial support for shared health goals, improving a sense of family connection around being healthy together.

One difficulty in the implementation of preventative family-based interventions may be in vetting, recruiting, and accessing participants that might benefit the most. Other researchers have identified primary care pediatric settings as a promising venue for obesity-prevention intervention because pediatric providers often have access to entire family systems, given that they interact with a wide range of parents, caregivers, and children with relatively high frequency (Bourgeois, Brauer, Simpson, Kim, & Haines, 2016). Involving primary care physicians (PCPs) in family outreach could improve the visibility and accessibility of an affordable family-based obesity-prevention program, creating a coordinated partnership between PCPs and the intervention program (Vine, Hargreaves, Briefel, & Orfield, 2013). Bourgeois et al. (2016) conducted focus groups with PCPs and parents of preschoolers and found that gaps between well-child visits, lack of physician time, and sensitivity to the topic of obesity-related behaviors prevented adequate intervention. Nevertheless, a family’s ongoing relationship with a knowledgeable PCP, who would also address the family’s obesity-related concerns, could only serve to strengthen the effectiveness of intervention programs, extending intervention relevancy throughout the course of the family’s lifecycle. In summary, primary care pediatric clinics could be an ideal setting for intervention because they enable provider and family voices to influence all aspects of the intervention development and testing.

**Healthy balance program**

We developed the Healthy Balance (HB) program, an 8-session, 12-hour, family-based group intervention, to address the critical gap in obesity-prevention interventions targeting families with preschool age children in
primary care settings. The primary goal of the HB intervention was to motivate parents to make small healthy changes to the home food environment, increase physical activities, and decrease sedentary behavior. HB was based on the findings of a similar intervention, Healthy Weight, which has demonstrated effectiveness in preventing obesity and eating disorder onset in adolescence (Stice, Marti, Spoor, et al., 2008; Stice, Rohde, Shaw, & Marti, 2012, 2013). Central intervention components included lifestyle improvement plans wherein participants develop their own family lifestyle goals and include children in decision-making. In the HB intervention, participants discussed both the benefits of making healthy lifestyle changes and the adverse effects of obesity as well as negative societal influences on family health.

The theoretical rationale behind the HB intervention is that if parents who have engaged in unhealthy eating and sedentary behaviors themselves can promote and adopt healthy lifestyle changes for the sake of their child’s health, then they will more likely commit to making behavioral changes to their family’s eating and activity habits on a long-term basis. Therefore, the caregivers were challenged to think together about changes they could make as a family unit, to set SMART goals and hold each other accountable in a group setting, and then to work through challenges that arose as they applied changes in their daily lives. Components of the curriculum addressed effective parenting practices more generally, especially surrounding parenting at meal times and routines that support physical activity goals. In addition, adult participants discussed how society at large, school, and relatives influence eating habits, body image, and the promotion of a sedentary lifestyle (i.e., screen time). Likewise, the groups trouble-shot barriers to change, such as lack of access to fresh produce and healthy meats and lack of time to exercise. The HB child groups were designed to be fun, experiential, and interactive. Interactive games in the child group curriculum incorporated developmentally appropriate psychoeducation about healthy eating and physical activity. Childcare was offered onsite for any children not participating in the intervention group.

For the randomized control study that tested the effectiveness of the HB intervention, we recruited 60 HB family participants in primary care pediatric settings and provided the intervention to all patient families with children between the ages of 3 and 5 years old who speak English and/or Spanish. The researchers prioritized the accessibility of the intervention to Spanish-speaking families, given (a) the large local community of Latina/o families, (b) health disparities experienced by Latino/a families, and (c) the disproportionately high rate of obesity experienced in Latina/o populations. Through the larger HB randomized control trial study, we measured intervention effects on BMI, blood pressure, heart rate, neck and stomach circumference, eating behaviors and attitudes, screen usage, and reports of
physical activity. Criteria for the HB randomized control trial pilot study included: (a) having a child between the ages of 3 and 5 years old and (b) being able to speak and read English or Spanish. Assessments occurred at baseline, post-intervention, and at 4 months follow-up.

**Qualitative study purpose**

The main purpose of this qualitative study was to examine the perspectives of caregivers and providers who have been directly involved with the HB obesity-prevention intervention. Given that our primary aim was to understand the socially constructed experiences of participants, qualitative methods were the most appropriate for our data collection and analyses (McLoud, 2011). Despite having elicited intervention participant and provider qualitative feedback throughout the entire process of intervention development and pilot testing, the research team believed we needed a more rigorous qualitative inquiry to improve understanding of participant perspectives on motivators for change, family engagement, intervention success indicators, and health attitudes and behaviors. As mentioned above, there is limited evidence of obesity-prevention intervention effectiveness and even less information about what families and providers perceive to be the largest gains from these programs (Bourgeois et al., 2016). Systematically interviewing primary care providers and community health workers ensured that we elucidated the most effective elements of the coordinated partnership. For this qualitative study, the researchers listened to the perspectives of both providers and the caregivers of 3- to 5-year-old children who participated in the HB intervention project.

**Methods**

Participant and provider experiences of the HB intervention project were explored. The study’s organizing, or grand tour, question was as follows: *What was your overall experience of participating in the HB project?*. The appendix outlines the follow-up questions used in the study in a semi-structured interview format. We designed the questions to gain understanding about how the participants experienced the HB intervention project and to reveal any perceived changes experienced by intervention participants. We designed semi-structured questions to elicit in-depth descriptions of participant experiences. There were two interviewers, both of whom are master’s-level clinicians who had received training in qualitative research methodology by the first author and principal investigator.

Phenomenological qualitative methodology allowed participants’ and providers’ voices to shape the overall narrative of the experience of the HB intervention project. Qualitative research allows participants to directly
Inform model and theory development rather than researchers using the data gathered to test a hypothesis (Creswell, 2007). Given the nature of the research question and the desire to understand the HB study participants’ experiences, we organized the research design and overall methodology phenomenologically. This methodology, specifically outlined by Moustakas (1994), has been historically relied upon to find the essential meaning and experience within a phenomenon. Grounded in the philosophical works of Husserl, Sartre, and Merleau-Ponty, phenomenological inquiry explores meaning-making across multiple individuals regarding their lived experiences with a particular phenomenon (Creswell, 2007).

**Participants**

A total of 11 interviews were conducted with a total of 19 participants: 5 providers and 14 intervention participants, including a married couple. Qualitative participants were recruited between December, 2015 and June, 2016. Any HB intervention participant who was assessed during this time was invited to participate in the qualitative portion of the study. Criterion sampling (Creswell, 2007) ensured that participants shared the common experience of being involved with the HB project. A total of 15 of the participants were female, 4 were male, and the majority of participants \((n = 11)\) identified as an ethnic or racial minority. Nine participants identified themselves as Latino/a. A total of 11 participants reported that Spanish was their native language or that they were bilingual (Spanish and English). Nine of the 19 participants identified as having low socioeconomic status based on income and/or educational attainment. All intervention qualitative participants had 1 to 2 children between the ages of 3 and 5 years old who participated in the child intervention groups. Table 1 provides a more detailed description of study participants.

**Data collection**

Before the study commenced, the institutional review boards at both the supporting university and medical institution approved all study protocols. All participants reviewed and signed consent for the qualitative follow-up study. The 18 semi-structured interviews were conducted face-to-face and lasted approximately 90 min. Timing depended on the scheduling availability of participants. Each interview started with the grand tour question and included the same follow-up topics with the goal of fully understanding the participant’s experience of the HB project. Each interview was audiotaped and transcribed verbatim by one of two research team members. All participants were assigned a code name that was used throughout the study to maintain their confidentiality.
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Type of participant</th>
<th>Race/ethnicity</th>
<th>Age range (years)</th>
<th>Gender</th>
<th>Language(s) spoken</th>
<th>Income</th>
<th>Education</th>
<th>Relationship status</th>
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<tbody>
<tr>
<td>(1) Maria</td>
<td>HB parent</td>
<td>Latina</td>
<td>25–29</td>
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<td>Spanish</td>
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<td>Some college</td>
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<td>30–34</td>
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<td>English</td>
<td>Above $60K</td>
<td>Graduate degree</td>
<td>Married</td>
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<tr>
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<td>25–29</td>
<td>Male</td>
<td>English</td>
<td>$35K–40K</td>
<td>Some college</td>
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</tr>
<tr>
<td>(4) Wanda</td>
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<td>Latina</td>
<td>30–34</td>
<td>Female</td>
<td>Bilingual</td>
<td>$55K–60K</td>
<td>BA/BS degree</td>
<td>Married</td>
</tr>
<tr>
<td>(5) Mariana</td>
<td>HB parent</td>
<td>Latina</td>
<td>30–34</td>
<td>Female</td>
<td>Spanish</td>
<td>$0</td>
<td>Some college</td>
<td>Married</td>
</tr>
<tr>
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<td>African American</td>
<td>30–34</td>
<td>Female</td>
<td>English</td>
<td>$0</td>
<td>Some college</td>
<td>Significant other</td>
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<td>(7) Jennifer</td>
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<td>45–49</td>
<td>Female</td>
<td>English</td>
<td>Above $60K</td>
<td>Graduate degree</td>
<td>Significant other</td>
</tr>
<tr>
<td>(8) Megan</td>
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<td>45–49</td>
<td>Female</td>
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<td>Above $60K</td>
<td>Graduate degree</td>
<td>Married</td>
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<tr>
<td>(9) Cecilia</td>
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<td>60–64</td>
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<tr>
<td>(10) Bonnie</td>
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<td>60–64</td>
<td>Female</td>
<td>Bilingual</td>
<td>Above $60K</td>
<td>Graduate degree</td>
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<td>Married</td>
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<tr>
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<td>$15K–20K</td>
<td>High school diploma</td>
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<td>Spanish</td>
<td>$20K–25K</td>
<td>11th grade or under</td>
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<td>35–39</td>
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<td>$55K–60K</td>
<td>BA/BS degree</td>
<td>Married</td>
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<td>(17) Aleks</td>
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<td>Bilingual</td>
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<td>Single</td>
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<td>(18a) Bob</td>
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<td>30–34</td>
<td>Male</td>
<td>English</td>
<td>Unknown</td>
<td>BA/BS degree</td>
<td>Married</td>
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<tr>
<td>(18b) Sue</td>
<td>HB parent</td>
<td>White</td>
<td>25–29</td>
<td>Female</td>
<td>English</td>
<td>Unknown</td>
<td>BA/BS degree</td>
<td>Married</td>
</tr>
</tbody>
</table>
Data analysis

Data analysis procedures followed the main steps outlined by Moustakas (1994) with the overall goal being to review the set of intervention group participants’ and provider participants’ transcripts. The first step of the data analysis included reading each transcript closely and identifying statements of meaning that related to the overall research questions, a process Creswell (2007) refers to as horizontalization. Each coder read the transcripts one time and then began the coding process on the second read, while being careful not to interpret meaning from participants’ words (Sandelowski, 2000). The coders created summaries that captured the overall essence of each transcript and presented those at the first data-analysis team meeting. The data-analysis team met on three different occasions and, each time, reconciled discrepancies in data interpretation. Therefore, the process was iterative in that each research meeting informed the next steps of the analysis. At times, it was necessary to re-code the same interview transcript more than once to ensure that the most advanced coding key was used (Grbich, 2007). These categories were reviewed across transcripts for thematic building, referred to as the vertical data-analysis process (Creswell, 2007). The findings section details the final themes and subthemes that emerged from this four-part process.

Several methods were used to increase the trustworthiness of our study findings. The first author acted as an internal auditor throughout the entire research study. In addition, the research team had frequent qualitative data collection and analysis training and debriefing sessions to ensure research study effectiveness and to ensure that emerging themes and categories fit the data. Iterative questioning was used to gather in-depth data from participants, as is customary with qualitative research. The research team also used bracketing strategies and peer debriefings to determine the personal beliefs and assumptions that contributed to the process of this study (Creswell, 2007). Specifically, peer debriefings were conducted throughout data collection and analysis to help the research team consider if and/or how the identified initial beliefs and assumptions informed emerging findings, and to increase the research findings’ dependability.

Findings

Themes and subthemes emerging across the intervention participants’ interviews primarily focused on changes in health behaviors and attitudes (i.e., the perceived effectiveness of the family-based treatment approach), impacts on family connection, perceived benefits of attending therapy in a group setting, barriers to participation, and family maintenance of health changes. Many of these themes similarly emerged from the healthcare providers, offering converging support for their significance. Healthcare providers also offered
additional insight into logistic barriers for their own involvement with such a program.

**Intervention participant themes**

Intervention participants reported that they gained knowledge about what constitutes “healthy” through their participation in the group. A total of 20 participants specifically described becoming more flexible around what healthy means, with the realization that healthy means different things to different people. In addition, intervention participants consistently discussed how their awareness and execution of health practices had shifted in ways that they attributed to their participation in the HB project. As predicted, the specific benefits of improving health habits and the influence of the HB project on the family as a system also emerged as themes identified by participants. Finally, interview participants offered insight into the benefit of receiving support in a group setting as well as barriers to program involvement and health change maintenance. These themes will be more fully explored below.

**Participant Theme 1: Expanded Knowledge Of What Healthy Means**

All but a few participants specifically said they had expanded their personal definition of being healthy after participating in the HB project. A total of 11 participants noted that, to them, being healthy means feeling better in their bodies. They described this as both a physical and mental experience. Physically, they described being healthy as having more energy, feeling strong, and being able to participate in the activities they care about, like playing with their children. Mentally, they described being healthy as having more confidence and feeling good about their bodies, whatever their fitness level. Intervention participants recognized multiple motivators for making positive health changes, such as sharing struggles with others, recognizing the value of trying, hearing about others’ outcomes when changes were made, learning new information, preventing obesity, keeping children and families healthy, and wanting to feel good about their health. Participants also emphasized the preventative power of healthy living. They mentioned diminishing the frequency of colds and decreasing their risk for developing diabetes, high blood pressure, and heart problems as added benefits of maintaining the changes they had made.

All participants defined healthy partially in terms of eating healthy, although this looked different for various participants. For 11 participants, eating healthy meant eating organic or natural foods, eating less fat and sugar, and avoiding unhealthy oils. For eight participants, eating healthy meant eating regularly throughout the day and paying attention to portion sizes. Overall, participants across interviews noted the importance of
conceptualizing what healthy means in a flexible way; this included being flexible with food choices, types of exercise, and body-image expectations. In addition to developing more flexibility about what it means to be healthy, participants noted other shifts in thinking that they attributed to their time spent in the group. A third of participants identified a shift in feelings of shame or self-criticism around health choices. Half of these participants described feeling proud of their eating and exercise habits after recognizing their efforts at being healthy. They noted that rather than feeling bad or giving themselves a hard time when they chose to eat something unhealthy or skipped exercise on a given day, they chose instead to accept their choices and commit to making healthier future choices.

A total of 12 participants reported a change in their all-or-nothing thinking. One participant stated that, before attending group, if he had chosen to eat something unhealthy early in a day, he would decide that it was “too late” and continue eating unhealthy things for the rest of that day, vowing to “try again” the following day. The participant discussed having realized that a whole day does not have to be lost just because of one poor choice and that healthy choices can be made any time of the day, after any choice already made. In other examples of more flexible thinking, 10 participants also noted that it was okay to exercise for 10 or 15 min instead of half an hour or an hour. Similarly, five participants reported they did not identify with participating in fad diets and instead had decided to focus on eating nutrient-dense food in moderation.

**Participant Theme 2: Changes In Individual And Family Health Awareness And Habits**

Intervention participants identified ways in which their family health habits have changed since participating in the intervention and indicated feeling optimistic about how their health could improve as a result. Participants described their involvement with the intervention as having influenced their awareness of food choices as well as decisions about portion sizes. This increase in awareness and thoughtful decision-making contributed to other changes they made in relation to their food consumption. More than two thirds of participants reported that they had decreased their food portions. Additionally, participants stated that their family members relied more on healthier foods. Seven participants noted that health and weight can sometimes be taboo topics; having a space to discuss them helped bring thoughts about health to the forefront of their minds.

A total of 10 participants talked about increased mindfulness and awareness about the food they eat, the food options they have, and how much they and their children eat. Half of the intervention group participants also reported feeling they had gained awareness about how to increase healthy behaviors, such as how to make healthy food choices and how to replace pre-
made snack foods with healthy snacks. They also mentioned that they had developed strategies for eating out less frequently, even when they are busy.

Parent participants regularly commented that their children had been making healthy food choices on their own since participating in the group. A total of 11 also stated that they and their children were more willing to try new foods and engage in different activities to be healthier. Similarly, five participants noticed changes their partners made as they and their children made changes. Participants mentioned that their partners were drinking fewer sugary drinks and eating more fruits and vegetables. Others also noted that they were spending more time exercising and cooking healthy meals with their partners. Overall, 12 participants noticed an increase in their family’s motivation to be healthy together.

Participants described the new daily and weekly routines they had developed for grocery shopping, cooking, and exercising. Eight participants discussed learning to cook with less oil, changing what aisles they visit at the supermarket, and keeping a routine for when to exercise and what to eat. They also described the new evaluative processes their children were using to decide what type of food to choose at school.

**Participant Theme 3: Increased Family Connection And Conversations About Health**

In addition to discussing habit changes, participants noted consistently that their families felt more connected as a unit after participating in the intervention groups. A total of 11 participants noted that they participated in more conversations with their partners and children about food and health, a change they attributed to their time in the intervention group. During these conversations, they talked about food changes and exercise activities as a family, and multiple people weighed in on what can they could eat or do. Because of the intervention, participants recognized the systemic changes that could occur across the family by creating a healthier environment. Participants did note, however, that these changes required some creativity and experimentation.

A total of 11 participants confidently reported that their relationship with food and exercise had a positive impact on their emotional state and relationships. A total of 10 participants reported that they increased their awareness of how food allows them to connect with others. At least four participants described the conversation about food and exercise as focused on being healthy, not fat or skinny. Six participants discussed making more time to get outside or play with their children to encourage exercise and movement, ultimately increasing the time spent in shared family activities. These participants also noted that their kids were eager to help with preparing food after having helped make snacks in the kids’ group. Intervention participants described their children as enthusiastic and excited to attend group, play
with their friends every week, and receive their certificate and medal at the end of the intervention. Overall, intervention participants identified learning how to be healthy individually and as a family unit as a key benefit of participating in the HB project.

**Theme 4: benefits Of A Supportive Group Setting**

In addition to learning how to be healthy and working as a family, participants most often identified as a benefit of participating in the HB project being able to spend time with other adults in a supportive group environment. Every participant noted in the interview that they had a positive experience being a part of the intervention group. Even if they were hesitant about the group format at first, participants reported that their positive group experience was due to three factors.

First, they appreciated the space to meet each week and talk about health, food, and maintaining healthy habits while parenting. Second, they acknowledged that the support of group members increased their sense of accountability, which helped them follow through with goals they made. Third, they appreciated the validation and normalization they experienced as group members. A total of 13 participants reported that just having the space to meet each week with other adults who had similar struggles helped them feel like they were not alone in their own health challenges.

Participants also reported feeling particularly supported by the interventionists because they did not feel pressured to conform to a specific idea of what healthy means. Instead they were encouraged to explore their individual definition of healthy and to make choices that aligned with that view. Participants also conveyed the benefit of having a direct connection with the interventionists as a resource for information.

**Theme 5: Barriers To Maintaining Healthy Habits And Program Recommendations**

Participants discussed what they saw as barriers standing in the way of maintaining changes they made during their time in the group. The most common barrier to maintaining health was lack of time. They noted that pre-packaged, and often unhealthy, foods can be accessed much more quickly, which can be appealing when they are very busy. Five participants also noted that the goals of eating healthfully, especially with their kids, can be compromised by other family members who like to “spoil” the kids with sweets. A total of 11 participants noted that they experienced difficulty maintaining some changes because of limited access to resources. In particular, they noted that healthier food is often more expensive. Other participants noted lack of access to transportation and limited information about health-related community resources as barriers.
Related to the HB intervention curriculum specifically, several of the participants disagreed with aspects of nutritional information provided through handouts, especially if participants followed vegan or high-protein and low-carbohydrate diets. However, most participants appreciated the psychoeducation and nutritional information distributed through intervention handouts. Seven participants identified cultural factors for Latino/immigrant families that could potentially lead to barriers. These factors included differences in perceptions of health matters, integration into a new society due to migration, and differences in attitudes toward food and exercise in a person’s home country compared to the U.S. Half of the interview participants also noted they wanted more relatable food options. Three participants noted they would have liked to have had longer groups and more information about what activities were provided in the child intervention groups. Two intervention participants initially believed the intervention would be either for only children or only parents until they attended the first meeting. Further, five intervention participants, most of whom participated in groups during the summer, cited busy schedules as an overall barrier to participation due to difficulty of making time to attend the group.

Theme 1: expanded knowledge about what healthy means
“Healthy to me means feeling well and being able to enjoy the things you like to do. Feeling confident, good about yourself.”
“I have realized that it is not so much about what we eat, but about portion control.”
“It’s not being super fit or super fat, it’s just knowing what you’re doing, what you’re eating, the sizes, portions.”

Theme 2: changes in individual and family awareness and health habits
“I really enjoyed the experience. I think I’ve learned a lot of stuff and we’re more aware of like I would have liked to have said I made healthy choices but you don’t really think about it, it’s just a natural reaction to just make a choice without really thinking of whether there may be better choices. I think it was really good, it was nice to have other families who could give input and have those ideas.”
“I wouldn’t say any grand thing changed, but little steps. And then of course, as I’m taking better care of myself and feeling better, I’m a better parent.”
“I noticed that I was more mindful of my health habits this weekend due to the discussions we have had in these meetings.”
“The class is motivating us, yes motivating us. It’s like a big motivation.”

Theme 3: increased family connection and conversations about health
“I have noticed that my daughter and I are talking more about what foods make our bodies feel stronger.”
“We’ve talked about as a family, taking the time out to go for walks and stuff. Obviously it’s raining right now, but we have dance parties, we can have dance parties inside.”
“Food is something you can be proud of and is a way to show love to other people.”
“Also it was fun for me that my daughter liked going and it was fun for me that she loved her prizes that she got; she was super excited about it. So that was fun too, she was like ‘I get to go to my meeting!’”
“This project seems to be about promoting health, promoting healthy families. Families that play together, laugh together, eat healthy food together, are going to have kids that grow up in that environment...making little changes in their lives is gonna improve everything.”

Theme 4: benefits of a supportive group setting
I don’t know, I think just comparing ideas. We talked about our kids a lot, and child rearing and stuff. And that was fun and interesting. So I think it was just sort of that support group aspect you know, just getting together with grown-ups in a similar part of their life and talking about things that you don’t normally talk about with strangers.

(Continued)
Healthcare provider themes

The comments expressed by the five healthcare providers frequently complemented and converged on the participant themes outlined above. Therefore, providers served as an important source of data triangulation. While participants’ conceptualization of “healthy” became more flexible following their participation in the program, providers similarly noted the importance of talking to families about what healthy means for them. This broader conceptualization of health and health-related behaviors also emerged when the providers named the potential benefits of the intervention program, such as becoming more active, getting health information from multiple sources, and discovering resources and activities to do with their families. These provider themes reflected the benefits that participants described regarding intervention delivery in a supportive group setting. Three of the interviewed providers noted that the group support format offered a clear benefit. Providers also alluded to the benefit of a coordinated partnership between interventionists, participants, and providers for promoting health behavior change. For example, one provider participant stated:

And for some families I think they need to hear messages in a different setting. Like somehow having the doctor say it, it’s like, ‘yeah, yeah, whatever,’ it’s one of the fifteen different things we talk to them about. But it [HB groups] sort of emphasizes what’s important, my doctor thinks it’s important, this group thinks it’s important, so they hear the information from multiple credible sources. I think that that is a real big positive.

In addition to outlining some of the same benefits as intervention participants, healthcare providers identified similar barriers to engagement. Mirroring barriers mentioned by participants, providers noted that often the families they thought might benefit most from the group were unable to attend due to time restrictions or lack of accessible transportation. In
addition to reporting on logistical barriers, providers also identified a shift in cultural factors specific to Latino/immigrant families, such as the availability of and status associated with fast food options. These culturally specific factors could inhibit health behavior change and negatively influence overall family health. An illustration of this sentiment is in the following pediatrician comment:

Many of my families come from Mexico, where they could just step outside and exercise. It’s really hard to do that here due to how much it rains here. I think families struggle to find a healthy lifestyle for their kids when things are so different here. Language is also a barrier for my families as well as transportation. Also, it is a huge mind shift to think about how organized sports are versus just letting your kids just go outside to run and play.

Healthcare providers also discussed limitations specific to their more consultative role in the program, which ultimately limited their engagement with the intervention. The providers who worked to recruit participants noted that they received little to no feedback from their patients after informing them about the project. Often, providers did not know if their patients had followed up and participated or whether the intervention provided benefits. Given that recruitment usually occurred at well-child visits, patients typically would not return to see their provider for another year or more. One provider wondered if other doctors might be more incentivized to recruit for the project if they were able to see the effects of participation on patients’ health more quickly. For the providers that did hear from their patients about having participated, the feedback received was generally positive. Two provider participants said they understood the general concept of the intervention but wanted more specific information about each group meeting’s activities.

Providers reported that due to their own busy schedules, limited time with patients, and a growing number of topics to address during appointments, recruitment for the project was difficult to fit in at the beginning. Once the pediatric clinic began attaching a flier to all patients’ appointment paperwork ahead of time, providers noted that recruitment became much easier as they had a reminder and readily available information. One of the providers discussed potential future directions for the intervention group, suggesting that the intervention could be made more accessible for families by integrating the information into an already-existing program.

**Discussion**

We aimed to examine intervention participant and provider experiences of the HB pilot study, a project that tested the effectiveness of a wellness promotion intervention with families with preschool age children. The data
we collected expand on the existing, albeit small, literature base centered on family and provider experiences with wellness and obesity intervention studies. By the ninth and tenth interviews, redundancies occurred in participant accounts of how their beliefs and perceptions of their own health and bodies had shifted and expanded. The scope of the participants’ experiences is congruent with previous research, which suggests that engaging parents in healthy lifestyle changes can be essential for addressing obesity in child populations (Luckner et al., 2012; Shrewsbury et al., 2011). Taken together, findings underscore the need for culturally relevant, family-centered interventions that meet families where they are in terms of their readiness for change and their health priorities.

A key takeaway from the feedback received from healthcare providers and intervention participants is the importance of maintaining flexibility in the definition of health. This shows up in a variety of contexts, such as physical and emotional health, and involves viewing health as feeling confident and being able to participate in important activities, rather than trying to achieve a certain body type. Participants noted these ideas far more often than they spoke about specific fitness or nutrition routines, and, in fact, several noted appreciating that the intervention group facilitators did not push a specific nutrition “agenda” but rather supported the participants in exploring their own ideas and goals around health.

Beyond the individual-level improvements the parent participants gained from the intervention, the more systemic changes to the family unit further highlight the value of obesity-prevention programs that are grounded in FST. Parents and children were reportedly all making healthier food choices and being more willing to participate in health-related activities. Importantly, these decisions appeared to be driven by increased motivation to be healthy together as a family unit. Such a finding is likely related to the parents’ reports of being more connected to their families after participating in the intervention. As families engaged in more congruent conversations regarding health and food, then family rules, norms, and rituals could be named and challenged. Likewise, when more time could be shared doing physical activities and joint food preparation, families seemed to realize the positive impact that family physical wellness activities could have on their relationships. In turn, this impact may have further increased their motivation for behavior change. Sharing goals across the family unit may have also enhanced behavior change by creating a more supportive environment.

Along a similar line of thinking, every participant noted the benefits of having the intervention presented in a group format – even participants who noted being reluctant to be a part of a group at the start. Having time set aside with other adults who understand the challenges of raising young children while trying to maintain a healthy lifestyle felt supportive and validating. Additionally, participants noted that the other group members’
awareness of their goals and weekly check-ins motivated them to follow through with changes they wanted to make. These are important themes from the interviews that could help shape the format of future health-related groups and are congruent with the evidence that multi-family group interventions are effective for the treatment of childhood illnesses (Distelberg, Williams-Reade, Tapanes, Montgomery, & Pandit, 2014; Lopez-Larrosa, 2013). Group settings that allow families to connect seemed important despite the challenge noted by provider and intervention participants of getting family units to a specific location at the same time, across multiple dates.

Previous prevention programs have fallen short in helping participants make lasting changes to their lifestyle habits. Through the structure of this intervention study, we hoped to target the family as a whole to lead to more systemic change within the family unit. Participant feedback seems to support the achievement of this goal, in that participants felt the process of the intervention left a more lasting impression than the actual content. Supporting families in exploring what healthy means to them and enabling them to formulate ideas for engaging in healthy lifestyle habits in a way that makes the most sense for them allows for change at a deeper level than merely offering nutritional information and exercise routines. Inviting families to participate in this process also allows them to be more flexible, as is necessary in the future, and may offer more “buy in” than a more informational approach. Families can use the skills they cultivated in group to examine and improve their health habits long after the group intervention has ended.

While providers are of course invested in supporting their patients in maintaining a healthy lifestyle, the realities of the healthcare system are such that providers have less and less time to meet with patients. Even finding the time to refer patients to the intervention study was difficult for providers at first, until the process was streamlined and integrated into their normal routine. These study findings were consistent with the barriers identified by Bourgeois et al. (2016) for primary care providers addressing obesity-related behaviors. Because it is so important for PCPs to support families in making healthy lifestyle choices, there needs to be creative thinking about ways to provide opportunities for this support given physicians’ limited time.

Limitations

While the qualitative interviews provided a range of information around what participants and providers found beneficial from the HB intervention group, it is worth noting that the interviews were conducted between a few weeks to a few months following the participants’ initial
involvement in the group. In some ways this was helpful because the interviews gathered their fresh thoughts on the experience. However, this study was not able to examine the potential long-term perspectives or factors that may contribute to participants being able to maintain lasting changes. Another potential study limitation is sampling bias. We cannot be certain of the extent to which study participants represent the total population of HB participants. In short, we do not know how the findings of this study may have varied if all HB intervention recipients or additional healthcare providers had participated. Interpretation of study findings could be skewed more positively due to limitations in the semi-structured interview questions themselves. Despite the redundancy and theoretical saturation of responses of responses, the themes that emerged could have been influenced by the questions asked. This may be a particular limitation when considering the data from the provider interviews. Finally, data collection strategies were based on self-report alone and not verified via multiple data collection strategies (e.g., validated instruments and structured observation). Despite these limitations, this study provided an in-depth qualitative exploration into the experiences of providers and intervention participants with a family physical wellness intervention.

**Clinical implications**

Important implications for clinical service delivery can be gleaned from the present study. First, families had the opportunity to participate in interventions together and therefore could (a) increase their awareness of strengths and areas of concern around health habits, (b) set goals for the family as well as each individual member, and (c) make changes together. As one participant stated, "Families that play together, laugh together, eat healthy food together, are going to have kids that grow up in that type of health environment." In other words, from the voices of participants, we learned that they valued what FST purports regarding a focus on targeting change in the family as a whole. It became clear that families ultimately spent more time together participating in health-related activities, such as cooking and physical activities. Allowing families to join together and increase their health literacy as a unit may also improve family functioning in other important domains, such as communication, cohesion, and intimacy.

While these outcomes were not formally assessed in this study, the information shared by participants does lend support for more comprehensive interventions that address physical, mental, and relational health simultaneously. Participants encompassed a broader, biopsychosocial conceptualization for their family health, clearly articulating how they had
expanded their views and awareness around what it means to be healthy. Family clinicians can capitalize on these expanded views and motivations by helping families to conceptualize their healthcare goals relationally in therapeutic settings. FST clinicians often aim to help families to be aware of and support each other in achieving their individual health goals and they can also guide families in reconciling natural conflicts that may arise between individual and family-level change. Lastly, given the stigma often associated with interventions that address obesity, participants provided justification for healthcare providers approaching clinical conversations with an open mind and helping families define what being healthy means for them. Assessing and increasing motivation for change seems to have helped families execute meaningful changes to their health practices.

**Conclusion**

The perspectives of participants in this study provide a deeper understanding of the experiences of caregivers and providers involved with a group intervention that targets health behaviors and attitudes, particularly related to obesity. Data from this study will provide a foundation for more in-depth inquiry on how family attitudes and beliefs can shift in a systemic and lasting way. For future research studies, we recommend further examination of the interplay of providing concrete health information and a supportive group environment that also helps keep participants accountable. Future research should also carefully attend to process and outcome indicators of longitudinal behavioral health changes that include markers of family functioning. In addition, it would also be important to examine how we can more effectively reach out to community members who may not have enough time or resources to attend a family intervention group across multiple weeks.

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References


**Appendix A**

**Qualitative interview questions**

*For participants*

What has been your experience with the HB project?
What are some of the changes that you have noticed in your family that you think may have something to do with your participation in Healthy Balance? Are there any differences in your relationship with your children/partner since you joined the group?
What are the best parts of the HB groups from your perspective? What changes would you recommend to the HB intervention?
What does “healthy” mean to you?
How have your diet or exercise habits changed?
Your child’s habits? Family’s habits?
Have you noticed any differences in the way you think about diet and exercise?
What was a memorable experience with Healthy Balance?
How would you describe your relationship with food? Exercise?
What factors might make it difficult for you to take what you have learned in the project and use it in your day-to-day life?

*For providers*

What has your experience been being involved in this project?
What do you see as the benefits of a lifestyle intervention like the HB for families with young children?
What do you think motivates people to make changes around healthy lifestyle choices?
What do you think are some barriers to participating in interventions focused on lifestyle?
What was your experience with recruitment for the HB project and similar type projects?
What improvements would you make to the HB project, from what you know about it?