

The Challenge of Preventing and Treating Obesity in Low-Income, Preschool Children

Perceptions of WIC Health Care Professionals

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Background: Obesity has become a common nutritional concern among low-income, preschool children, a primary target population of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Nutrition counseling efforts in WIC target childhood obesity, but new approaches are needed that address the different perceptions about obesity that are held by clients and health care professionals.

Objective: To develop these new approaches, we examined WIC health care professionals' perceptions about the challenges that exist in preventing and managing childhood obesity.

Design: A qualitative study using data transcribed from audiotapes of focus groups and individual interviews. We independently read each transcript and coded themes; then, the common themes were selected through group meetings of the authors.

Setting: Kentucky WIC.

Participants: Of the 19 health care professionals participating, all had provided nutrition counseling in WIC and all but one were white women.

Results: Twelve major themes clustered into 3 domains. The first domain centered on how WIC health care professionals perceived the life experiences, attitudes, and behaviors of the mothers they counseled. They perceived that mothers (1) were focused on surviving their daily, life stresses; (2) used food to cope with these stresses

and as a tool in parenting; (3) had difficulty setting limits with their children around food; (4) lacked knowledge about normal child development and eating behavior; (5) were not committed to sustained behavioral change; and (6) did not believe their overweight children were overweight. The second domain described WIC health care professionals' perceptions of counseling interactions. They felt that (7) they might offend mothers when talking about weight, (8) counseling was driven by protocols, and (9) their nutritional advice often conflicted with the advice from the mothers' relatives, friends, or primary care physicians. The last domain described programmatic suggestions WIC health care professionals offered to address childhood obesity: These included (10) promoting a more client-centered approach to counseling, (11) establishing behavioral change goals that were small and endorsed by the mother, and (12) working with primary care physicians to create a more uniform approach to counseling on obesity.

Conclusions: To become more responsive to the problem of childhood obesity, WIC should consider the following: (1) providing staff training in counseling skills that educate parents on child development and child-rearing and that elicit the client's social context and personal goals, (2) shifting time allocation and programmatic emphasis in the WIC visits away from nutritional risk assessment and toward counseling, and (3) developing collaborations with primary health care providers and community agencies that impact childhood obesity.

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FOR 30 YEARS the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has provided supplemental foods, nutrition education, and health care referrals to low-income mothers and children considered at nutritional risk. Among the concerns that motivated the development of WIC was that many low-income children were inadequately nourished to have optimal growth and development. Although such concerns still exist, obesity is

a far greater nutritional problem facing children enrolled in WIC.¹ The WIC program is evaluating whether its traditional strategies in food supplementation and nutrition counseling are the most appropriate for preventing the problem of obesity in young children.^{2,3} The WIC program has the potential to influence the problem of childhood obesity because almost half of all infants in the United States and one fourth of the 1- to 4-year-olds are enrolled in the program.⁴ The magnitude of the childhood obesity problem, the current lack of proven in-

PARTICIPANTS AND METHODS

To explore the complex and multifaceted topic of obesity, qualitative research methods were used to avoid the use of close-ended questions that often implicitly add the perspective of the researcher.^{7,8} The research was carried out in conjunction with the development of a documentary videotape entitled *Beyond Nutrition Counseling: Reframing the Battle Against Obesity*.⁹ The videotape was part of a larger project called *Fit WIC* whose overall aim was to increase the responsiveness of WIC to the problem of childhood obesity. We designed the videotape to be used as a stimulus when conducting facilitated group discussions among WIC health care professionals to help them identify ways in which the program might be more effective in addressing the problem of childhood obesity.

Between April 11, 2000, and September 19, 2000, we conducted 3 focus groups with a total of 19 health care professionals who had provided nutrition counseling for the Kentucky WIC program. We explored with these health professionals what they perceived as barriers and solutions to addressing the problem of obesity among children enrolled in WIC. In addition, 6 of these health care professionals participated in individual interviews. The institutional review board at Children's Hospital Medical Center, Cincinnati, Ohio, approved the study. Informed consent was obtained from all participants.

The focus groups were assembled through convenience sampling, but they aimed to include the varied types of health professionals that provide nutrition counseling in the Kentucky WIC program. One focus group involved 6 health care professionals from the Nutrition Work Group. The Nutrition Work Group is composed of health care professionals from local WIC agencies across Kentucky, and its function is to meet regularly with state-level WIC administrative staff to discuss program procedures and policy changes in the Kentucky WIC program. Another focus group was conducted with 5 health care professionals from a rural WIC clinic serving 900 WIC participants. The last focus group was composed of 8 health care professionals from an urban WIC clinic serving a caseload of 1400 participants.

Of the 19 health care professionals participating in the focus groups, 7 had backgrounds in clinical nutrition and 12 had nursing backgrounds. All 19 had provided WIC nutrition counseling in the past; 13 were providing it. Of the 13 providing nutrition counseling, 10 had at least 6 years or more of experience. All were female and all, but one, were white. Based on self-reported height and weight, 2 health care professionals had a body mass index (ie, weight, in kilograms, divided by the height, in meters, squared) of 30 kg/m² or higher and 6 had a body mass index of 25 kg/m² or higher.¹⁰

All 3 focus groups lasted 1 hour and were moderated by a trained facilitator (S.N.S.) with the research team. Broad, open-ended questions were followed by probing questions that clarified participant's responses and narrowed the discussion. These questions (available from us) were similar to those previously used with focus groups of mothers of children enrolled in the Kentucky WIC program.⁶

One of us (R.C.W.) observed 2 of the focus groups (Nutrition Work Group and urban WIC clinic) and conducted 20- to 30-minute individual interviews with 3 participants from each of these groups. These 6 interviewees were selected because they were the most articulate during the focus groups. With some of them, we also wanted to explore, in greater depth, particular comments they made in the focus groups that had a potentially more sensitive dimension that might not be revealed in the group setting.

Each focus group and individual interview was transcribed from an audiotape and placed in a computerized transcript database. A "comment" was defined as any uninterrupted utterance in response to a question. Each of the 785 participant comments was assigned a unique comment number. Four of us (L.A.C., S.N.S., S.W.P., R.C.W.) read the transcripts, independently identified common themes, and selected comments as examples of each theme. Twelve major themes were identified by group consensus and then organized into 3 domains. A total of 370 unique comments supported these 12 themes, and 2 comments were chosen as examples of each theme (**Table**). The remaining 415 comments were incomplete thoughts, complete thoughts that could not be organized into any major theme, or brief utterances (eg, yes) that merely expressed agreement with another's statement.

interventions for prevention or treatment of obesity, and the ability of WIC to reach so many children should make all those providing health care to children interested in how WIC addresses the problem of obesity.

There is evidence that the dialogue that is occurring in WIC nutritional counseling sessions between WIC health care professionals and the mothers of preschool children is failing to increase awareness and action in mothers about the problem of obesity in their children. For example, the vast majority of mothers who have overweight preschool children enrolled in WIC do not identify their children as being even "a little overweight,"⁵ and most mothers have views about the definition, cause, and management of obesity that differ greatly from those of most health care professionals.⁶ This gap in perception between those providing nutrition counseling and the mothers receiving that counseling must be better understood before new strategies can be developed to prevent obesity in the WIC population. Having previously examined the perspectives of WIC mothers,⁶ this study explored the perceptions of WIC

health care professionals about the challenges that exist in preventing and managing childhood obesity and about ways these challenges might be met.

RESULTS

DOMAIN 1. PERCEPTIONS ABOUT THE MOTHERS OF CHILDREN ENROLLED IN WIC

Theme 1. Mothers Are in a "Survival Mode" Because of the Challenges They Face in Their Lives

Mothers were described as operating in a survival mode while navigating their complex and ever-changing social circumstances (Table). The stressful and unpredictable lives of these mothers interfered with implementing the nutritional advice that they received from WIC. It was felt that these mothers faced competing demands that often required immediate action and that contrib-

Results of the 3 Domains Studied*

Domain 1. Perceptions About the Mothers of Children Enrolled in WIC

Theme 1: Mothers are in a “survival mode” because of the challenges they face in their lives

“And so, if mom’s stressed out, she’ll let the kids kind of do what they want to do. If it’s eating, taking a bottle or whatever and, so, they do, they use food. And that’s the mom’s choice to let them do what they want to do at the time, if she’s under stress, so that she has that few minutes to herself—being so young, the mothers.”

“If [mothers are concerned about] where they’re going to stay the night or where they’re going to get their next gallon of gas, they’re not going to worry about the Food Guide Pyramid or anything related to nutrition.”

Theme 2: Mothers use food as a coping mechanism and as a parenting tool

“So, I think people start to use food as a reward at a really young age, and it usually tends to be a junk-food type kind of thing, a fast food, or something that’s sweet. And then that pattern establishes itself, so you can’t, it’s really hard to change it.”

“I think it was something that she could do to make him happy, whereas she couldn’t go out and buy him a new present or some new toys. But, the food, she could go out and get him those chicken nuggets and it was something that made him happy and probably quieted him down for a while—and kids learn food is a reward rather than nutrition sometimes.”

Theme 3: Mothers have difficulty setting limits with their children around food

“I said something like, ‘He doesn’t need to eat these chicken nuggets all the time, maybe once a week.’ And she said, ‘But that’s what he likes, that’s where he wants to go to McDonald’s.’ I said, ‘Well he doesn’t drive and he’s not paying, you know, you’re the one who’s doing that.’”

“A lot of times it’s easier for the parents, instead of saying no, you can’t have it, just to say here, you know, here’s some juice, here’s some milk, because they’re not crying and fussing. Parents sometimes tell me that their kids get in the refrigerator and get what they want. The kids are the ones who are deciding what they’re going to eat and when they’re going to eat it and the parents just let them have it.”

Theme 4: Mothers lack knowledge about normal child development and eating behavior

“People don’t understand that babies cry because they’re tired or they’re just overstimulated or their diaper’s wet. A lot of times people think that every time the baby cries that they need a bottle and that every time they cry out, even during sleep, even an older child, that they need to wake up and have a bottle. That’s not always the case. They may be easily comforted, patted, and whatever, and they’ll go back to sleep on their own. Other things can be done; a change of scenery, maybe pick the baby up for a little while.”

“Toddlers, in particular, tend to be picky eaters at certain ages and have variable appetites. And the parents have very unrealistic ideas on what they should be consuming. They think in terms of what they [themselves] consume. ‘Why is this child not eating as much as everybody else in the family and how can they possibly be growing?’”

Theme 5: Mothers are perceived as not motivated or committed to changing behavior

“I think that WIC vouchers and the food are perceived as a program—free food. The counseling that goes with it, they don’t want to hear. It’s just ‘Give me the vouchers and leave me alone.’

“Most of our clients, when they come in, they want you to fix everything right away. And if they can’t see it happening relatively quickly, then it’s like a lost cause, because it’s not happening. Even though the benefit may not come right away, they can’t see that far in the future. I’m thinking, they just want a quick fix. As it related to the diet, they don’t want to put in a lot of time making modifications if they don’t see the weight coming off right away.”

Theme 6: Mothers do not believe their overweight children are overweight

“I have noted that a lot of times the mother or father will not perceive their child as being overweight. And even though they are overweight, sometimes they are actually offended if you say that they are above the 95th percentile. And they’ll say, ‘Well, they’re just large for their age.’ And they don’t see any need to cut back on the fats and sugars in their diet.”

“Usually most of them associate a fat baby as a healthy baby, and they don’t perceive the baby as gaining too much weight. Really, everyone is marveling at that baby and saying ‘Oh, what a big baby. Look at those legs, they’re so big.’ So they see that as something really good.”

Domain 2. Perceptions About WIC’s Nutrition Counseling

Theme 7: Health care professionals fear they will offend the mother

“Well, I never use the word *overweight* or *obese*.”

“A whole lot of times, I’ll just tell them, the child’s above the 95th percentile, and show them on the graph too without actually saying *overweight*.”

Theme 8: The WIC program’s counseling is protocol driven

“Well, I think really the growth chart helps because you can show them. It’s not just talking, you can show them where they should be and where they are.”

“I’ll give them the handouts that we have that describe what the child should be eating, point to them exactly, maybe the areas we are concerned about or where it says that they should not be having these types of food, and say, ‘Take it home.’”

Theme 9: Mothers receive conflicting advice from WIC staff, physicians, and other family members

“We’re telling them one thing, the family doctor may tell them something, and then what they read on that baby food jar or at the store is different. So they’re getting conflicting information.”

“And everybody has their two-cents worth of advice, and if you’re kind of a little bit insecure, especially with that first baby, and you’re young, then you take everybody’s advice and you’re feeding the child everything.”

(continued)

uted to high levels of chaos and low levels of control in their lives. In this context, modifying family dietary patterns was competing in these mothers’ lives against more pressing problems with housing, transportation, employment, and personal relationships.

Theme 2. Mothers Use Food as a Coping Mechanism and as a Parenting Tool

As evidenced in the preceding comment, the health care professionals believed that the high levels of

stress for these mothers caused them to use food as a coping mechanism. Mothers imbued food with functions in parenting beyond providing nutrition. Foods were used to calm, reward, and emotionally nurture their children. The health care professionals felt, for example, that mothers used food to control their children’s behavior by frequently giving their children sugared snacks with low-nutrient density as a reward for good behavior. Food was also viewed as an affordable way of indulging and expressing affection for their child.

Results of the 3 Domains Studied* (cont)

Domain 3. Potential Solutions in the WIC Program for the Problem of Childhood Obesity

Theme 10: Redesign the WIC program to promote a more client-centered approach to counseling

"I think that we'd be more effective if we could just find out where the person is that day and not be required in the 10 minutes we have with them to go through all the information we are required to give them, because it's probably not the right time for them to be hearing it. And we could be more effective in our timing if we counseled more on where the person was, instead of what we were required to cover."

"I feel that WIC is asked to do too many things. The more things that we're asked to do the less well we're going to do counseling. And personally, I feel that my time gets taken up more by income screening, identification, residence, shot records, and blood work. That all is a major hurdle and nutrition is the least of it. If I can make it through all of that stuff, maybe I have time to do nutrition counseling. And if you haven't antagonized the parent in the process of going through all that identification and income screening, you're lucky to have a receptive audience by that stage of the game too, to still have a good rapport. There's a limit to what the WIC program can do, and they need to decide if nutrition is indeed the priority or other things are the priority such as time and staffing."

Theme 11: Set behavioral change goals that are small and that are endorsed by the mother

"But if you can just make a change and work on that particular thing with that person, sometimes that really works out really well. But I think it's easier to make one small change than to make a lot of different things at one time."

"Just choose one thing. It might be just getting your child off Kool Aid®, for the next 3 months or cutting down from 3 cups to 1 cup a day. So, I really try to work with the parent on a goal together and let them establish the goal."

Theme 12: Develop between WIC program staff and physicians a more united and coherent approach to obesity

"I think it [obesity] is more than just WIC's problem. I think it's everybody that comes in contact with that child and that parent. Because then you can be giving subtle messages from a lot of different areas and impact more readily rather than just have it be WIC."

"[The parents are] surprised to see the [growth] chart or they're surprised to see that it's maybe been a trend, maybe for some time and nobody has ever mentioned it, [including] the physician's office. I've been asked, 'Do my doctors use that same chart?' or 'They've never showed me a chart.' So, I think a lot of time, the doctor comes in, they'll do the examination, maybe not focus on the child's weight or even their nutrition at all, unless maybe the mom brings it up."

*WIC indicates Special Supplemental Nutrition Program for Women, Infants, and Children.

Theme 3. Mothers Have Difficulty Setting Limits With Their Children Around Food

In the opinion of these health care professionals, many mothers lacked the knowledge or ability to effectively discipline their children and, as a result, often ended up giving their children whatever they demanded. The health care professionals felt this problem in parenting greatly affected the children's nutrition because mothers were often unable to set limits in their children's diets. The health care professionals spoke often of situations in which the child was exercising too much control over decision making.

Theme 4. Mothers Lack Knowledge About Normal Child Development and Eating Behavior

Another experience familiar to the health care professionals was that the mothers often lacked knowledge about normal child development. This lack of knowledge about child development, as in the case of child discipline, was felt by the health care professionals to affect the maternal-child feeding interaction. For example, the health care professionals reported that it was common for mothers to give children foods and portion sizes that were inappropriate. The health care professionals felt that mothers were often unable to tell when their children's cry, poor mood, or negative behavior was coming from hunger and when it might signal another distress such as fatigue, loneliness, or anxiety.

Theme 5. Mothers Are Perceived as Not Motivated or Committed to Changing Behavior

The health care professionals characterized many of the mothers they counseled as unwilling to make long-term changes in their own or their children's diets. This perception was based on counseling experiences when parents did

not seem to adopt the suggestions that were provided by the health care professionals. The health care professionals perceived that most mothers were primarily interested in solutions that offered immediate results and that many mothers were not interested in nutrition counseling.

Theme 6. Mothers Do Not Believe Their Overweight Children Are Overweight

The health care professionals pointed out that many mothers who had overweight children did not feel their children were overweight. The health care professionals identified this maternal perception as a major obstacle to successful counseling around the prevention or treatment of obesity. When the subject of overweight was raised, even delicately, many mothers appeared offended at the suggestion of such a label for their child. The health care professionals offered some possible explanations for this maternal perception. Mothers might simply feel that a "large" or "plump" child, especially in infancy, was healthier or more attractive. A number of mothers, it was thought, were certain that their overweight child would "outgrow" their weight problem by school age.

DOMAIN 2. PERCEPTIONS ABOUT WIC'S NUTRITION COUNSELING

Theme 7. Health Care Professionals Fear They Will Offend the Mother

The health care professionals were so aware that many mothers were uncomfortable with the suggestion that their child may be overweight or become overweight that the topic of weight was often avoided altogether (Table). Fearful of offending mothers, health care professionals would talk only indirectly about weight, search for the least offensive terminology to describe

the child's weight, or use the growth chart as an objective support of their concern about the child's weight being abnormal.

Theme 8. The WIC Program's Counseling Is Protocol Driven

Although they were aware that obesity was a sensitive subject for many parents, the health care professionals often felt obligated to share nutritional information and growth chart parameters with each client according to the guidelines prescribed in WIC protocols. The health care professionals did not appear comfortable working outside the WIC counseling protocols, especially in addressing the clients' social problems, because "social work" was not part of their formal training as nutrition counselors or their training within the WIC program. This fear of working beyond the protocol was exacerbated by having such a small amount of time for counseling after completing the heavy administrative requirements in certifying an individual for WIC program eligibility.

Theme 9. Mothers Receive Conflicting Advice From WIC Staff, Physicians, and Other Family Members

The health care professionals remarked that mothers often received advice that appeared to contradict what they had been told in WIC nutritional counseling sessions. For example, many WIC clients claim that their pediatricians have not advised them that their child was either overweight or at risk of becoming overweight. The health care professionals felt their credibility and effectiveness was eroded when they provide information that was not corroborated by other health care professionals, especially primary care physicians. Furthermore, members of the extended family, especially grandparents, provided nutrition information based on their own life experiences. Because many WIC clients live with relatives, the clients found it difficult to negotiate the differing opinions between the WIC health care professionals and family members about how best to feed children.

DOMAIN 3. POTENTIAL SOLUTIONS IN THE WIC PROGRAM FOR THE PROBLEM OF CHILDHOOD OBESITY

Theme 10. Redesign the WIC Program to Promote a More Client-Centered Approach to Counseling

The health care professionals felt they needed more time for nutrition counseling and more flexibility to work outside established WIC program protocols so that they could focus their efforts during the counseling session on those needs, even if not purely nutritional, that the client identified as having highest priority (Table). There was also the suggestion that the administrative burdens of the WIC certification process kept health care professionals from having the time to establish the kind of rapport with a client that is required to understand a client's life context and to give advice that is sensitive to that context.

Theme 11. Set Behavioral Change Goals That Are Small and That Are Endorsed by the Mother

The health care professionals recognized that changes in a client's dietary behavior could only occur in small steps. According to these health care professionals, counseling sessions needed to involve changing behavior in small increments with short-term goals that were established in conjunction with the client. The health care professionals also felt that the process of setting nutritional goals should be respectful of the client's social circumstances. Failing to focus on short-term, achievable, client-centered goals was likely to make the client feel overwhelmed and uninterested.

Theme 12. Develop Between WIC Program Staff and Physicians a More United and Coherent Approach to Obesity

These health care professionals felt that the responsibility for preventing obesity in the population of children served by WIC should not be carried by the WIC alone. In particular, they felt that WIC needed the help of community physicians to create a more unified message for parents about childhood obesity. For example, there was concern that physicians may be interpreting the growth charts differently than the WIC health care professionals and communicating messages to the mothers about the children's weight that were different from those being given by WIC staff. The health care professionals found it difficult to express concern to a mother about her child's weight if the child's physician had not also raised the concern. Thus, the health care professionals felt their efforts to discuss obesity with mothers were often undermined by physicians whom the mothers regarded as the more authoritative source of information.

COMMENT

Recent changes in the social and economic environment, ranging from increased television advertising of foods¹¹ to increased portion sizes¹² to increased demands on parents in the workplace¹³ to increased concerns about neighborhood safety,¹⁴ can all present major challenges to parents who are trying to shape the developing dietary and activity patterns of their young children. Thus, the nutritional counseling in WIC can be thought of as an attempt to help parents buffer their children from the many environmental factors that promote obesity.

Based on the results of this and related studies,^{6,15,16} we propose below some possible explanations for why WIC is having difficulty preventing and managing childhood obesity, how WIC might better address the problem, and why these issues in WIC are relevant to those providing health care services to children. While we cannot generalize findings from this qualitative study, the explanations we propose can be evaluated in other settings and with different research designs.

As in much of primary care pediatrics, the counseling in WIC is a dialogue between health care professionals and parents, usually mothers, that occurs about chil-

dren. In this dialogue, the perceptions of each party about the other strongly shape the content and the outcome. Whatever the parent takes away from the dialogue constitutes the causal pathway by which these counseling sessions can affect the child's health. Likewise, what the health care professional takes away is likely to affect future dialogues with that parent and even with other parents. In the dialogue about childhood obesity, we believe there is often an impasse between mothers and WIC health care professionals.

What leads to the impasse? Many WIC health care professionals may understand that their clients have socioeconomic circumstances that affect the perception of obesity and, in turn, the desire or ability to prevent or treat obesity. However, this understanding may not be successfully conveyed to WIC clients. Most health care professionals see that to address obesity, their program needs to move beyond its traditional framework for nutritional counseling. However, neither the time allowed for nutrition counseling in the program nor the content of that counseling appear adequate to address the problem of childhood obesity.

The only way that the WIC health care professional can spend more time on nutrition counseling without increasing costs is to spend less time on the process of certifying families for WIC benefits. This certification customarily requires that clinical encounters in the WIC program begin with a screening evaluation for nutritional risks. Obesity poses a particular problem in relation to this screening process. A growth chart, whose basis may not be accepted or understood by many parents,⁶ is used to define a problem for the child that most parents do not believe exists. In identifying obesity as a health problem or a potential health problem, a condition, already stigmatized, may be added to a long list of nonnutritional problems that already exist for most low-income children. The process may also implicitly blame parents for the problem. The problem-directed counseling that follows risk screening does not allow adequate time to understand the parent's perspectives on obesity. Time is needed, for example, to inquire about whether obesity is even a concern for the parents, about the parents' own history with obesity, and about the specific social context influencing obesity in the family.

Thus, the problem of obesity provides an opportunity for the WIC health care professional to reevaluate the current role of nutritional-risk screening, as it has done recently with dietary risk assessment.¹⁷ In this reevaluation, the WIC program administrators may choose to consider the following: (1) the time that screening now occupies in the already short clinic visit; (2) the way in which the results of the screening, rather than the client, defines the subsequent agenda and atmosphere for counseling; and (3) whether risk identification is the appropriate emphasis for conditions such as obesity in which evidence is lacking that the intervention of the program alone will change the outcome.

Even if more time were reallocated from certification to nutrition counseling, the program may need to consider altering the method and content of the counseling. Such changes might allow a dialogue between health care professionals and clients that generates client-

What This Study Adds

Obesity is an increasing nutritional problem among the large number of low-income children served by the WIC program. Mothers of low-income preschool children do not have the same perceptions about obesity as WIC health care professionals, and exploring these differences in perception may improve obesity prevention strategies in the administration of the WIC program. Although those providing nutrition counseling in the program understand many client perceptions about obesity and the social context that shapes those perceptions, they are often unable to respond to those perceptions because of limitations in their training and programmatic constraints in the WIC program. To be more responsive to the problem of childhood obesity the WIC program should consider (1) expanding the scope of counseling beyond nutrition, (2) shifting programmatic emphasis away from nutritional risk assessment and toward counseling, and (3) developing collaborations with primary health care providers and community agencies that affect childhood obesity.

centered goals for behavior change. To achieve such a paradigm shift, the WIC program administrators should consider providing staff training that emphasizes listening skills to elicit information about the client's social context, barriers to change, and perceptions about obesity. The process of listening is likely to build trust between the health care professional and the client. This, in turn, may also lead to more behavioral change if the client feels that the health care professional has taken time to understand one's life circumstances before giving advice. The technique of motivational interviewing incorporates many of these concepts, and it may provide a useful model for the WIC program administrators to consider in approaching childhood obesity.^{18,19}

The health care professionals reported that, in many cases, the parents were unable to implement nutritional advice without first acquiring a better understanding of their child's development and more capabilities in child-rearing. Thus, to be more responsive to the problem of childhood obesity, WIC health care professionals may need the training to provide anticipatory guidance about normal child development and aspects of parenting such as establishing routines, setting limits, and child discipline.

The WIC program may be able to play a more important role in preventing obesity if it partners with those providing primary health care to children. Aside from the co-location of primary health care and WIC program services, there needs to be more dialogue between WIC program administrators and WIC health care professionals about the services provided, the approaches to nutritional counseling, and the specific messages conveyed. Eliminating duplicate services may allow more time in both health care and WIC program settings for more counseling. In addition, health care professionals and the WIC program need to establish a coherent and unified approach to growth assessment and the use of the growth charts. Primary care providers must use their well-earned influence with families to support the efforts of

those in the WIC program and to avoid the appearance, though likely unintended, of contradicting or undermining the efforts of WIC health care professionals. As has been recently emphasized by the American Academy of Pediatrics, children will be the primary beneficiaries of a closer collaboration between WIC and primary health care professionals.²⁰

Addressing the problem of childhood obesity raises many questions for the WIC program. Among them are whether (1) there should be a different approach to nutritional risk screening, (2) the content of counseling should expand beyond nutrition to include factors influencing obesity such as child development and parenting, and (3) stronger partnerships should be built with the health care provision system or with other community organizations that also have the ability to influence the problem of childhood obesity. Answering these questions will require a broader public and political dialogue about the best way to reshape a program that still has enormous potential to influence the health and well-being of low-income families, but which, like the health care system, is currently struggling to deal with obesity.

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