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## In Our Country *Tortilla* Doesn't Make Us Fat: Cultural Factors Influencing Lifestyle Goal-setting for Overweight and Obese Urban, Latina Patients

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### Abstract

Obesity disproportionately affects Latina adults, and goal-setting is a technique often used to promote lifestyle behavior change and weight loss. To explore the meanings and dimensions of goal-setting in immigrant Latinas, we conducted four focus groups arranged by language ability and country of origin in an urban, public, primary care clinic. We used a narrative analytic approach to identify the following themes: *the immigrant experience*, *family dynamics*, and *health care*. *Support* was a common sub-theme that threaded throughout, with participants relying on the immigrant community, family, and the health care system to support their goals. Participants

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derived satisfaction from setting and achieving goals and emphasized personal willpower as crucial for success. These findings should inform future research on how goal-setting can be used to foster lifestyle behavior change and illustrate the importance of exploring the needs of Latino sub-groups in order to improve lifestyle behaviors in diverse Latino populations.

### Keywords

Latino/Hispanic populations; obesity/overweight; behavior change; exercise/physical activity; health care professionals; goal-setting

Obesity in any population is associated with higher mortality,<sup>1</sup> and an increased risk for multiple co-morbidities.<sup>2,3,4,5</sup> Among the diverse groups constituting the United States (U.S.) adult population, Latinos have the second highest rate of obesity, with 38.7% of Latinos obese compared with 32.4% of non-Latinos.<sup>6</sup> Because of a combination of cultural, social, and genetic factors, 41% of Latina adults in the U.S. are at risk for obesity.<sup>7</sup> Obesity is an emerging public health problem in Latin America as well, with significant social and economic costs.<sup>8,9,10</sup> Yet, several studies suggest the U.S. may be a particularly obesogenic environment since immigrants from Latin American countries often gain weight when they come to the U.S., and the number of years in the U.S. is associated with a higher risk of obesity.<sup>11,12,13</sup> Thus, it may be that Latino populations need culturally appropriate care to reduce this health disparity.<sup>14</sup>

*Goal-setting* is a social cognitive theory-based technique commonly used to promote behavior change in primary care settings.<sup>15,16</sup> Goal-setting processes correspond to the “Agree” component of the 5As behavior change counseling framework (Assess, Advise, Agree, Assist, Arrange) recommended by the U.S. Preventive Services Task Force (USPSTF).<sup>17</sup> Based on USPSTF recommendations, an approach that is consistent with the 5As and includes goal-setting is endorsed by the Affordable Care Act and required by the Centers for Medicare and Medicaid Services (CMS) for provider reimbursement of obesity-related intensive behavioral counseling.<sup>18,19</sup> Despite these endorsements, the evidence is unclear about goal-setting being either appropriate or useful among immigrant Latino populations.

A systematic review of goal-setting for lifestyle behavior change in primary care presented the technique as an effective way to promote diet and physical activity changes across many racial and ethnic groups.<sup>20</sup> That review, however, did not look at findings concerning Latino participants separately, although they have unique medical decision-making preferences<sup>21,22,23</sup> and may be less likely to recognize obesity as a health problem.<sup>24,25</sup> There are known socio-economic,<sup>26</sup> cultural,<sup>27</sup> linguistic,<sup>28</sup> environmental,<sup>29</sup> nutritional,<sup>30</sup> and health literacy factors<sup>31</sup> that may affect the implementation of goal-setting with Latinos. Some studies with Latino subjects have included goal-setting as part of successful, multifaceted lifestyle interventions, or have focused on goal-setting specifically tailored to one area such as physical activity.<sup>32,33</sup> However, no studies that we are aware of have qualitatively examined goal-setting for health promotion purposes with Latino patients.

Several qualitative studies have identified common ways that the immigrant experience affects eating and physical activity that provide anticipatory clues to potential barriers to achieving lifestyle goals in Latino populations. From an analysis of four focus groups with 25 Mexican women, Lindberg and Stevens<sup>34</sup> identified barriers to healthy eating that included less support from family after immigration, social isolation leading to increased stress, and increased abundance of fast food. Participants in this study perceived food in the U.S. to be more processed and less fresh than food eaten in Mexico. Hoke *et al.*<sup>35</sup> also found that time and scheduling restraints related to work schedules in the U.S. made it difficult to prepare healthy food. Other studies confirm those findings.<sup>36–42</sup>

One major critique of this literature is the almost exclusive focus on Mexican or Mexican American populations. Although Mexicans are the largest sub-group of Latinos in the U.S.,<sup>43</sup> the overall Latino population in the U.S. is heterogeneous with regard to country of origin<sup>44</sup> and level of acculturation.<sup>27</sup> Both these factors affect food preferences and lifestyle<sup>45</sup> and may affect goal-setting for weight loss. For example, Ayala *et al.* conducted a study with 357 participants, composed of mostly Mexican immigrants, and found increased consumption of fast food in younger, more acculturated, employed immigrants. In contrast, a study of 1,219 Puerto Rican adults found an inverse relationship between acculturation and obesity,<sup>47</sup> suggesting that lifestyle may actually improve when this population immigrates to the continental U.S. Therefore, a Latino immigrant's place of origin may affect risk of obesity. In New York City, Puerto Ricans and Dominicans represent the majority of the Latino population (at 30.98% and 24.69%, respectively).<sup>48</sup> Mexicans are the next largest Hispanic group in New York City, constituting 13.67% of the Latino population, with the rest from Spanish-speaking Central and South American countries.<sup>48</sup> Consequently, the current literature might not be a good guide to Latinos in New York City and other cities where Mexicans are not the dominant Latino group.

Although the current literature provides insights into experiences that may affect goal-setting processes, none of these studies qualitatively examined goal-setting with Latino patients. Thus, the purpose of this qualitative study was to explore the meanings and dimensions of goal-setting for weight loss and lifestyle behavior change in urban, Latinas in the primary care setting. Secondly, we sought to identify unique factors that might contribute to overweight and obesity in Latinas (thus affecting the types of goals they set) and inform strategies for health care providers and systems to effectively promote goal-setting for behavior change in this population.

## Methods

We conducted an exploratory qualitative study using a narrative analytic approach to examine the meaning and dimensions of the phenomenon of goal-setting in immigrant Latinas. Narrative analysis closely examines how participants tell the story of their experiences<sup>49</sup> and, because goal-setting is a time structured event, narrative analysis also fits well with analyzing time-related experiences.<sup>50</sup> Since our study involved language translation, narrative analysis also fits better than other qualitative approaches because the stories told are examined as wholes and there is less risk for loss of conceptual meaning due to translation.<sup>51,52</sup> Culturally, Latinos often share experiences through storytelling,<sup>53</sup> so

encouraging narratives as a way to answer a question ensured the method was culturally congruent with the study's sample.

### **Setting, participants, and recruitment.**

We used purposive sampling to recruit Latinas for the study from New York City's largest free-standing public clinic. There the patient population is largely Latino and most providers have basic discourse competence in Spanish. Participant eligibility criteria included overweight or obese (BMI  $\geq 25$ ) Latinas over the age of 18. Although we initially aimed to include patients from any Latin American country, we discovered early in the recruitment process that there were too few patients from Central and South American countries attending the clinic to have separate focus groups. We decided to limit recruitment to self-identified immigrant patients from the Dominican Republic (DR), Puerto Rico (PR), and Mexico to reflect the dominant demographics of the New York City Latino population that patronizes public clinics. We planned to conduct three to five focus groups with six to 12 participants in each one until we achieved data saturation. In focus group studies, saturation is often achieved after three to four focus groups.<sup>54</sup>

Trained research assistants approached 235 patients in the clinic waiting room to invite them to participate and to screen for eligibility. Of those, 131 declined to participate. Out of the 104 willing to participate, 21 were excluded, eight did not meet the BMI criteria, and 13 were from Central or South America. Research assistants then called the 83 eligible patients, and of those, approximately 40 were scheduled to attend. We organized focus groups by country/region of origin and language preference to ensure cultural and linguistic congruency within the groups.

### **Focus group interview guide development.**

After consulting with a medical anthropologist who had extensive experience conducting research with Latino populations, we developed an interview guide based on existing evidence related to our study's aims. We designed the questions to elicit patient narratives that would reflect their understanding of, preferences for, and barriers and facilitators to goal-setting while reflecting on experiences with their local health care system (providers and settings) with regard to lifestyle behavior change counseling. The New York University School of Medicine and New York City Health and Hospitals Corporation Institutional Review Boards approved the protocol and all study materials and consent forms in both English and Spanish.

### **Data collection.**

We conducted the majority of the focus groups in Spanish with only one held in English because of participant preference. Investigators first read the consent form to participants and then obtained written informed consent from each person. Participants then completed a 16-item questionnaire on demographic information. We determined body mass index through self-reported weight and height.<sup>55</sup> We opted not to weigh participants before the session because a private screening area was not available and we did not want to cause stress to participants by weighing them publicly.

Bilingual colleagues moderated the focus groups. Each session lasted one and one half hours and was digitally audio-recorded. At least one team member was present to take notes during the sessions. A bilingual, native Spanish-speaking translator transcribed the recordings verbatim and then translated them into English. Translations were checked for accuracy prior to analysis. We achieved data saturation after four focus groups.

### Data analysis.

Our approach to data analysis was iterative. Using a qualitative data management software (ATLAS.ti qualitative data analysis software; ATLAS.ti Scientific Software Development GmbH Version 7, 2012.), we analyzed transcripts using axial coding methods focused on the stories told to answer the questions. Two investigators coded the English translation versions of the four transcripts (MJ, DG), while the translator, who did not attend focus groups, coded all original transcripts in the language spoken by the participants. This process served as both confirmability and dependability checks for the analysis. The three coders worked independently and then discussed findings with the larger research team at regular intervals (seven times over eight weeks) to examine the coding process, correct previously unnoticed translation errors, harmonize the terminology used by the coders, and identify patterns and themes.

### Results

Twenty-five immigrant Latinas participated in the four focus groups, with an average of six participants in each group, and Table 1 reports their demographic characteristics. One group comprised Mexican women, one had a mix of participants from PR and the DR, another was heterogeneous with respect to country of origin from Spanish-speaking Latin America, and the last was an English-language focus group with participants from PR and the DR.

Participants ranged in age from 23–77 years with a mean age of 59 (SD=14). Puerto Ricans constituted 40% of the participants, 24% were Dominican, 32% came from Mexico, and one participant was from Colombia. The Colombian participant had originally been screened but not selected because she did not meet the inclusion criteria based on country of origin. However, we decided that asking her to leave would negatively affect group dynamics. Based on our transcript analysis, we determined that her presence did not significantly affect our findings. Participant BMI ranged from 21–40, with a mean BMI of 30 (SD=4.6). One person brought her previously obese daughter, who had lost over 100 pounds and had a current BMI of 21. Although she did not meet our original inclusion criteria, we decided that her perspective would be valuable. On average, the women had been in the U.S. for 31.84 years (SD=16.88).

Three themes related to goal-setting emerged from our analysis: *the immigrant experience*, *family dynamics*, and *health care*. Additionally, *support* from friends, family, and health care providers appeared as a sub-theme that threaded throughout the three major themes. Categories that emerged from the coding process that helped explain the dimensions of goal-setting included *causes and consequences of weight gain* and *barriers and facilitators to goal-setting*. We defined causes as reasons that participants cited for their weight gain, often beyond their control, and consequences as results of weight gain and/or unhealthy lifestyle

choices. Barriers and facilitators to goal-setting derived from multiple sources, ranging from the individual herself to the health care system at large. Box 1 details these four categories and illustrates the complexity that could be involved with goal-setting in these groups.

Generally, participants demonstrated knowledge about the medical consequences of obesity. In every group, participants listed common health problems associated with obesity (e.g., heart disease, diabetes, hypertension, arthritis) without much prompting. This finding suggests that lack of knowledge about the consequences of obesity was not a barrier to goal-setting. Participants also cited many health benefits to losing weight, and believed they should maintain a healthy weight.

Key differences between groups emerged that could influence the effectiveness of goal-setting for lifestyle behavior change during obesity counseling. These included traditional food preferences specific to their country of origin (e.g., tortillas vs. rice), eating schedules in their home countries, and beliefs about harms and benefits of individual foods. For example, several participants in the group from Mexico discussed how plain water (i.e., water not containing additives or sweeteners) caused them to feel “nauseated,” but this did not come up in the other groups.

Overall, participants defined the term “goal” similarly. They described goals as what individuals wish to achieve in the long term that usually represent an improvement over their current status (e.g., losing a specific amount of weight, eating more vegetables, walking 10 blocks per day) and plans as the daily steps individuals need to take to reach these goals (e.g., buying carrots, setting a date to walk with a friend) but often used the terms *goal* and *plan* interchangeably. We found that participants in the English-speaking group, with origins from PR and the DR, could better verbalize the difference between a goal (*meta*) and plan (*plan*). This group was more educated (all participants had completed high school), which may explain the difference. However, all women expressed the idea that goals were important and derived satisfaction from setting and achieving goals in their daily lives in the domains of work, education, family (including family planning), and lifestyle.

Additionally, the concepts of personal willpower and motivation emerged frequently in each group. While support from community, family, and health care providers was seen as critical, participants placed an even stronger emphasis on individual willpower as an important factor in determining whether they could stick to their lifestyle goals and lose weight. The following passage (translated from Spanish—heterogeneous group) illustrates this dynamic.

Participant A: Oneself, I think so. Part of that is to put the will on that.

Participant B: To put the will on that, make a deal with oneself.

Participant C: Because if you don't have the will you're not going to lose [weight].

The following discussion defines and describes the three major themes that emerged from our analysis, presented by illustrating commonalities and differences between the groups.<sup>56,57</sup> The analysis illustrates the complexity of factors that can potentially influence a Latina's ability to make and achieve goals centered on lifestyle behavior change.

### The immigrant experience.

Changing countries had a profound impact on participants' goal-setting processes and lifestyle choices. Despite wide variation in participant demographics, the immigrant experience strongly influenced their orientation and attitudes toward healthy living for all participants. Women in all the groups compared their food choices in their home country with those in the U.S. They expressed pride in their ability to prepare delicious, traditional foods in a healthful way and reminisced about the dishes prepared and served in their home countries. They perceived adapting traditional dishes to include healthier ingredients as a primary way to maintain a healthy lifestyle while allowing them to keep their traditional food patterns. Despite this, they overwhelmingly agreed that they gained weight when they came to the U.S. (translated from Spanish–Mexican group):

Participant E: I came here thin, thin, thin . . . And I gained a lot of weight.

Participant F: Yes, thin like a stick.

Participant G: Three years and I gained like this. I went to Mexico and I lost weight; I came back here and the same.

As a result, most of the participants expressed the belief that the food and food quality is different in the U.S. compared with food in their home countries and that these differences cause weight gain. Although they agreed and acknowledged that traditional foods are not always healthy, they believed that they did not gain as much weight when they ate them in their home countries.

We also found a pervasive belief that “chemicals in the food” in the U.S. cause weight gain. The topic emerged in the three Spanish-speaking focus groups with some mention in the English-speaking group. Generally, this issue arose as a way to emphasize their lack of agency to control what they eat and as a factor they felt could potentially interfere with their perceived ability to achieve dietary goals. In the Mexican group, this topic arose continually throughout the session (translated from Spanish—Mexican group).

Participant H: For me food here is mixed with chemistry . . .

Participant I: Because there are a lot of chemicals.

Participant H: That's the word I was looking for.

Participant J: . . . this food has a lot of sodium,

Participant I:—um-hmm, a lot of chemicals and a lot of fertilizers.

Participant J: And that's what swells you.

Participant H: Yes, the chemicals. In our country *tortilla* doesn't make us fat, and here it makes us fat.

In addition to chemicals, they believed that the food in their countries was fresher because it came directly from the garden or from a tree. Participants saw foods obtained directly from the source of production as more natural and thus, less weight-inducing. They viewed organic foods as the closest equivalent in the U.S., but reported that cost prohibited integration of these foods into their diets.

The lifestyle changes driven by the immigrant experience also increased women's stress levels and further contributed to difficulty achieving lifestyle goals. Furthermore, women reported skipping meals in the U.S. because of the faster pace of life and less time available to prepare food. This was true whether or not they were employed outside the home. They linked the immigrant experience to stress, anxiety, and depression as barriers to behavior change with specific references to those things as reasons for overeating, increased fast food consumption, and/or eating at night.

The immigrant experience also changed child-rearing patterns and family caregiving patterns, both of which led to decreased support for initiating and maintaining healthy lifestyles. Participants also identified personal health problems, limited English proficiency, and economic pressure as immigration-related stressors. All these affected personal willpower and were named as barriers to behavior change.

With individual and familial changes causing stress, participants sought support from their immigrant communities, and, similarly, wanted to support other immigrants. Women stated that they attempted to provide support for others in multiple ways, including offering advice, offering to work together with another person to achieve common goals (e.g., going for a walk every morning), and sharing available resources (e.g., the Naturally Occurring Retirement Community services for seniors).

Seeking community support was a dynamic that also emerged within the three Spanish-speaking focus groups. Women offered to cook for each other, help provide respite care for sick family members, partner to achieve common goals, and suggested places where they could meet in the future. The focus group sessions created an additional space where participants shared ways to make healthier lifestyle choices and traded recipes. This supportive dynamic was not as evident within the English-speaking group.

Some women expressed frustration when their "supportive" efforts were not effective in helping community members. They believed that negative health consequences occurred when others failed to follow their advice or that of other members of the community. For example, one participant described trying to help a friend change his unhealthy behaviors without success (translated from Spanish—PR/DR group):

I have a person I am helping . . . I was telling that person. "Look don't drink soda." Well he was drinking the whole bottle of soda. . . and I was like, "Listen this is too much sugar." Now he is blind, he has high [blood] pressure, he's heartsick . . . I told him many times that he got blind because of drinking soda . . . There are many things that are harmful and people don't see that, you say something and they think you're a know-it-all.

### **Health care.**

Many factors influenced the women's experiences with the health care system, including their economic mobility, language ability, length of time in the U.S., and economic/insurance factors. Overall, the "health care" theme reflects how interactions with providers and the system influenced goal-setting in the lives of focus group participants. Again, *support* emerged as a strong underlying sub-theme with providers as the source. Participants



categorized health care providers as either barriers or facilitators to weight management depending on how they communicated and interacted with them during the visit. Participants named physicians and nutritionists as being their main source of counseling and information about how to lose weight and make healthy lifestyle choices. Only one mention of nurses occurred and referred to a visiting nurse. Otherwise, participants did not mention nurses, nurse practitioners, and physician assistants in the interviews. This is likely because the clinic where most of the women obtain care does not have mid-level providers on staff, and nurses there do not provide lifestyle counseling.

Interestingly, several narratives emphasized how a provider's general communication style, rather than language concordance itself, could impede motivation for healthy lifestyle change. It became clear that the quality of the provider-patient relationship played a central role in goal-setting and healthy lifestyle choices. The women expressed the need for a sustained relationship with their providers and wanted providers to know them as individuals. They valued the opportunity to meet with nutritionists, but stated that they discussed weight more frequently with their primary care providers.

Both nutritionists and physicians, however, could hinder healthy behavior change when they failed to work together with the patient on goal-setting. For example, participants described feeling frustrated when providers told them to lose weight without offering specific suggestions and planning advice (English language PR/DR group):

Like I went to my doctor last week and she just told me, "Oh, I see here that you're a little bit of overweight." And just in my head I was like of course you just see me, of course you know I'm overweight. But she didn't tell me what I should do, she just told me I was a little bit overweight . . . they should maybe advise us, "Oh, I recommend you to do this," "Why don't you try this, or try that?"

In another clue to preferred communication styles around goal-setting, participants wanted providers to give structured advice that was relevant to them as individuals. They expressed a desire to have engaged health care providers who would adequately assess their individual needs and preferences and then collaboratively set behavior change goals. Participants suggested that providers work with patients to take small and attainable first steps early on to work toward the larger goals (originally in English—PR/DR group):

This just has to start, little by little. The person tells them, you know "Start by walking two minutes in your house from here to whatever if you have stairs, you know, go up the stairs, five or six times, until you start getting used to walking," and then they're gonna' notice like they're gonna' feel better, so. Those just work the way up to those 10, 20 minutes that the doctor wants them to walk.

Participants also emphasized the importance of support, encouragement, and continued follow-up to build lasting momentum toward change.

A surprising consensus about a provider's weight arose in the mixed focus group. Participants viewed providers who appeared fit and not overweight as more credible than others when giving advice about diet, exercise, and healthy lifestyles. One participant

summarized the group's perceptions as follows (translated from Spanish—heterogeneous group):

Because if you're a [provider] you're supposed to be thin and things like that, but how can a [provider] ask you to lose weight if it looks like they're not following the advice they're giving the patient.

Although it is difficult to generalize based on one group, this finding suggests that some participants will associate appearance with a provider's own lifestyle choices, that appearance may be associated with the credibility of the advice presented, and subsequently, may affect a Latina's implementation of lifestyle modification advice.

At the organizational level, participants wanted to see regular, low-cost weight management and healthy lifestyle programs to support their goals. They welcomed support groups and other in-person, group activities as strategies that they believed facilitated goal-setting and lifestyle changes resulting in weight loss and improved health. One participant also linked provider advocacy, or lack thereof, to the presence of organizationally supported groups (translated from Spanish—DR/PR group):

There used to be [more services] but the government has been cutting a lot of things, because doctors and nurses aren't being stronger to fight against the government. That's how I see it, okay? There are a lot of restrictions, and they should understand that.

In addition to programs and groups, participants wanted individual and public health agencies to provide more access to visual and audio-visual materials to support learning. They specifically mentioned educational materials in the form of pamphlets and messages on television as ways to inform and support making and achieving healthy lifestyle goals in the Latino population. One participant in the English-speaking group wanted organizations to provide a list of credible websites as resources that they would use for healthy lifestyle choices. Multiple participants suggested the use of media as a helpful strategy to disseminate information about healthy lifestyle choices to all age groups.

### **Family dynamics.**

Participants described how family members could be either supportive or unsupportive of goal-setting and healthy lifestyle choices. The women often humorously described how relationships with and responsibilities to family members could be both rewarding and frustrating. These dynamics influenced their ability to achieve their own lifestyle goals.

Supportive actions for healthy lifestyles for their families often included cooking healthy foods and modeling healthy behaviors for their children (English language PR/DR group):

I use olive oil in my rice, I don't put salt and I've been doing that for several years. My daughter likes it. When she goes to Grandma's, she says "Mom, Grandma's rice tastes different," and of course, I know she likes it [laughter] but we don't go there a lot.

The participants felt they worked hard to keep their families healthy and, as with community members, expressed frustration that the support they gave to help their family improve

lifestyle did not always lead to positive behavior changes (translated from Spanish—heterogeneous group):

My husband shouldn't eat salt because he has high pressure . . . So I try to cook his food apart, right? . . . but what happens, that the little man comes and eats what I prepared for him and then he eats what I cooked for the rest too [laughter] so he's already getting sick.

Family care-giving responsibilities were therefore both barriers and facilitators to goal-setting, and sometimes even had unexpected benefits. One woman described how learning healthy behaviors (e.g., how to prepare salad) from a visiting nurse assigned to her dependents helped her make healthy changes for herself (translated from Spanish—DR/PR group):

For example my mom had a nurse who was really good. As long as she was with my mom, I was eating healthy because she was preparing salad for my mom so I was forcing myself to eat salad . . . it's really hard to prepare salad . . . she used to rinse [the vegetables] and I used to prepare it.

Some participants commented that they felt obligated and motivated to stay healthy themselves so that they could continue to care for others who depended on them, while other participants perceived accountability to their children's concerns regarding their health and wellness habits as helpful to adhere to dietary goals. Expectations from children could be particularly powerful but psychologically complex motivators to achieve goals or plans, as illustrated by the following participant's comments (translated from Spanish—DR/PR group):

Participant K: For me, a goal is that my son sends me every day to walk [laughter]. And he's like that I have to lose weight . . .

Participant L: That's a good thing. He proposed something for you, that's a goal, that's good.

Participant M: But she doesn't want it, the son is [making the goal for her].

Participant K: I don't want that.

Participant M: It's an obligation.

In summary, although participants viewed family support as an important factor for generating and maintaining motivation to achieve healthy lifestyle goals, they did not always view the support strategies employed by family members as uniformly helpful.

## Discussion

Our study identified important meanings and dimensions with regard to goal-setting for facilitating lifestyle behavior change in Latinas. Processes of goal-setting for healthy lifestyle changes may be influenced by factors grounded in individual, familial, health system, and immigration experiences. We found that regardless of country of origin, Latina patients living in New York City provided similar examples of goal-setting, and that they almost all set goals in their daily lives.

Despite these similarities, our findings also highlight the importance of accounting for individual and region-specific factors that might affect goal-setting. Many studies of Latinos collapse findings across groups and this diminishes the rich cultural differences among various groups of Latin Americans in the U.S.<sup>36,58,59</sup> Avoiding assumptions of homogeneity may facilitate patient-centered goal-setting. Goal-setting, therefore, is a potentially useful tool to promote lifestyle behavior change as long as the individual's context and interaction with their environment is well understood and appreciated.

Goal-setting for healthy lifestyle changes is complex in most populations and, for immigrant women, has added layers of complexity due to the immigrant experience, language barriers, their interactions with the health care system, and their family dynamics. The choice to migrate is itself a life-altering goal, driven by both individual factors and the desire to improve quality of life for family members. With that in mind, a goal-setting approach to lifestyle change can be useful for providers working with Latino immigrant populations.

Bandura's self-efficacy theory<sup>60,61,62</sup> may offer an organizing framework that is useful for clinicians using goal-setting with Latina patients. According to Bandura, people with high self-efficacy or strong belief that they can accomplish a task or goal, are more likely to view that endpoint as attainable. In other words, one's sense of self-efficacy can affect motivation and play a major role in how one approaches goals, tasks and challenges related to behavior change.<sup>62</sup> Other studies have demonstrated the usefulness of the theory when applied to Latino populations and lifestyle-related behavior changes.<sup>63,64</sup> Our participants emphasized that personal motivation and willpower were important determinants of positive behavior change, thus highlighting the need for clinicians to support patients' self-efficacy in order to improve motivation. We also found factors that may negatively affect self-efficacy, such as perceived inability of participants to control their food environments (e.g., the source of their food and the "chemicals" added), the immigration-related stressors that affected mental health, and family obligations that affected their ability to control their eating schedules. Similar factors have been described in other qualitative studies of Latinas from Mexico and the Dominican Republic.<sup>65,34</sup>

Participants provided some direction about how clinicians can support Latinas' self efficacy to help them achieve goals. Our participants endorsed the view that clinicians should advise patients to start with small specific goals (e.g., walking two blocks, as one participant mentioned) and then work their way to larger goals. Evidence supports the importance of specific and proximal goals<sup>15</sup> as well as SMART goals (Specific, Measurable, Achievable, Relevant, and Timed) for lifestyle changes.<sup>66</sup> A similar approach was taken in a study with 56 Latino participants, where they successfully used goal-setting as part of a larger weight loss intervention that included diet and exercise.<sup>33</sup> Additional research is needed to determine which approach is optimal for Latino patients. Furthermore, since our participants showed resistance to being told to change behaviors by family members and providers, clinicians may be more effective if they elicit a patients' own goals rather than suggesting to the patient what to change. Providers can learn to elicit a patient's preferences and ideas using goal-setting techniques such as Brief Action Planning (BAP),<sup>67</sup> which is consistent with the theory and supporting evidence for Motivational Interviewing (MI). Motivational Interviewing is a counseling method used to elicit behavior change by encouraging patients

to identify and manage ambivalence.<sup>68</sup> When applying the “spirit of MI,” practitioners evoke a patients’ own motivation for change rather than attempting to instill it.<sup>68</sup> Of course, in order to practice these skills with Spanish-speaking Latina patients, health care team members must be fluent in Spanish. This underscores the need to train and recruit Spanish-speaking clinicians.

In addition, our study highlights both the positive and negative traits of Latino family dynamics that may influence goal-setting and that women may seek additional support from the community. Providing venues for Latinas to come together may be a way for health care providers to further support behavior change goals. Community-based, group weight management programs are often effective in promoting weight loss and would fit well within the Latina cultural dynamic.<sup>33,69</sup>

We were somewhat surprised that some common findings in the literature did not emerge in our study. For example, we anticipated that language would be mentioned more frequently as a barrier to healthy behavior change. Although participants perceived lack of education and English language proficiency as strong financial barriers, they did not perceive language itself as a hindrance to setting goals. This might be because of the large number of Latino immigrants in New York City or because most providers speak Spanish at the clinic where we conducted the study. We were also surprised that religion did not come up spontaneously in the group sessions since religion or spirituality often play an important role in many aspects of Latino cultures.<sup>70</sup> It is unclear whether this is because the moderators did not ask enough questions about religion. However, Campesino and Schwartz *et al.* describe two common spiritual values in Latinas that may be more important than religious affiliation and church attendance—*personalismo* (closeness and empathy in personal relationships and a personal relationship with the divine) and *familismo* (loyalty to family).<sup>71</sup> These values were certainly apparent in our focus group discussions. Future studies should further explore the impact of religion and spirituality on goal-setting.

Like all qualitative studies, our first limitation centers on our inability to generalize findings and, in the case of a focus group approach, the possibility of groups being biased by particular participants.<sup>72</sup> The natural overlaps that occur in group discussions also made some parts of the audio difficult to transcribe, also a known challenge of focus group data collection approaches. We lost some data from the English-speaking group because of a technical issue with the digital recorders. Although we took notes, we might have missed some data generated by this group. Another limitation came from our methodological choice to use three different moderators for the four groups. Differences in style and perspective might have elicited different responses, making it difficult to say whether differences in findings between groups reflected differences in ethnicity or language rather than moderator style. However, there may be some counter-balancing strengths to using different moderators in eliciting different aspects of the topic guide. We used self-reported height and weight, which may bias our descriptive data. Since women commonly underestimate weight and overestimate height,<sup>73</sup> the mean BMI reported in Table 1 is possibly an underestimate. Finally, logistical difficulties precluded our ability to present our findings back to the focus group participants for further confirmation.

In conclusion, our study supports the use of goal-setting as a potentially effective strategy for health care providers working with Latina patients. It also suggests that current goal-setting models and techniques (such as the use of SMART goals, Brief Action Planning, and Motivational Interviewing) may be effective in this particular Latina population but this requires further testing. Finally, the themes that emerged from our study provide guidance for future studies exploring goal-setting in Latina patients for lifestyle behavior change and weight loss.

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**Box 1.**  
**MAJOR CATEGORIES OF PARTICIPANT  
 RESPONSES**

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**Causes and Consequences of Weight Gain**

- Mental health issues
- Medications
- Pain
- Food choices/availability
- Chronic disease
- Weight-related stigma
- Family obligations<sup>a</sup>
- Scheduling constraints<sup>a</sup>
- Food effects (e.g. chemicals in food)<sup>a</sup>
- Media<sup>a</sup>

**Barriers and Facilitators to Goal Setting**

- Willpower or lack of willpower
- Family support or family obligations
- Social support or lack of social support
- Relationship with healthcare provider
- Education or lack of education
- Access to healthy/unhealthy food
- Outcome expectancy
- Mental health issues<sup>b</sup>
- Work (housework, childcare, outside employment)<sup>b</sup>
- Cost of food<sup>b</sup>
- Weight-related stigma<sup>b</sup>
- Food effects (e.g. water causing nausea)<sup>b</sup>

<sup>a</sup> Only a cause

<sup>b</sup> Only a barrier

**Table 1.****CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS**

Age (years)	
Mean (SD): 59.08 (13.95)	
Range: 23–77	
< 30	2 (8.0)
30–45	1 (4.0)
46–60	6 (24.0)
>60	16 (64.0)
BMI	
Mean (SD): 29.96 (4.64)	
Range: 21– 40	
<25	2 (8.0)
25–30	11 (44.0)
>30	12 (48.0)
Country of Origin	
Mexico	8 (32.0)
Puerto Rico	10 (40.0)
Dominican Republic	6 (24.0)
Colombia	1 (4.0)
Education Level	
< High school graduate	15 (60.0)
High school graduate	4 (16.0)
> High school graduate	4 (16.0)
No response	2 (8.0)
Language Spoken at Home	
Spanish	20 (80.0)
English	3 (12.0)
Both English and Spanish	2 (8.0)
Years Living in the US	
Mean (SD): 31.84 (16.88)	
Range: 10– 61	
<10	0
10– 20	10 (40.0)
21– 35	5 (20.0)