Exploring the Meaning of Excess Child Weight and Health: Shared Viewpoints of Mexican Parents of Preschool Children

Leigh Small
Bernadette Mazurek Melnyk
Deborah Anderson-Gifford
Jeffrey S. Hampi

In the United States, the prevalence of childhood overweight and obesity has reached epidemic levels, with U.S. Hispanic children, a sub-group mainly composed of children of Mexican decent, disproportionately affected. Prior research has suggested that Mexican parents may view overweight in early childhood as desirable; however, it is unclear if this is still the case. Therefore, this qualitative study explored the beliefs of 11 Mexican parents of preschoolers regarding weight and health. Following coding and clustering of themes from the transcribed audio-recorded meetings, six patterns were identified: (a) meanings and relationships about excess weight in childhood and child health, (b) causes of overweight and obesity, (c) uncertainty about knowing and not knowing, (d) from Mexico to America: enticements of a new land and time as a commodity, (e) the effects of society on personal and parental goals: the work of parenting in the United States, and (f) identified needs and action strategies. In summary, parents involved in this group discussion readily associated overweight/obesity with poor mental and physical health; however, they were uncertain how they would “know” if their children were overweight.

Overweight and obesity are now estimated to affect an alarming 65% of U.S. adults, 37% of children 6 to 11 years of age, and 21% of preschool U.S. children 3 to 6 years of age (Institute of Medicine of the National Academies of Sciences [IOM], 2006; Ogden et al., 2006). Despite this alarming prevalence, there is a paucity of available research evidence to support effective methods to prevent or treat overweight in children (Kirk, Scott, & Daniels, 2005; Melnyk, Small, & Moore, 2009; Small, Anderson, & Melnyk, 2007; Stice, Shaw, & Marti, 2006; Summerbell et al., 2005, which leaves little direction for pediatric health care providers charged to care for children and their parents facing this issue. This discordant state has created an urgent need for evidence-based, healthy weight programs to avoid the development of chronic childhood health conditions that may persist into later adult life (Olszanski et al., 2005). However, creation and testing of effective prevention or treatment programs are contingent upon parental acknowledgment that excess child weight is unhealthy or may have negative health ramifications.

The purpose of this exploratory, qualitative study was to describe the meaning of overweight and its relationship to health as perceived by Mexican immigrant parents of preschool children. Understanding the relationship between health and weight from the perspective of Mexican parents is fundamental to learning if prevention or treatment intervention strategies would be culturally acceptable and relevant.

Objectives and the CNE posttest can be found on pages 367-368.

Review of the Literature

It has become widely publicized in both lay and scientific literature in the United States that the incidence of childhood overweight (greater than the 85th body mass index [BMI] percentile) has rapidly increased (Ogden et al., 2006). This contemporary childhood phenomenon has reached epidemic proportions, with the prevalence of overweight tripling in the last three decades (Flegal, Ogden, Wei, Kuczmarski, & Clifton, 2001; Hedley et al., 2004; Ogden et al., 2006; Summerbell et al., 2005). However, it is not widely recognized that these increased prevalence rates extend to the preschool child population (3 to 6 years of age) (Kuczmarski et al., 2002; Lycznicki, Young, Riggs, & Davis, 2001; Ogden et al., 2006). Estimates of overweight or obesity gained from census data are as high as 60%.
as 40% to 50% for U.S. Hispanic preschoolers and school-aged children (Ogden et al., 2006; Treviño et al., 1999). This high prevalence within this ethnic sub-population of children is significant given that excess weight in childhood often tracks into adulthood (Fontaine, Redden, Want, Westfall, & Allison, 2003; Guo, Wu, Chumlea, & Roche, 2002; Krebs, Jacobson, & the American Academy of Pediatrics, 2003; Whitaker, Wright, Pepe, Seidell, & Dietz, 1997). Additionally, overweight at any age is associated with a number of comorbid and chronic health conditions, which include type 2 diabetes mellitus, cardiovascular disease, metabolic syndrome, increased asthma symptoms, sleep apnea, and mental health disorders, such as depression (Lynziicki et al., 2001; Ogden et al., 2006; Olshansky et al., 2005).

A Critical Period of Weight Development: Adiposity Rebound

Factors that predict adult obesity cluster around the time of adiposity rebound and can be identified early in childhood. Adiposity rebound is thought to be a critical time of fat (adipose tissue) development in young children during which excess infant adiposity, sometimes referred to as “baby fat,” and BMI decline and then begins its increase, which continues throughout life. Adiposity rebound routinely occurs between the ages of 5 and 7 years (Dietz, 2003; Whitaker, Pepe, Wright, Seidel, & Dietz, 1998; Wiseman, Maynard, Guo, & Siervogel, 2000); therefore, overweight and obesity prevention and treatment intervention strategies that occur during or prior to this time are likely to alter children’s growth trajectories and halt the process of excess weight development.

Prevalence of Overweight and Obesity in Mexican Children

It has been estimated that Mexicans may comprise 66% of the U.S. Hispanic population (Borrell, 2005; Eló, Turrá, Kestenbaum, & Ferguson, 2004; MacDonnman, Minino, Stroblino, & Gug, 2002), and current national estimates indicate that Mexican immigrant children constitute the largest increase (up to 90%) of the growth of the general U.S. immigrant population (Borrell, 2005; MacDonnman et al., 2002). National cohort studies based upon the National Health and Nutrition Examination Survey (NHANES) II and III data sets have compared the prevalence trends of overweight and obesity in children (6 to 11 years and 12 to 17 years) with regard to age, gender, and ethnicity as reported by parents/legal guardians. These study findings have consistently identified higher rates of Hispanic children in the 85th and 95th weight percentiles compared to the total number of U.S. children within the 6 to 11-year-old sub-group, as well as the non-Hispanic White and non-Hispanic Black child sub-groups (Fontaine et al., 2003; Ogden, Flegal, Carroll, & Johnson, 2002; Olshansky et al., 2005). This finding of ethnic disparity was again underscored in the IOM’s report “Preventing Childhood Obesity: Health in the Balance” (IOM, 2005b) in which it was reported that U.S. children of Hispanic origin, especially Mexican-American children, have the highest rates of obesity. These data confirm that ethnic differences in weight development exist in childhood (Daniels, 2006; Daniels et al., 2005; Kirk et al., 2005).

Previous Intervention Programs Targeting Overweight in Mexican Children

Some successful preliminary studies conducted with older children of Mexican origin support the involvement of parents in effective programs (Sharma, 2007; Stice et al., 2006; Summerbell et al., 2005; Treviño et al., 2004). Some programs initiated in elementary school settings and targeting school-age children (6 to 118 years) of Mexican origin and their parents have demonstrated efficacy in reducing dietary fat intake, increasing the intake of fruits and vegetables, and reducing blood glucose levels (Valdez, Greenlund, Wattigney, Bao, & Berenson, 1996). One such example is the Bienestar Program (Treviño et al., 1998, 1999, 2004), a program designed to prevent the development of type 2 diabetes mellitus that target ed fourth grade children and their parents. The findings of such effective intervention programs suggest that Mexican and Mexican-American parents of school-age children are willing to be involved in these efforts, and thus, may see unhealthy weight and prevention of diabetes mellitus as a troubling health problem that affects children. What is not clear is whether parents of younger children hold a similar perspective.

The Mexican population. (IOM, 2005a, 2005b, 2006; Rolls, 2003). Key to any action agenda or intervention trial is the critical and culturally based knowledge regarding the perceived threat of this childhood health dilemma by the parents who would be required to attend to and carry out suggested strategies with their children. This accumulation of findings emphasizes the need to gain input from Mexican parents of young children to appreciate the felt importance of this issue.

Prior Studies with Mexican-Heritage Parents of Preschoolers Regarding Weight

Several qualitative and quantitative studies were conducted in the late 1980s and early 1990s with Mexican parents of preschool children (Alexander & Blank, 1988; Alexander & Sherman, 1991; Alexander, Sherman, & Clark, 1991; Sherman, Alexander, Clark, Dean, & Welter, 1992; Sherman, Alexander, Dean, & Kim, 1993; Sherman, Alexander, Dean, & Kim, 1995). Findings from these studies suggested that Mexican parents identified overweight in young children as an ideal or desired state, thereby equating overweight in the preschool years with good health. More recently, Crawford and colleagues (2004) conducted a series of eight focus groups and concluded that the participating Mexican mothers of preschool children had difficulty acknowledging overweight in their children. A key finding was the poor association made by these mothers between the health of a young child and overweight. The authors concluded that because the mothers did not appreciate this relationship, traditional counseling (such as nutrition counseling) might not be effective with them. This comparison of study findings may indicate significant differences in attitudes and beliefs within the Mexican-American parent population. These potential differences bear attention because this could greatly affect the manner in which health care providers approach and engage Mexican parents of preschool children in healthy weight programs.

There has been a significant increase in the number of scientific and lay publications regarding the prevalence of childhood overweight and the multitude of related health consequences (Dietz & Robinson, 2005; Must & Anderson, 2003; Troiano & Flegal, 1999). This increase in available literature has led to more pediatric health care providers and many parents becoming aware or
more aware of this child health problem. It is unclear if the increasing prevalence of childhood overweight and obesity, increased publicity, or the identification and publication of the increased risk for overweight or obesity and its comorbid health problems within the Mexican community in America has resulted in changes in parental perception of this child health dilemma.

Theoretical Framework

Health, illness, and wellness are culturally defined and encompass much more than physical symptoms and medical conditions. The purpose of this project was to use Pumell’s model for cultural competence (Purnell & Paulanka, 2005) as the underlying conceptual framework within which to examine the constructs of health and overweight from the perspective of Mexican parents of preschool children. This model, consistent with the ethnographic tradition, identifies 12 cultural domains providers should respect when providing care in a culturally responsive manner. These conceptual domains (including health care practices, nutrition, high-risk behaviors, biocultural ecology, health-care practitioners, heritage, communication, family roles and organization, workforce issues, pregnancy, death rituals, and spirituality) have been schematically depicted by the authors (Purnell & Paulanka, 2005) to encircle a central phenomenon (such as overweight and health as perceived by Mexican parents of preschoolers), which cannot be definitively placed in any of the specified areas of the model. Health phenomena that are not defined within their cultural context are difficult to assess or address in a culturally appropriate manner.

Because the current researchers were unclear about the domains that would be associated with childhood overweight at the outset of this study, semi-structured, open-ended questions were developed to pose within a focus group to learn how Mexican parents felt about this phenomenon (see Figure 1). For example, the researchers of the current study believed that the parent responses might associate childhood overweight with a genetic, inherited, ethnic, or physiological condition, such as increased calorie consumption or lack of physical activity. These are examples of Pumell’s domains of biocultural ecology or high-risk health behav-

![Figure 1. Planned Semi-Structured Questions to Place a Phenomena in a Cultural Domain](Image)
Figure 2.
Placing the Six Emergent Themes Stemming from Conversations with Mexican Parents of Preschoolers about Childhood Overweight into Purnell’s Domain of Health Care Practices

Purnell’s Domain of Health Care Practices:
Individual and Parent’s Responsibility for Health of Children

Meanings and Relationships Regarding Excess Weight in Childhood and Child Health
- Poor physical health
- Illness
- Poor mental health

Causes of Excess Weight
- Poor self-care
- Poor self-esteem
- Poor self-regard

Uncertainty about Knowing or Not Knowing
- How parents know if their child is overweight/obese
- Who would tell parents their child was overweight/obese
- What would they do if their child was overweight/obese

From Mexico to America: Enticements of a New Land and Time as a Commodity
- Employment opportunities
- Material desires to ease assimilation
- Increased work hours

The Effects of Society on Personal and Parental Goals: The Work of Parenting in the U.S.
- Parent as provider of material desires
- Parent as monitor of activities
- Parent is rule maker and enforcer

Identified Needs and Action Strategies
- Education
- Nutrition ideas
- Family activity ideas

Methods
Design
Following approval by the university’s Institutional Review Board, an audio-taped focus group convened to explore the meaning of excess child weight as described by English-speaking, Mexican parents of preschool children. In the tradition of ethnography, a focus group with participant observation is one method to gain the perspective of participants, in this case, Mexican parents of preschool children. Focus groups are useful for problem identification, planning, and program implementation, and they efficiently produce credible, valid, concentrated, in-depth, local data that otherwise might not be known or easily available (Teitelman, Watts, Meisel, Woodard, & McFarland-Smith, 2001). Given that the researchers were trying to explore a sparsely researched topic – the experiences and perspectives of Mexican parents – a focus group was the ideal vehicle with which to glean valuable insights and a greater understanding of their attitudes and beliefs regarding weight and health (Crist, Velazquez, Duman, & Ramirez-Figuera, 2006; Morgan, 1997; Morrison-Beedy, Côté-Amesault, & Feinstein, 2001).

Participants
Researchers worked with employees of a small clinic that provides health care to a large population of Mexican immigrant and Mexican-American families regarding their potential interest in hosting a focus group meeting. The health care providers and other staff members responded enthusiastically to this opportunity. A person working at the clinic, who was well connected with families in the surrounding area,
quickly took on the role of meeting organizer and encouraged many community parents to participate in the group discussion. This unexpected recruitment effort resulted in a greater amount of parent interest than anticipated. Additionally, posters were placed in the clinic, and flyers were distributed to parents of young children who attended the clinic to encourage participation in the group meeting in exchange for monetary compensation for their time.

Eleven parents of preschool-aged children agreed to meet for this parent group discussion. All participant parents had immigrated to the United States from Mexico during their childhood or young adolescence and were now parents of young children. This was a mixed gender group in that there were two male and nine female parents in attendance. These parents comprised a heterogeneous, convenience sample of parents with similar cultural backgrounds. Researchers sought this selective sampling strategy to facilitate conversation and arrive at concentrated points of discussion important to all in a similar manner. Due to the small size of the group and the potential that members may not be legal American citizens, demographic data were intentionally not collected.

Setting
The clinic where the focus group was conducted was very small, but it was centrally located near a school and well known within the community. This geographically small community exists within the context of a larger urban area in a southwestern U.S. border state, and is composed primarily of economically disadvantaged people either from Mexico or of Mexican descent, some with American citizenship status. All attending the group meeting received their health care or their child’s health care at the clinic and lived in the surrounding community. Therefore, holding the gathering at the clinic after the close of regular business hours and after the staff had left for home provided a familiar and convenient meeting place for all parents.

Procedures
A doctorally prepared research nurse and graduate nurse research assistant planned and attended the group gathering. Different roles of the researchers for the parent meeting were agreed upon ahead of time; one would operate the recorder and note all non-verbal body language of the participant parents with field notes taken during the meeting, and the other would act as meeting moderator. The largest room at the clinic that would accommodate the parents and additional relatives who were anticipated was the ".patient waiting area" in the front of the main office. Therefore, chairs and end tables were brought into a casual circle so that everyone could sit comfortably and see one another. The group tape recorder was positioned and multiple microphones were placed about the room so that conversations could be clearly captured for later analyses.

All invited parent members spoke English but seemed to engage fluently in Spanish banter with each other at the start of the meeting. The criteria of English speaking was set a priori to encourage some similarity in level of acculturation and screened for prior to the group meeting. After several minutes of chatting and informal introductions to family members and children, the parents settled in the large front room and their children were brought to a back room where there was adult supervision and planned activities. Adults were greeted in the meeting area. Following more formal member introductions and a brief statement about the purpose of the group, there was a short discussion about the meaning of confidentiality and study volunteerism. Everyone was collectively and individually encouraged to ask questions as the formal consenting process was completed. The consenting process included meeting with each parent individually to explain the study, and written consent was then obtained. Parents were offered $15.00 for their time and participation in the group. Next, the beginning of the audio-taping was announced, and the purpose of the group was discussed.

The meeting was planned to last approximately one hour or until participants had exhausted the topics that they brought forward for discussion. In this way, the meeting would not delay families from conducting normally scheduled evening activities. The topics were exhausted after approximately one and a half hours, and many people stayed to talk after the meeting.

Data Collection
Two persons, independent of those conducting the focus group, later transcribed the recorded conversations separately, and those transcriptions were combined into one document to ensure that all recorded conversations were included in the final verbatim transcription. Both researchers in attendance at the meeting reviewed this document independent of one another to validate the content of the transcribed recording. Missing or unrecognizable words from the tape-recorded session were added into the transcription once content was collectively approved upon by the researchers. Field notes were then added to complete the data. This process was conducted to assure that information from all participating parents was accurately portrayed in the final transcription used for analyses.

Data Analysis
Qualitative research methods as outlined by Miles and Huberman (1994) guided examination of data. The verbatim transcript was initially color-coded using some general start-up codes (Miles & Huberman, 1994). At that point, similar parent responses to questions led to the creation of a more refined coding schema that reflected themes from the data. These themes, when clustered, led to the development of six main patterns. The patterns were titled: (a) meanings and relationships about excess weight in childhood and child health, (b) causes of overweight and obesity, (c) uncertainty about knowing and not knowing, (d) from Mexico to America: enticements of a new land and time as a commodity, (e) the effects of society on personal and parental goals: the work of parenting in the United States, and (f) identified needs and action strategies (see Figure 2).

Following the group meeting and the analysis of oral data, the generated patterns and exemplar quotations were reflected back to a group member to verify accuracy, representativeness, and cultural appropriateness during the member checking process. Additionally, an independent bilingual individual (English and Spanish-speaking) of Mexican origin reviewed the audio-taped session, the final transcription, and the resultant data analyses and confirmed their accuracy. The findings from this data analysis are described below.

Findings and Discussion
Meanings and Relationships Regarding Excess Weight in Childhood and Child Health
At the outset of the discussion, the parents involved in the focus group clearly described their perception of excess weight in adulthood and childhood in terms of poor health. Many
parents related experiences of having adult family members suffering with chronic medical conditions (such as diabetes mellitus, aching joints, inability to move around) as a result of being an unhealthy weight. In response to the question, “Tell me what overweight or obesity means to you,” the unexpected and immediate response from one person was, “It means being unhealthy...to me, it is an illness.” More than half of the parents offered physical and mental descriptions of what being overweight meant to them, and these included difficulty breathing and limited abilities to perform tasks and play sports. Similar comments throughout the meeting resulted in the development of this theme into an integral pattern (see Figure 2).

One individual provided vivid details about memories of being obese, the medical and emotional consequences of that excess weight, and the struggle to reach a healthy weight.

And like me when I was a kid. I went to Mexico first to begin my studies in school, and I was so overweight that my dad took me to a tailor so he could fit me into a uniform I was seven years old, and I remember because it was the first time I went to a tailor. I told my dad, “Why should I? How come I can’t just go to a regular store just like everybody else?” And he told me that I was too fat... I was [that large] at that point and now I am suffering from the results from that particular period of time in my life until now. It has caused a lot of effects in my life... Yes, that’s right. Because right now, as we speak, I am sick.

There was not one person in the group who indicated in any way that overweight, obesity, or “thickness,” as labeled by some group members, was a healthy state of being, even for young children.

There was a short and interesting discussion initiated by some group members regarding their perceptions of children who are “solid” and how they felt this was different from being “thick.” Some suggested that being “solid” was a preferred quality and healthier than being “thick.” The descriptions offered about “being solid” included words such as being active, eating good and healthy foods, and being strong. It seemed that these parents may have been distinguishing between a large body size due to muscular development rather than excess body fat. A parent participant later affirmed the authenticity of this discussion during an in-depth personal exchange with the primary author regarding the subtle meanings and cultural connotations of the words and her recollection of group discussion. The group members did not identify how a person would know if a child were “thick” or “solid,” and the deliberation ended quickly as the parents collectively decided that “you just know.”

Causes of Overweight and Obesity

A significant number of parent members felt that overweight or obesity was attributable to poor self-care and that this was the direct result of poor self-esteem and poor mental health. Descriptive terms such as “lack of self-responsibility,” “lack of self-control,” and “a negative state of mind” were phrases used by group members to characterize people who were overweight.

Many parents indicated that obesity was related to “how a person is raised from childhood,” and childhood overweight, particularly with young children, is the responsibility of the parents. One woman related her own experiences with her child.

...My husband’s family, they are overweight. Okay? And I don’t want my son to be that way; I want him to learn from being little. [If] you’re gonna eat that type of food, you gonna get more weight. You are not gonna be able to enjoy life if you are just gonna be eating and munching food. You’re gonna be embarrassed of yourself. I try not to be harsh on him because he is a 4-year-old... But I think it’s your eating habits and how you [a parent] can discipline your kids regarding eating healthy or unhealthy.

Other people shared similar perceptions regarding the responsibilities inherent in parenting: “But with my son, we have to kind of show him. Okay, this is how we eat at home.” Another participant stated: “It’s not just about the food. It’s that we [parents] are not strict. Cause if we are not strict, then they are not gonna be strict. If we don’t follow rules, then they are not gonna follow the path.”

Parental modeling, outlining rules about nutrition and activity, and then firm adherence to those rules appeared to be valued principles that these parents felt would result in normal weight gain in young children.

Uncertainty about Knowing and Not Knowing

Another recurrent theme that surfaced in a variety of discussions was the parents’ concern that they might misunderstand information or lack knowledge regarding their child’s weight and health. Four parents shared that they were uncertain if their child was a healthy weight or was overweight. The idea of “knowing” or “not knowing” was important to this group of parents, as evidenced by the recurrence of the theme. They discussed at length how they would “know” and who would tell them. Most agreed that their child’s health care provider would provide this information to them. For example, one parent was confident in “knowing” if a child was overweight or obese because a health care provider had once explained how to check it for.

I went to the doctor with my middle child when I lived in California. There is a little thing right here [pointing to the c-3 vertebral body]. Go over like that [the person indicated that you need to check this spot with your finger]. I am happy for that right over there [the ability to feel the spine]. Like, all like that. A skinny back. When you put your thumb right here [checking for a fat pad that might obscure the boney prominence].

After having demonstrated this way of assessing a child’s weight to the group, he later privately requested confirmation from the primary author about this method. Other parents talked about a variety of other ways that they would “know” if their child was an unhealthy weight. These ways of “knowing” included asking their child’s health care provider, comparing their child’s size to other children, and inspecting their child’s waist for “extra skin.” Interestingly, almost every person confidently explained how he or she would “know” but sought validation later during or following the meeting. From these conversations, it appeared that this group of parents was very interested in “knowing” if their child was a healthy weight but was uncertain of how they would “know.” This recurring pattern regarding the parents’ uncertainty of their child’s weight/BMI status was another primary pattern that developed, as depicted in Figure 2.
From Mexico to America: Enticements of a New Land and Time as a Commodity

As the meeting went on, group members compared stories of weight gain and loss, personal experiences, and those of friends and family. Several people talked about gains of greater than 14 pounds occurring within 2 or 3 weeks of coming to live in the United States, so they began to hypothesize why that might have occurred. People pointed out many cultural differences that may have contributed to the weight changes, particularly the abundant lifestyles found in the U.S.

There is more homemade cooking [in Mexico] than over here because everybody works. So they [people in the United States] just order pizza, that’s it.

We do a lot more activities in Mexico; no one has a car.

On Sunday, after church [in Mexico], you get outside in a little town and the kids run around and there are no cars around that they can get run over by.

Two years ago I was down there [Mexico] for a month. For a month, I walked every place. To the store, to the pharmacy, to the church. Here [in the U.S.] you get out of your house, get in your car, drive, come back, drive.

Oh yeah. Like I was telling this gentleman right here. Every kid in America wants to be like every kid in America that has an X-Box® or Playstation®.

Child and family needs were characterized as "...a problem, they [U.S. parents] just want to get rid of it." Rather than investing time caring for their families, parents in the U.S. were seen as prosperous, time-pressed, and overworked individuals willing to prioritize their work demands over the needs of their families and their parenting responsibilities.

In Mexico, the regular schedule from 8:00 [am] to 3:00 [pm] or 5:00 [pm] maybe. And here, it’s maybe 7:00 [am] to 6:00 [pm], or at night. It’s even nights moms come home. But Saturday, it’s 9:00 to 10:00 at night.

If parents aren’t there [in the United States], they don’t have to control the kids, ‘cause in my point of view, this system [the U.S. societal system] gives a lot of power to the kids.

The Effects of Society on Personal and Parental Goals: The Work of Parenting in the United States

When comparing life in Mexico to that in the United States, parents remarked about the abundance of possessions and excess snack and fast food that their children and families expected now that they were a part of the U.S. society. They also commented about how difficult it was to provide these things for their families, causing them to work long hours.

In addition, parents talked about the increased parenting responsibilities involved with monitoring their children, who had access to large amounts of snack and fast foods and other standard items, such as video games, computers, and bedroom televisions. Living the “American Dream” was difficult because they were less available to fulfill their parenting and family duties as a result of long work days. This was later confirmed and expounded upon by a group member who indicated that Mexicans often immigrate to the U.S. because of the abundant employment opportunities they hear of but are often surprised at the cost of living and the amount of work necessary to make the income needed to live. The very things that placed their children at risk for overweight and obesity (such as increased use of video games and TV watching, eating snack foods, going to fast food restaurants) were seen as items that these parents felt obligated to provide to their children to be a part of the perceived social norm. Many parents indicated that while the burden of parenting in the United States was different because of the increased number of temptations children face (watching TV, playing video games, having increased access to snack foods and fast food), it was incumbent on parents to be strict, exercise self-control and judgment, and model healthy behaviors.

Identified Needs and Action Strategies

Repeatedly, parents told researchers about the toll of their employment in terms of time and energy, the burdens of parenting in the U.S., and the enticements that surrounded their families in the U.S. The researchers were curious to learn what would be helpful to them in light of the increasing prevalence of childhood overweight and obesity. The responses were highly variable.

I think with us Hispanics, we let our kids do their own thing. And we’re just tired after work or whatever. And we sit home. But doing some things as a family... maybe we are getting old. Just doing some sports, I think that’s it, just some ideas.

I know some stuff that is good for them and some stuff that is not, like fast food. But nowadays, it’s hard to know what’s good for you and what’s not.

The thing is 99% of [Mexican] people really lack education [regarding childweight]. They need education to be able to handle [weight] problems.

These and other responses suggest that these parents sensed they had educational needs regarding nutrition and activities, and they indicated that some ideas of family activities would be helpful.

Discussion

Contrary to previously published research (Alexander et al., 1991; Alexander & Sherman, 1991; Sherman et al., 1993, 1995), findings from this focus group suggest these parents of Mexican descent identified excess weight as a state of poor physical and mental health, even in young children. Similar to other parents in the U.S., they struggle to balance the time demands of their employment with parenting and family responsibilities. Because they want their children to “fit in” to the U.S. culture, they seek to provide items that their children would not have had in Mexico (such as video games, computers, fast food). These same items had come with an unexpected price tag that included the need to monitor their children more closely and deal with resistance when trying to guide their children and model healthy behaviors, such as going for evening walks, exercising at home, and choosing healthy food at the grocery store or when at restaurants.

Most importantly, these parents indicated that they were not certain how they would “know” if their child was overweight. The overarching pattern of perceived lack of knowledge or “not knowing” carried over into the discussion of their needs. In addition to the needs for education (such as
nutritional information) and parenting skills (such as dealing with children’s resistance to changing behavior), this group of parents identified the need for ideas of family activities in which they could engage. This information outlines strategies that may provide helpful guidance to health care providers caring for children and their families of Mexican origin who disproportionately struggle with overweight and obesity in childhood.

The rigor and validity of qualitative research is classically judged on four criteria: credibility, transferability, dependability, and confi rmability (Lincoln & Guba, 1985; Meilyk & Fineout-Overholt, 2005; Powers & Knapp, 1995). Although significant planning efforts were extended to increase the trustworthiness of the data to be collected and transferability of later fi ndings, this study’s fi ndings are limited by the convenience sample that volunteered to participate. It is difficult to know if the ideas expressed in this group were representative of other Mexican parents or if the cultural attitudes detected were an example of the great range in attitudes among subsets of populations (such as acculturation, urban or rural roots, generational differences, gender variations). While it is unusual that males and females were both in attendance in a focus group, the researchers wanted to open the group for all who wanted to engage in this discourse. The researchers perceived any power differentials related to gender and culture to be minimal. Additionally, the female parents were quick to respond to their outnumbered male counterparts when they disagreed. Perhaps this was due to the level of acculturation of these group members or the larger number of females than males present in the group.

Application of Findings to Nursing Practice

Discrepancies between fi ndings from this study and previous research may be explained by the acculturation level of group members. Immigrant parents who speak English may have a different level of acculturation than those involved in prior research. The importance of acculturation has been strongly supported in other quantitative studies targeting nutrition and child weight and involving Mexican participants (Alexander & Blank, 1988; Sherman et al., 1992, 1993, 1995). Although this may be a limitation of this study, these fi ndings have provided a different perspective than what is prevalent in the published research literature. These parents felt that excess weight in children was unhealthy. They also indicated they did not know if their children were overweight. This finding stresses the need for child health care providers to inform and talk with parents when their children are found to be overweight.

Providing culturally relevant and acceptable health care is a challenge. In this study, as a result of the discussion with these parents, the researchers have aligned the phenomena of childhood overweight primarily within the contextual domain of health (illness) or health care practices (parent responsibility for child health), which has been depicted in Figure 2 (Purnell & Paulanka, 2005). Given the findings from this study, providers are empowered to understand the perspectives of their patients and offer culturally astute care during interactions with parents of Mexican origin. Perhaps using open communication styles, such as motivational interviewing (Emmons & Rollnick, 2001; Gance-Cleveland, 2005; Rollnick et al., 2005; Sindelar, Abrantes, Hart, Lewander, & Spirito, 2004), providers will be better able to explore parents’ perceptions of their children’s weight status and beliefs about the association of excess child weight and health (see Figure 3). This knowledge will assist health care professionals to work together with parents to identify relevant and acceptable health goals for children and their parents.

Finally, it should be remembered that although this group of Mexican parents of young children identified particular issues and strategies that may optimize the care of many children of Mexican descent, each child must be seen as an individual within the context of his or her family. Therefore, attention should be paid to individual, personal, and cultural beliefs, as well as unique prior social experiences and knowledge gaps. Although the prevalence of childhood overweight and obesity have reached alarming levels and this child health dilemma disproportionately affects

### Figure 3.
Practice Recommendations to Work with Mexican Parents of Preschool Children Regarding Child Weight Based Upon the Findings of This Focus Group

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<th>Practice Suggestion</th>
<th>Possible Statements</th>
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<tr>
<td>Complete BMI percentile identification for all preschool children (3 to 5 years).</td>
<td>It is important to us to learn what your child’s weight and height is and how that compares with other children.</td>
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<td>Explain in easy-to-understand terms how their child’s BMI compares to that of other</td>
<td>Your child is bigger than most boys/girls his age. If your child was in a room with 100 boys/girls of the same age, only 10 of those children would be bigger.</td>
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<td>children of a similar age and gender.</td>
<td>What do you think about your child’s size now that we have compared that with other boys/girls of the same age?</td>
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<tr>
<td>Ascertain what the parent understood you to say about his or her child’s BMI.</td>
<td>What do you think about all of this?</td>
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<tr>
<td>Learn what this information means to the parent.</td>
<td>What do you think other people in your family and home will think about this information about your child’s size?</td>
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<tr>
<td>Appreciate the context of the family with relationship to the child’s BMI.</td>
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<tr>
<td>Learn what the parent believes may have caused any excess weight.</td>
<td>How do you think that he/she became this size?</td>
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<td>Using motivational interviewing, work with the parent and encourage him or her to</td>
<td>Based on this information, are there any changes in the home that you would like to make?</td>
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<td>suggest some child and family health goals.</td>
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<tr>
<td>Identify your role in the goals set forth.</td>
<td>How can I be helpful to you and your child as you work on these things? What would you like me to do?</td>
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children of Mexican descent, all families of this cultural heritage should be treated in the same way. More research regarding this critical issue is necessary to avert catastrophic health consequences to our nation’s children.

Future Research Recommendations

The sampling strategy and conduct of this focus group meeting may have limited the usefulness of the data generated. Further study might involve individual interviews of critical cases to more fully saturate the developed patterns and appreciate the transferability of this study’s findings. Additionally, future work could be completed through an iterative constant comparative method using smaller samples to gain information from a more heterogeneous sample. It would be useful to both practitioners and to researchers to understand if these findings are prevalent in particular subgroups of Mexican parents (for example, those more acculturated), especially in light of evidence suggesting that Mexican immigrants with higher acculturattion scores also have higher BMIs (Alexander & Blank, 1988; Sherman et al., 1992, 1993, 1995). It is critically important to gain an understanding of the perspectives of different ethnic and cultural subpopulations that are at high risk for obesity and its comorbid consequences so that culturally responsive intervention efforts can be developed and tested.

Previous research literature outlines a schism that appears to exist between health care providers’ understanding of child BMI or weight status and related health consequences, and parents receiving and/or understanding the message that their child is overweight or obese. As a result, the child’s health may be compromised. There are several potential contributors to this communication gap. It has been repeatedly published in the research literature that pediatric health care providers’ documentation of BMI percentiles is low, suggesting that health care providers may not recognize some children who are overweight or obese, thus interfering with their communication of this to parents. Communication between parents and health care providers is further stymied by the multiple terms used to label children in different BMI percentiles (such as at risk for overweight, weight, over) which may contribute to parents’ confusion regarding their child’s status. Additionally, researchers have identified some parents of infants and young children as failing to understand or acknowledge that their child is overweight, thus having been told. Moreover, credible research evidence suggests that some parents believe excess body weight in infancy or toddlerhood signals good health. This small focus group study offers another perspective. Researchers may want to focus future efforts on the various components of the communication of weight status between health care providers and parents of overweight or obese children (such as identifying BMI percentile consistently, clearly communicating a child’s weight status, verifying a parents’ understanding of the child’s weight) because engagement with early prevention or intervention efforts may be dependent upon these critical conversations.

References


