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The Lived Experiences of Mexican Heritage Mothers Caring for Overweight Preschool Children

Susan McDonald

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THE LIVED EXPERIENCES OF MEXICAN HERITAGE MOTHERS CARING FOR OVERWEIGHT PRESCHOOL CHILDREN

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
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Abstract

THE LIVED EXPERIENCES OF MEXICAN HERITAGE MOTHERS CARING FOR OVERWEIGHT PRESCHOOL CHILDREN

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Mexican heritage children are at greater risk to become overweight or obese than children of other ethnic or racial groups. There is limited information in the literature about how the mothers care for their preschooler after they are classified as overweight or obese. The objective of this study was to gain insight into the lived experiences of Mexican-heritage mothers caring for overweight or obese preschool children. A concept analysis was conducted develop an operational definition of perception and framed the study. A qualitative, hermeneutic phenomenological design was selected for this study. Saturation was achieved with 12 mothers of Mexican heritage. Data collection and analysis was guided by the phenomenological approach of Max van Manen. Six themes and sixteen subthemes emerged from the data. Maternal caring practices were influenced by their Mexican heritage, emotional burdens, perceptions of child's weight status, disconnectedness and connectedness with family and health care professionals, being resourceful, and the linking of past family history and practices with present needs in order to protect children from untoward consequences of overweight.

The results of this study reinforce nursing's stance that clients be treated in a holistic manner. Cultural influences, social support, past experiences, available resources, and emotional status all play integral roles in a mother's ability to partner with nurses in developing a working plan to effectively care for overweight children. Future research should target interventional strategies to provide evidence-based guidelines that would ultimately lead to behavioral changes and healthier children outcomes.

Keywords: Mexican heritage mothers, caring, lived experience, preschool, obesity, phenomenology, van Manen

Chapter 1
Overview of the Research

In the United States, approximately one third of low-income children under the age of five are obese. Alaskan native children have the highest rate of obesity followed by Hispanic children (Centers for Disease Control and Prevention, 2011). Upon closer examination of persons of Hispanic origin, Mexicans accounted for three-quarters of the 15.2 million increase in population from 2000-2010. The Mexican origin population grew from 20.6 million to 31.8 million in the U.S., an increase of 54% (Ennis, Rios-Vargas, & Albert, 2011). There were 7.2 million births contributing to this growth (Pew Research Center, 2011). This will increase the number of preschool children at risk for becoming overweight or obese among this population.

In Texas, multiple public health initiatives have been designed to combat childhood obesity (Health and Human Services Commission, 2011). As a pediatric nurse practitioner, I was puzzled about how little impact these programs had on my growing number of Mexican-heritage clients. Texas is one of three states with the highest Hispanic population, the majority originating from Mexico (Ennis, Rios-Vargas, & Albert, 2011). When reviewing the literature, most studies reported on the Hispanic population as a whole and did not distinguish country of origin. Multiple studies identified contributing factors to the rise in numbers of overweight Hispanic children but there were few that gave a voice to the numbers. There appeared to be a "disconnect" between what the experts recommended and what was happening in the children's homes.

Munhall (2007) observed that most of our practices as health care professionals came from perceptions of our own reality rather than those of our clients. The overall purpose of the study was to explore the subjective experiences of my clients' mothers and to incorporate these perceptions into my practice as I partner with them in the care of their children. The research question that evolved was: What are the lived experiences of Mexican-heritage mothers caring for overweight preschool children? The methodology chosen to explore this phenomenon was hermeneutic phenomenology as influenced by Max van Manen, a Canadian social scientist and educational philosopher. Hermeneutic phenomenology is the study of essences and the description of the experiential meanings. Taking into account the sociocultural and historical traditions that have given meaning to our ways of being in the world, the researcher examines what it means to be a person. "The aim is to construct an animating, evocative description (texts) of human actions, behaviors, intentions, and experiences as we meet them in the lifeworld" (van Manen, 1990, p. 19). In preparation to undertake my study using this approach, I immersed myself in the world of phenomenological inquiry as recommended by Munhall (2007). This was done by gaining an understanding of the theoretical underpinnings of hermeneutic phenomenology through many hours of extensive readings and completing a summer intensive seminar, Qualitative Analysis 2: Phenomenological & Narrative/Discourse Methods, at the University of North Carolina at Chapel Hill.

A demographical information form (Appendix A) and a low-literacy consent were developed (Appendix B). The research proposal received approval from the Institutional Review Board at the University of Texas at Tyler (Appendix C).

Introduction of the Articles

My interest in finding ways to effectively change health behaviors began prior to my enrollment in doctoral studies. When examining change theories, the term perception was frequently mentioned. This made sense to answer the question of why would someone want to change if they did not perceive the need to change. While at the University of Texas at Tyler, I had the opportunity to write a concept analysis on perception. The first article, "Perception: A Concept Analysis" (McDonald, 2012), was published in the International Journal of Nursing Knowledge. It evolved from coursework required in Theory Construction and Evaluation. From this work, an operational definition of perception was developed, and acts as a frame for my body of research. Permission to use this work as part of the dissertation portfolio was obtained from the publisher (Appendix D).

The second article, "The Lived Experiences of Mexican-Heritage Mothers Caring for Overweight Preschool Children", is being prepared for submission to The Qualitative Report. This work is the portrait of the mothers in my study. I had the privilege of interviewing 12 mothers in their homes. Using a hermeneutic phenomenological approach, I immersed myself in their worlds and discovered six themes and sixteen subthemes that embodied their stories. During phenomenological reflection, I stepped back and focused on what these mothers were saying to me. This reflection gave rise to a manuscript, "The Mothers Speak" (Appendix E), an imagined letter written from the participants to the researcher. It will be submitted to the lay literature to enhance understanding of the phenomenon by the general public. This manuscript completes the portrait of the lived experiences of Mexican heritage mothers caring for overweight preschool children.

Chapter 2
Perception: A Concept Analysis

Abstract and manuscript prepared for *The International Journal of Nursing Knowledge*

Abstract

Purpose: Concept analysis methodology by Walker and Avant (2005) was used to define, describe, and delimit the concept of perception.

Data Source: Nursing literature in the Medline data base was searched for definitions of "perception".

Data Synthesis: Definitions, uses and defining attributes of perception were identified; model and contrary cases were developed; and antecedents, consequences, and empirical referents were determined.

Conclusions: An operational definition for the concept was developed.

Implications for Nursing Practice: Nurses need to be cognizant of the how perceptual differences impact the delivery of nursing care. In research, a mixed methodology approach may yield a richer description of the phenomenon and provide useful information for clinical practice.

Keywords: concept analysis, perception, nurses and perception

Manuscript

As nurses, the only perceptions we are privy to are our own. This often comes to light as nurses encounter ethnically diverse clientele in their everyday practice. Conflict between nurse and client perceptions can lead to miscommunication and suboptimal outcomes. Understanding self and client perceptions are important for nurses to effectively meet clients' unique needs in this global health arena.

Perception is a key component of several theoretical frameworks used in nursing research. A well-known conceptual structure for understanding what drives persons' health decisions is the Health Belief Model. This model proposes that the key elements to taking health actions are the individual's perceptions of susceptibility, severity, benefits, and barriers in regard to their health (Daddario, 2007). Perceived benefits of action, barriers to action, and self-efficacy are elements of the *behavior-specific cognitions and affect component* of the Pender Health Promotion Model (Pender, Murdaugh, & Parsons, 2002).

The notion of perception as a driver of health actions makes this concept of particular importance to nurses as they attempt to manage health outcomes by encouraging positive actions. To improve health outcomes, it is critical appreciate the uniqueness of an individual's perceptions and to understand how perceptions are formed. An operational definition is needed to assist disciplinary knowledge and improve nursing care. This paper will attempt to define, describe, and delimit the concept of perception.

Background

Perception involves the way one sees the world. Nurses use tools that attempt to uncover and perhaps reframe the perceptions of a client or group. The wide variety of subjective instruments to measure perceptions has resulted in a lack of global consensus

on any singular best practice. Instruments are usually situation-specific or population-directed which makes finding a general measure of perception challenging. Visual analog scales have been used with success to measure perceived pain. Satisfaction surveys attempt to capture patient perceptions about the health care they received. The health-related quality-of-life instrument, the SF-36® Health Survey purports to examine respondents' perceptions of eight domains of health: physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, and mental health. In addition, the instrument asks respondents to report how they perceive their current health compared with their health one year ago. These are a few examples of the instruments used to assess patient perception. However, the issue of identifying the elements of perception and understanding exactly what is being reported remains elusive.

Baldwin (2008) describes concept analysis as a rigorous and pragmatic approach to define concepts that can significantly contribute to knowledge and can be applied to nursing practice. Walker and Avant's (2005) concept analysis method was used to examine the structure and function of the concept "perception". This method uses eight steps to capture the essence of the concept: (1) selecting a concept; (2) determining the aim of the analysis; (3) identifying all possible uses of the concept; (4) determining the defining attributes; (5) identifying a model case; (6) identifying additional cases; (7) identifying the antecedents and consequences; and (8) defining empirical referents. The aim of the study was to develop an operational definition of "perception" in order to provide a linguistic basis for what is being evaluated with the various measures of patient perceptions about health and actions.

Data Sources

The Medline data base was used to conduct a literature search of the term "perception". Only articles in the nursing literature from 2006 to 2011 were included. Both quantitative and qualitative articles that focused on participant perceptions were viewed. In the 449 articles, there were no articles that defined the term "perception". A possible explanation for why none of the articles clearly defined *perception* may be an underlying assumption that the reader simply understood the term.

Results

Uses of the Concept

Walker and Avant (2005) recommend using dictionaries, thesauruses, available literature, and other sources to identify uses of the concept which revealed subtle differences in how perception is described. The term *perception* is a noun. Wikipedia (2008) defines perception as "the process of attaining awareness or understanding of sensory information." The *Collins Essential English Dictionary* (2006) describes perception as: "1. insight or intuition 2. way of viewing [Latin *perceptio* comprehension]." The Merriam-Webster (n.d.a) lists these definitions: "1 a: a result of observation; b: a mental image; 2. *obsolete*: consciousness; 3 a: awareness of the elements of environment through physical sensation; b: physical sensation interpreted in the light of experience; 4 a**:** quick, acute, and intuitive cognition appreciation; b: a capacity for comprehension." The Merriam-Webster Online Thesaurus (2009) adds this: "1**.** the ability to understand inner qualities or relationships; 2. the knowledge gained from the process of coming to know or understand something." Synonyms in *Roget's II: The New Thesaurus* (1995) include awareness, cognizance, consciousness, sense, concept, conception, idea, image, notion, and thought. Other related terms are: attention,

cognition, heuristic, information, intelligence, mental model, and understanding (Wikipedia, 2008).

Perception is a uniquely individualized experience. One can only draw from what is known to oneself. In literature, the poem "*The Blind Men and the Elephant*," written by John Godfrey Saxe in the 19th century, exemplifies the need to be exposed to something in order to have any perception of it. The poem tells the tale of six blind men. They encounter an elephant and try to identify appropriate comparisons for this unknown entity. Each man touches the elephant and the limited area within each man's reach influences his conclusion. Each has a different mental image based on past experiences. They debate that an elephant is like a wall, snake, spear, tree, fan, or rope. Each man is confident in his own perception. A heated argument ensues. To quote W. Paul Young (2007) from the novel *The Shack:* "Paradigms power perception and perceptions power emotions" (p.197).

The interdisciplinary concept of perception is complex and has many layers. In physiology, perception is examined on the basis of the neurons that enact it (Freeman, 1991). The neural pathway is affected by both the mind and the body as exemplified in a study on the effectiveness of placebo analgesia on relieving pain (Roche, 2007). Patients' beliefs, attitudes, and expectations shaped their perception of pain before and after using placebo analgesia. Placebo analgesia and pain are two functions of the same neural network. The effectiveness of placebo analgesia may be dependent on brain components involving affective and emotional processes. Evidence exists to show that suggestion/expectation cognitively triggers powerful neurohumeral mechanisms in patients' brains, bodies, and behaviors that will either relieve or exacerbate pain.

Perception is also discussed at length in psychology. A general internet search for the keyword "perception" directs the reader to numerous psychology and cognitive websites where awareness and understanding of sensory information is discussed. These sites address the mechanics of vision and hearing, touch, taste, and smell. All of these are stimuli that are presented to an individual and interpreted in a specific and personal way.

Perception of objects in the visual world is influenced by features such as shape and color as well as the meaning and semantic relations among them (Hwang, Wang, & Pomplun, 2011). In psychiatry, there are often distortions in sensory informational processing. When studying the perception of body image among dancers and anorexic girls, digital pictures were taken of the participants in street clothes. The images were then cropped and resized on the computer. The participants were asked to adjust their image to correspond with how they perceived they actually looked. The participants perceived themselves to be heavier than they were. This distortion can lead to maladaptive eating (Urdapilleta, Cheneau, Masse, & Blanchet, 2007).

Kuhn, Amalani, and Resnick (2008) postulate there is a shared interest between magicians and cognitive scientists in understanding human perception and cognition. Magicians perform acts that are perceived to defy the laws of nature and induce a sense of wonder. When performing, magicians use misdirection and illusion to control attention, distort perception, and influence choice. The authors propose the development of a "science of magic". This science would explain all known magical effects in terms of known perceptual and cognitive mechanisms. All known magic effects may be reduced to a set of basic, relatively well-understood operations. Any effects that are not reducible

would indicate the existence of an unknown perceptual or cognitive mechanism which may have existential or religious underpinnings.

Religions portray the perception of God or the Supreme Being differently which impacts how the individual views God. Chara and Gillett (2004) published a study examining possible synesthetic perceptions of God. One hundred eighty-seven college students were surveyed about their sensory image of God and found the religious experience was one of high individuality. Religious orientation influenced these sensory images: hearing, smelling, seeing, tasting, and touching God. The majority described God as speaking quietly and in prose and having a pleasant aroma. The most frequent color choice for God was yellow. Nearly 80% reported they tasted God and saw that God was good. Those who identified their primary value as "spiritual growth" were twice as likely to report being very close or close to God compared to those who reported "money" or "pleasure" as their core value. The researchers found participants' images of God were frequently correlated with biblical revelation of God and that this agreement may reflect influences that are phenomenological. Peoples' experiences in a biblically influenced culture color their perceptions.

Social influences may affect one's perception, including gender and socioeconomic status. Research by Kimura (2004) and Geary, Gilger, and Elliott-Miller (1992) show a gender difference in cognition. Socioeconomic status influences where you live, what you eat, what you wear, and how you are educated. All of these are the basis for the formation of memories and life experiences. A child from a housing project and a billionaire's child would have two very different views of a mansion.

Perception is a personal manifestation of how one views the world which is colored by many sociocultural elements. Markus and Kitayama (1991) concluded that people in different cultures have strikingly different perceptions of self and others. These differences can be seen when comparing two distinct cultures. The nature of the individual experience can also be influenced when two cultures meet. Perception of pain in childbirth was found to be increased when the ethnicity of the laboring woman was different than that of the predominant ethnicity of the attendants (Olayemi, Morhason-Bello, Adedokun, & Ojengbede, 2009).

The act of perceiving has been pondered by philosophers for centuries. In the philosophy of perception, the metaphysics of the mind is explored looking to answer the questions of what is perception, what is the nature of perceptual consciousness, and how can one fit an account of perceptual experience into a broader account of the nature of the mind and the world (Noë & Thompson, 2002). BonJour (2007) discusses the evolution of the epistemological issues concerning perception. The author notes that philosophers such as Descartes and Locke attempted to answer the question of the root of our awareness in sensory or perceptual experiences. Many theories have been debated over the centuries including the sense-datum theory, the adverbial theory, phenomenalism, representationalism, and direct realism. When describing perception, the phenomenological philosopher, Merleau-Ponty (1947/1964) states:

> " By these words 'primacy of perception', we mean that experience of perception is our presence at the moment when things, truths, values are constituted for us; that perception is a nascent *logos;* that it teaches us, outside of all dogmatism, the true conditions of objectivity itself; that it summons us to tasks of knowledge and

> action. It is not a question of reducing human knowledge to sensation, but of assisting at the birth of this knowledge, to make it as sensible as the sensible, to recover the consciousness of rationality" (p. 25).

The conclusion that can be drawn is that perception is a multifaceted concept that is as complex as the human mind itself.

Defining Attributes

Walker and Avant (2005) use defining attributes to describe those factors which must be present in order for the concept to be identified. The definitions, synonyms, and related terms of perception were examined. Perception utilizes sensory and cognitive processes to appreciate the world around us. It is a unique way of understanding phenomena by interpreting sensory information based on experience, processing information, and forming mental models. In order for perception to occur, these defining attributes must be present:

1. Sensory awareness or cognition of the experience.
2. Personal experience.
3. Comprehension that can lead to a response.

Model Case

Model cases are used to exemplify all of the defining attributes of a concept (Walker & Avant, 2005). This model case is simple and contains all of the defining attributes for perception.

> Janice had been a nurse in the skilled nursing facility for 5 years. She enjoyed her contact with the residents. She was especially fond of Mrs. Hudson, a lively 83-year-old widow, who enjoyed sharing her opinion about what she read in the

paper and viewed on television. One morning, when Janice made rounds, Mrs. Hudson was sitting in her armchair, gazing out of the window. She barely acknowledged Janice's entrance. When Janice inquired how Mrs. Hudson was doing, the response was a brief "fine". Janice was puzzled by the change in Mrs. Hudson, who was far from her usual, cheerful self. Janice drew up a chair, sat next to Mrs. Hudson, and noticed tears in her eyes. A newspaper was lying on the windowsill. Janice told Mrs. Hudson that she did not appear to be "fine" and asked what was bothering her. With a tearful voice, Mrs. Hudson told Janice that she had just read the obituary of her best high school friend. With Mrs. Hudson's consent, Janice called the resident's son and requested he come to the facility to be with his mother.

In this case, Janice had a *sensory awareness* of the situation by observing the verbal and body language of Mrs. Hudson. What she saw did not correlate with previous *personal experiences* she had in the past with this resident. Her *comprehension* of the situation enabled her to assess that her resident was in need of emotional support which led to her *to respond* and call Mrs. Hudson's son.

Contrary Case

This case exemplifies a lack of any of the defining attributes**.** Walker and Avant (2005) advocate the use of these cases as a part of the internal dialogue used to examine the defining attributes. Contrary cases exemplify what is "not the concept".

John, an 85-year -old widower, lived alone. Due to a severe hearing deficit, he used bilateral hearing aids. At bedtime, he removed his aids and placed them in a case on his nightstand after which he fell asleep quickly. A strong storm struck

during the night causing considerable wind damage to the large pine tree in his front yard. Upon awakening, he was shocked to see a hole in the roof over his bedroom and debris scattered across his property.

In this case, John had no perception of the event that occurred during the night. His hearing deficit did not allow *sensory awareness* of the weather which eliminated the possibility of *personalizing the experience*. Further, his *lack of comprehension* interfered with his ability to take action to protect him from potential harm.

Antecedents and Consequences

Antecedents must occur prior to the concept and must be present for the concept to happen (Walker & Avant, 2005). With perception, processing information and coming to an understanding is complex. Before perception occurs, intact neurons are required. In addition, the person must have the capability to interact with the environment through at least one of the five senses.

Consequences are what happen as a result of the occurrence of the concept. It involves what one will do with the information that was just processed. It can result in increasing one's knowledge, understanding, and comprehension. The consequence of perception is formulation of a mental image which contributes to the decision to act or not. In healthcare, if the individual draws on unique experiences and views a situation as normal, the likelihood of taking action is minimal. Even if the understanding is in error, it is still the individual's understanding of the situation based on perception. Perception does not necessarily result in "truth" or perhaps even "knowledge," but it does culminate in the individual's comprehension of the situation.

Empirical Referents

Walker and Avant (2005) define empirical referents as ways to measure the concept in the real world. There is a proliferation of articles describing tools or instruments to measure the perceptions of groups or individuals. Tools have been shown to be successful in some attempts, but fail in others.

In health care, quality indicators have been developed to capture the patient's perceptions regarding the hospital experience, especially about the quality of nursing care they received. Dozier et al. (2001) developed a 15-item tool, Patient Perception of Hospital Experience with Nursing (PPHEN), based on the Swanson-Kauffman framework of caring. It does not require patients to compare their expectations of care with the care received, as do patient satisfaction surveys, but only whether their needs were met. The authors concluded their tool was internally consistent and represented a single construct best described as feeling "cared for."

Since no reliable body size perception instrument for children had yet been identified, a pilot study was conducted to validate the use of photographs from the Centers of Disease Control (CDC) Web site as a tool to assess maternal perceptions of children's weight (Reifsnider et al., 2006). These photographs are used by the CDC for professional Body Mass Index (BMI) training. The authors looked at Hispanic mothers' perception of children's body size and explored their views of child growth, diet, activity, and health. The mothers and their preschool children were weighed, measured, and their BMIs calculated. Using CDC photographs of children of various body sizes, the authors found no congruence between the mothers' perceptions of body size in the pictures and their children's sizes. Regardless of their children's BMIs, what the mothers perceived

were happy, active children accomplishing normal childhood activities. Their children were not viewed as overweight. The authors concluded that the use of standardized pictures would not be an effective tool to educate these mothers about BMI. Perception is more than matching a photograph with a mental image.

In qualitative research, contextual descriptions are a way to arrive at perception. One such method is descriptive narrative analysis. This method serves as a tool to ask a person to describe perceptions of a phenomenon. Comparing the description to norms can be valuable in developing a treatment plan. The use of descriptive narrative analysis enabled the researchers to explore the anorexic voice experienced by 21 women with anorexia nervosa (Tierney & Fox, 2010). The inner voice was very real to these women. The participants described the voice as changing from positive to negative over time. The voice was a comfort at times but would change to a voice that was loud, forceful, and demanded obedience. The study gave the researchers insight into the dilemma faced by the participants. When contemplating life without the seduction of the anorexic voice, the participants revealed the voice still had some attraction for them. The authors concluded acknowledging the presence of the voice could assist anorexic patients in their recovery.

Discussion

Study Limitations

Perception is described by numerous disciplines. Both space and time limit the identification of all of its uses. This review is in no way exhaustive.

Study Strengths

This concept analysis is limited to the concept in relation to nursing science. By analyzing the concept, one develops an appreciation of its complexity. The only "real"

perception is self-perception, but that does not negate the need to acknowledge that another person may have a different way of comprehending the same phenomenon. "Perception of experience is what matters, not what in reality may appear to be contrary or more 'truthful'" (Munhall, 2007, p.161).

Theoretical Implications

According to Walker and Avant (2005), a theorist introduces the reader to the critical defining attributes by using theoretical definitions, which are usually abstract and may not be measureable. In order to be able to measure a concept, an operational definition is employed.

An operational definition of perception includes:

- an individual's or group's unique way of viewing a phenomena
- involving the processing of stimuli
- incorporating memories and experiences in the process of understanding

The concept of perception plays a role in both descriptive and explanatory middle-range theories. In qualitative research using phenomenology, the individual's unique way of viewing a phenomenon is explored. This methodology can use a descriptive approach, where the **e**mphasis is on describing universal essences, or an interpretive (explanatory) approach**,** emphasizing understanding the phenomenon in context. Quantitative studies have been done using the Health Belief Model and the Health Promotion Model to examine what is perceived by the target population to explain health behaviors.

Conclusions

Perception is an individual's view making it a powerful driving force for action. Processing sensory information and relating to past experiences enables one to create a

lens in which to view the world through a filter of sociocultural influences. In the clinical setting, each individual comes with personal life experiences that influence perceptions. Nurses need to be cognizant of the how these differences can impact the delivery of nursing care.

As has been stated, the only perceptions we know are our own and a conflict between nurse and client perceptions can lead to miscommunication and suboptimal outcomes. Rather than label a client or parent as "non-compliant", the nurse needs to explore what is influencing the individual's perceptions, identify what the client and nurse share in common, and utilize these findings to develop strategies to positively impact health.

Perception is never objective. It is an individual's or group's unique way of viewing a phenomenon that involves the processing of stimuli, and incorporates memories and experiences in the process of understanding. In nursing research, valuable information is gained through studies that incorporate conceptual models such as the Health Belief Model and Health Promotion Model. Often, these studies do not give nurses insight into what influences perceptions. Quantitative research methods can sometimes answer the question "what" but not give voice to the question "why". Qualitative methods use "different *ways of seeing* to uncover and discover *understanding"* (Munhall, 2007, p.xv).Because perception is a unique experience, a mixed methodology approach may yield a richer description of the phenomenon, enhance understanding, contribute to the body of nursing knowledge, and provide useful information for clinical practice to improve client outcomes.

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Chapter 3

The Lived Experiences of Mexican-Heritage Mothers Caring for Overweight Preschool Children

Abstract and manuscript prepared for *The Qualitative Report*

Abstract

Purpose: Mexican-heritage children are at greater risk to become overweight or obese than children of other ethnic or racial groups. There is limited information in the literature about how the mothers care for their preschoolers after they are classified as overweight or obese. The objective of this study was to gain insight into the lived experiences of Mexican-heritage mothers caring for overweight or obese preschool children.

Design and Method: A qualitative, hermeneutic phenomenological design was selected for this study. Saturation was achieved with 12 mothers of Mexican-heritage. Data collection and analysis was guided by the phenomenological approach of Max van Manen.

Results: Six themes and l6 subthemes emerged from the data. Maternal caring practices were influenced by their Mexican heritage, emotional burdens, perceptions of child's weight status, disconnectedness and connectedness with family and health care professionals, and the linking of past family history and practices with present needs in order to protect children from untoward consequences of overweight.

Practice Implications: Implications for health care providers highlight the importance of acknowledging cultural influences and ensuring that accurate, understandable, and useful information is disseminated to parents, families, and other experts, such as schools,

daycares, and WIC. Addressing this problem now with early intervention will impact the rising health care expenditures and co-morbidities associated with obesity.

Keywords: Mexican-heritage mothers, caring, lived experience, preschool, obesity, phenomenology, van Manen

Manuscript

Childhood obesity is increasing at an alarming rate and health care providers are having limited success in reversing this trend. Elevated Body Mass Index (BMI) values among children indicate increased risk for future adverse health outcomes or development of disease (Ogden & Carroll, 2010). The Centers for Disease Control and Prevention (CDC) reported, in the National Health and Nutrition Examination Survey (NHANES), an increase in overweight and obesity (CDC, 2009) in all age categories. Children with BMI values at or above the 95th percentile for sex are categorized as obese. In previous years, children above this cutoff were labeled as overweight. The changes were based on the recommendations of experts in the Institute of Medicine and American Academy of Pediatrics (AAP, 2011). In children, ages two to five years, the rate of obesity has more than doubled in the past 30 years from 5% to 10.4% (Ogden & Carroll, 2010).

Among the states, Texas has the sixth highest rate of childhood obesity (IOM, 2009). In 2008, 30% of low-income preschool aged children enrolled in Texas Women Infants and Children (WIC) Program were overweight or obese (Texas Interagency Obesity Council, 2011). Among these children, Hispanic children had one of the highest rates of overweight or obesity (Texas Department of State Health Services, 2011).

The purpose of this study was to explore the lived experiences of Mexican mothers caring for overweight or obese preschool children. This study utilized a hermeneutic phenomenological approach to examine both the descriptive and interpretive aspects of the phenomenon. Methods of sample selection, data collection, and analysis that are congruent with this approach will be described.

Significance of the Topic

Elevated BMI values can cause problems in childhood and adulthood. According to the AAP (2011), excessive weight is linked to physical, emotional, and social health problems. Physical health problems include glucose intolerance and insulin resistance, Type 2 diabetes, hypertension, dyslipidemia, fatty liver disease, cholelithiasis, sleep apnea, asthma, skin conditions, menstrual abnormalities, and orthopedic problems. Children who are overweight are more susceptible to low self-esteem, negative body image, and depression. They are stigmatized and the targets of teasing and bullying, negative stereotyping, discrimination, and social marginalization. These problems can continue into adulthood because obese children are more likely to become obese adults (Texas Department of State Health Services, 2011).

Hispanic children are at significantly higher risk for developing obesity (Hackie & Bowles, 2007; Kimbro, Brooks-Gunn, & McLanahan, 2007; Maher, Li, Carter, & Johnson, 2008; Procter & Holcomb, 2008; Whitaker & Orzol, 2006). They are twice as likely as either black or white children to be overweight or obese (Kimbro, Brooks-Gunn, & McLanahan, 2007). Multiple factors have been identified including socioeconomic status, parental education and perception, sweetened beverage intake, and nutrition in the home.

In East Texas, 25.8% of the population falls below the poverty level (U.S. Census Bureau, 2011). Low income has been noted to be a risk factor for obesity among Hispanics (Hackie & Bowles, 2007; Maher et al, 2008; Procter & Holcomb, 2008; Reinke, 2008; Welsh et al., 2005; Whitaker & Orzol, 2006). In a study of 4,382 Mexican American families, the household income to poverty rate ranged from 33.4% for third-

generation Mexican Americans to 75.6% for first-generation families (Burgos, Schetzina, Dixon, & Mendoza, 2005).

Among many ethnic and racial groups, low parental education has been demonstrated to be associated with the development of childhood obesity (Dubois, Farmer, Girard, & Peterson, 2007; Hackie & Bowles, 2007; Jingxiong et al., 2009; Warschburger & Kroeller, 2009). Mier et al. (2007) found that along the Texas-Mexico border, Mexican American preschool children's risk of obesity was associated with lower levels of parental education. Two-thirds of adults had less than a ninth-grade education. Home diets exceeded the recommended daily allowances for total energy, fat, and carbohydrates. When Reifsnider and Ritsema (2008) examined the demographic information for overweight Mexican American preschool children in South Texas, maternal education averaged 10.7 years. Parents, including with low education, were also more likely to misclassify their children (Hackie & Bowles, 2007; Warschburger & Kroeller, 2009). While Hispanic parents are less likely to recognize their child as being overweight (Hackie & Bowles, 2007; Small, Melnyk, Anderson-Gifford, & Hampel, 2009), this trend has also been associated with low parental education (Hackie & Bowles, 2007; Warschburger & Kroeller, 2009). Increased parental weight or body mass index (BMI) was correlated with an increased incidence of children being overweight or obese (Jingxiong et al., 2009; Kimbro, Brooks-Gunn, & McLanahan, 2007; Reinke, 2008; Warschburger & Kroeller, 2009). The BMI of Mexican American parents of overweight children was significantly higher than the BMI of parents of normal weight children (Reifsnider & Ritsema, 2008).

Several studies found a statistically significant correlation between the intake of sweetened beverages and being overweight (Dubois et al., 2007; Welsh et al., 2005), and increased Kool-Aid© intake in obese Mexican American children has been observed (Reifsnider & Ritsema, 2008). Mexican American parents verbalized that a balanced diet was important to their preschool children's health (Gallagher, 2010; Lindsay, Sussner, Greany, & Peterson, 2011; Small et al., 2009). However, although parents acknowledge this need for a balanced diet, they may not be providing it at home. For Hispanic children, child care outside of the home was protective against the development of being overweight, although it contributed to being overweight in non-Hispanic children (Maher et al, 2008). It has been hypothesized that Hispanic mothers tend to hold to the belief that "healthy" is equated with "chubby" (Kimbro et al., 2007; Lindsay et al., 2011). Mexican-American parents have voiced an uncertainty about knowing if their child was overweight; who would tell them if there was a problem; and what to do if their child was overweight (Small, et al., 2009).

Gaps in the Literature

The literature does not often differentiate the country of origin and identifies samples as Hispanic or Latino rather than Mexican, Columbian, Puerto Rican, or as other ethnicities. Further, no literature could be located that reflected Mexican mothers' behaviors after being told their child is overweight or obese. As healthcare providers, it is important to understand the mother's perception of her child's weight status and how she thinks she should care for her child in order to develop effective interventions. Hermeneutic phenomenology as influenced by Max van Manen was used to explore the lived experiences of Mexican-heritage mothers caring for overweight preschool children.

Methods

Research Question and the Hermeneutic Phenomenological Approach

Van Manen (1990) explains that hermeneutic phenomenology tries to be attentive to both terms of its methodology: it is descriptive (phenomenological) because it wants to be attentive to how things appear; it is interpretive (hermeneutic) because it claims there is no such thing as an uninterpreted phenomenon. The facts of the lived experience need to be captured in language and this is an interpretive process.

Van Manen (1990) sees his approach to research as an active and ongoing interplay among six research activities: turning to a phenomenon of particular interest to me; investigating experience as it is lived rather than how we conceptualize it; reflecting on the essential themes which characterize the phenomenon; describing the phenomenon through the art of writing and rewriting; maintaining a strong and oriented relation to the phenomenon; and balancing the research context by considering parts and whole. The phenomenon of interest for this study is Mexican-heritage mothers caring for their preschool children who are overweight. Van Manen (1990) observes that in our desire to find a systematic intervention, we have the tendency "to forget that the change we aim for may have different significance for different people" (p. 7). Van Manen's approach was determined to be the most appropriate method to address the phenomenon of childhood obesity in the Mexican-heritage population. The research question for this study was: What are the lived experiences of Mexican-heritage mothers caring for overweight preschool children? According to Munhall (2007), "Perception of experience is what matters, not what in reality may appear to be contrary or more 'truthful'" (p.161).

Sample and Participant Selection

Participants were solicited in the East Texas area by placing Spanish and English brochures at pediatric clinics, Head Start, local churches, and daycares. Print advertisements were placed in both the local Spanish and local daily newspapers. I was interviewed by the Spanish paper to spark interest about the study in the Mexican community. On-site solicitation took place in a university-based, regional maternal-child clinic. Recruitment of participants took place between October 2011 and January 2012.

Purposive and snowball sample recruitment strategies were used. Inclusion criteria were mothers who were born in Mexico or had at least one parent born in Mexico and who have at least one child, ages two to five years, diagnosed as being overweight or obese. Exclusion criteria were adults other than mothers of preschool children, mothers from other ethnic or racial groups, and mothers with children who do not fall within the set age or weight parameters. Recruitment continued until the achievement of data saturation.

Screening of potential participants was done with the initial personal or telephone contact. The purpose of the study was explained and questions were encouraged and answered. Once it was established that the inclusion criteria were met, I made an appointment with the participant at the location of the participant's choice. For participation, mothers received a $25.00 gift card honorarium and a book for their child.

A total of 12 participants were recruited for the study (Table 1). The mean age was 32. The mean length of United States residency was 12.2 years. All participants had spent part of their lives in Mexico. One mother was born in the U.S., but moved to Mexico as a child. More than half had three or more children and had at least graduated

from high school. All but one lived with her spouse. Many lived in trailer parks or neighborhoods with other families who came from Mexico. Their residences were located in three East Texas counties.

Protection of Human Subjects

The proposal was approved by the University of Texas at Tyler Institutional Review Board (IRB) before implementation. Written informed consents were signed after participants validated their understanding of the study. A translator was available when consent was obtained to assure that participants had a clear understanding of the research process.

Data Collection Procedures

Prior to the first interview, a reflective journal was initiated to address any presuppositions and biases, so that I could be open to what the participant was saying. By making presuppositions explicit, I do not forget them, but following van Manen's (1990) approach, hold "them deliberately at bay and even turn this knowledge against itself . . . thereby exposing its shallow or concealing character" (p. 47). The criteria for place of interview were that it be conducive to audio-taping and that the mother felt free to openly discuss her experiences and thoughts. All of the mothers chose their homes. I conducted interviews with the assistance of a native Mexican translator when needed. Interviews were audio-taped using a digital recording device. A semi-structured interview guide with open-ended questions was used (Appendix B).

Data Management and Analysis

The analysis process began during the interview as I grasped the meaning of the conversation. Field notes were written immediately following the interview and

included: initial interpretations about "messages" received during the interview; non-verbal language as well as the "tone" of the interview; methodological considerations, such as environmental noises, researcher or participant distractors; and, any other tangential information useful to interpreting the meaning of what the participant intended to convey. During the interviews, I solicited frequent feedback to assure understanding of the participants' answers and to facilitate more in-depth explanations. The translator was also used to verify the data and observations. Interviews were transcribed and then read while listening to the audio recording to assure accuracy. Field notes were used to contextualize the transcripts.

When examining the interview transcripts and field note entries, each text was considered by reflecting back and forth between the parts and the whole and vice versa. Field notes were used to enable me to again place myself in that time and place where the interview took place. One of the approaches recommended by van Manen (1990), the highlighting approach, was used to help isolate themes. The transcripts were listened to and read several times to find phrases and statements that were essential to understanding the mothers' experiences. These statements were then highlighted.

Trustworthiness

Lincoln and Guba (1985) describe trustworthiness as important to evaluate the worth of a study, and they have established criteria to operationalize this construct. Trustworthiness is determined by evaluating four criteria: credibility, transferability, dependability, and confirmability. By having prolonged engagement with persistent observation of Mexican-heritage mothers for 15 years as a pediatric nurse practitioner, my credibility with this population was established. Credibility was enhanced by

personal interviews, field notes, a reflective journal, peer debriefing with an experienced qualitative researcher, and member checks. Interviews took place in the participants' homes, and reflected an immersion process into the mothers' worlds to gain an in-depth understanding of their lived experiences. Participant recruitment continued until data saturation was obtained. Feedback was solicited from the participants and the translator during and after the interviews to ensure accuracy of the data and analysis. Negative case analysis was accomplished in two ways. Each transcript was reexamined to determine whether the characteristics of the emerging themes were applicable to each participant's experience. There were no negative cases. Next, the following statement was posed to Teresa: I do not need support from my child's health care provider, WIC, school, or my family to be able to care for my son. Her response was, "Of course it is needed!"

Transferability was accomplished by illustrating themes and subthemes with vivid descriptions that incorporated participants' experiences and verbatim quotes. This detailed information is an essential element of transferability (Polit & Beck, 2012). All demographical data and transcripts were organized using pseudonyms. Audio recordings of the interviews were compared with the numbered lines of the transcripts to safeguard accuracy, ensuring dependability. An audit trail consisting of raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes, personal notes, and demographical data sheets was made available to a skilled qualitative researcher. This was congruent with confirmability recommendations by Lincoln and Guba (1985).

Results

Thematic Analysis

At the beginning of the interview, I asked the participants, "Tell me about your last visit to the doctor--what did the doctor say about (child's name) health?" I solicited mothers' descriptions of their children's health and their perceptions of their weight. Through their eyes, were the child's health and weight problematic? We discussed what others, including family and health experts, have said to them and if they were given any advice. I asked how the mothers cared for the children since their last contact with a health care professional.

The transcripts and field notes were examined individually and together. The context as a whole, in parts, and the fit with the bigger picture were considered. Through thematic analysis, caring behaviors and internal and external influences of the behaviors for this group of mothers were identified (Figure 1). Six essential themes with 16 subthemes evolved from the data and are explained in the following section. The names of the participants have been changed to maintain their anonymity. The term "provider" is inclusive of physician, advanced practice nurse, and/or physician's assistant. Experts include the providers, WIC personnel, and/or the schools/Head Start programs.

Theme 1: Being Mexican: there and here, then and now.

Spanish was the common language for the participants. They lived in communities with other families from Mexico. Traditional foods were the mainstay of the family diet, with tortillas being the most discussed food. The tortillas were described as their "fork or spoon" and "the worst thing to eat. They're good. I love them".

Resource differentials: less is good, more is bad.

The participants reflected on childhood experiences growing up in Mexico, comparing their lives there with their new lives here. Several recalled having very little as children and being able to have more for themselves and their families living in the United States. Vivian, the 32-year-old mother of a five-year-old daughter, recalled being unable to afford anything but bare necessities and summed it up by saying, "I can eat all this stuff that I couldn't when I was young growing up in Mexico--and my little girl, too". Having more comes with a sense of wonder as well as a sense of concern. Olivia, a 25-year-old college student and mother of three children stated that people in Mexico are healthier because they walk more and do not have money to buy food. She recalls having chickens in her yard, growing crops, and not being able to buy much meat. As a young child arriving in the U.S, she recalled her reaction to seeing a table full of food: "We were, like, 'wow' and we just start chowing down. Now that we're over here, I'm guessing that we have food and we want to take as much of it as we can." Food stamps have enabled the Mexican families to buy more at the store, including chips and other snacks. She concluded, "I think now we don't just get what we need, we get more than what we need."

Other mothers made similar comments about having more may not equate with being healthier. There was concern regarding the quality of the available food here, as Veronica, a 37-year-old mother of three stated: "Here . . . if you work, you have money, but it's not natural here. All our fruit, it's natural, but here they . . . put in more stuff (chemicals)." Lidia, a 25-year-old mother of two living in Texas for 10 years, agrees:

> A lot of times, we go to Mexico and see kids that are running around everywhere barefooted in cold weather, outside, no jackets, but they never get sick and my husband says, "They're probably eating more healthy than we think because they don't have the money to go get pizza, they don't have the money to get the fried chicken, so they eating more healthy, more vegetables and more healthy stuff." And over here, it's faster to say let's go get that . . . (it's) already made . . . more convenient.

For Lidia, this is part of the problem.

Resourcefulness.

Lessons learned in childhood about being resourceful were a valuable tool that influenced the mothers' caring behaviors. Most of the mothers stated that they did not find it difficult to purchase healthful foods here. In addition to family income, most of the mothers received assistance from WIC if their child was less than five years of age. This enabled them to obtain milk, cheese, fruits, vegetables, and cereal. Vivian would share what she had with her family living in Mexico. Whatever cereal her family did not consume was boxed and sent to Mexico. Some of the families also received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps). The mothers described stretching their resources by buying foods on sale, which left more in their budgets to buy organic foods that were considered to be better than the less expensive alternatives.

Time was considered a valuable resource. The plight of the working mothers was discussed by those who were working as well as by the stay-at-home mothers. In Elvira's opinion, the working mothers had to resort to buying "the hamburger . . . the pizza . . .

junk food" because it was the easiest thing to do. She felt blessed because she was at home with her daughters and "can cook everything the right way." The description of being "too busy, too tired" with "not enough time," led the working mothers to feel they were not being able to give what was needed to the child. Balancing work and family obligations and the cultural expectation to prepare family meals required time management. Some mothers were more successful with this than others. Lidia, a full time employee, relayed what happened when her friend came for a visit and their children were playing in the room. Her friend turned to her and said, "When are you giving your son time? Are you giving your son any time?" Lidia said, "I felt so bad. I even turn red because I'm not giving my son enough time." Lidia was one of the mothers who relied on fast food.

Planning quick, healthful meals after coming home from work was discussed by Veronica. Time constraints did not prevent her from feeding her family, "because I cook easy things and not that fat. I cooked baked potato; I cook scrambled egg, and they like tostados with beans and cheese." She opened her refrigerator, lifted out a package of organic cheese and stated, "It's not fat." She does not use eggs or cheese from WIC because they are not organic.

Theme 2: Seeing the child through many eyes.

How the mothers "see" their children and the influences on their perceptions were explored during the interviews. Many eyes are looking at the same child: the mother, the family, and the experts (providers, WIC personnel, and school officials). Three subthemes emerged: perceiving normalcy, acknowledging excessive weight, and softening the blow by experts and family members.

Perceiving normalcy.

Being healthy, looking like other family members, having a "strong build," and being in a temporary phase were descriptions used by the mothers to rationalize their children's weights and to feel they are normal. When describing children as healthy, mothers correlated this with "being active," "running around," "eating fruits and vegetables," and "not getting sick." After describing her daughter as the grandfather's clone or "Mini-me," Ana, the mother of a three-year -old girl, said, "They're just kids and it's not a disease." She saw her daughter as "very active, she runs like any, you know, like any normal, skinny baby." She attributed her child's size to "that's just her body figure because she came out big, like when you look at her baby pictures, she's been big since she was little." The image of being big and strong came through in the interview with Olivia, who described her four-year-old son this way: "You can't pick him up. He's heavy, but not the fat kind of heavy. He's just strong built . . . so that's the kind of heavy he is."

For several mothers, this was not their first child who had been classified as overweight. "I know my other kids--they've gone through this before. They go through this phase where they get chunky, but then they outgrow it," explained Teresa, a 29-year-old mother of three. These mothers viewed "being chunky" as a phase.

Acknowledging excessive weight.

For several of the mothers, there was concrete evidence that the child's weight was a problem. For example, for Vivian clothing size was a factor that made the issue clear: "Size 6 didn't fit. She was wearing size eight and 10 for a five-year old."

In the providers' offices, words and tools brought the message home for several mothers. Lidia discussed believing what her son's provider had said: "The doctor told me at the last visit that he was overweight. Well if the doctor says that, he knows." Maricela, a 38-year-old mother of three expressed concern about her two-and-one-half-year-old son: "In the clinic they have a diagram where they show where he's supposed to be for his age and he was way above the chart." The visualization of the growth chart had a powerful impact.

Softening the blow.

While speaking with the mothers, there was a sense of a downplaying of the weight issue by others with whom they had a relationship. When discussing how others viewed their children, most of the mothers relayed they had been told that their child was "just a little bit overweight" by healthcare providers and family members. Veronica explained "My sister says (my daughter) looks a little fat. She looks a little, but not much."

With healthcare providers, a child's height in relation to their weight was referred to frequently. Teresa's statement exemplified what about one-third of the mothers heard from the healthcare providers: "Well the doctor just told me that he is overweight a little bit." She said she was told not to worry, "because he is too tall for his age. She (the provider) would be more worried about it if he was short and big, but he's big and tall, so that's what she told me." The significance of this softening from a cultural perspective was clarified for me during a discussion with Leticia, a 49-year-old mother of two: "It doesn't help to say he's okay because we as Mexican people, we think if they tell us a

"little bit" . . . a little bit for us is a little, little bit. We make it the smallest." With softening, mothers hear what they want to hear instead of what they need to hear.

Theme 3: Bearing the emotional burden.

Suffering under the weight.

During the interviews, the most prevalent emotion expressed by all was worry--they worried about their own children, other children in the extended family, and about the Mexican people. If the children were not at home, they pointed to their picture and pictures of other children in the extended family. The conversation with Graciela, a 37-year-old mother of a four-year-old daughter depicts the impact of this pervasive emotion. Speaking about her overweight daughter she said, "I really worry because I always tried to take care, not giving her things to make her fat." She brought a picture of her overweight nephew to the kitchen table where the interview was taking place:

> He's suffering because he's fat . . . other children . . . make fun of him . . . now is bigger than that picture and he's obese and he's having problems. I worry a lot because he's my nephew and I feel like he's my own son. I love him. . . . I am worried about the Mexican people because we do have a rough time keeping our children healthy and even ourselves.

The mothers spoke about the weight issue being their fault and feeling guilty because they were not doing something right. "Most of the time I feel like it is my fault that he's big," Lidia explained. Maricela said, "I felt guilty like I was doing something not right." Mothers expressed how hard it was to see any progress, despite their effort. "You know, I would give her fruit and vegetables and stuff and it just wouldn't work. I

mean it's not working," stated another participant. Another summed up her feelings with, "I don't know how I can help her."

The weight of emotional burden these mothers carried was palpable. I could see it in their eyes and in their hand gestures, and could be hear it in their emphatic speech. It was obvious that this was a major predominant force in their minds.

Struggling to keep control.

The mothers described feeling as though they could not control what was happening in their child's life. Some described the fathers giving in to whatever the child wanted: "Her daddy takes her somewhere--he's always giving her Cheetos or cookies. He says he wants to keep the baby happy, so he gives her whatever she wants." Inconsistencies in caring behaviors among those entrusted with the children's well-being added to a perception of the mothers not being in control. Lidia expressed her frustration that the school should be taking care of her children by encouraging healthy foods, but instead they give them "hamburger and the pizza." Fear of being blamed for the inability to control the situation was expressed by Ana:

> I don't want her to blame me for being the way she is because it seems like everybody else is blaming me, you know, and it's like I can control it. I should be able to because I'm her mom, but it's just not that easy.

The stay-at-home mothers told stories of working friends that fed their children fast foods such as pizza and hamburgers because there was no time for them to cook at the end of a long day. Leticia recently reunited with her husband after a separation and talked about quitting her job one week prior to the interview in order to be able to regain control of the situation at home. She hopes to be able to take her son to the park more

often and prepare healthful meals. But as a consequence of being unemployed, there is now less money to buy food. Olivia's parents worked when she was a child, and this experience influenced her to delay entering the workforce, to be an active participant in her son's life, and to have more control over meal preparation.

Theme 4: Feeding the issue: disconnectedness.

"Disconnects" were clearly evident as transcripts were examined separately and as a whole. Several of the mothers experienced disconnectedness at home, but more often there were disconnects involving the experts in whom the mothers had entrusted the care of their children.

Disconnectedness: among the experts.

The feedback many mothers received from the child's provider, the WIC office, and Head Start often was contradictory. This caused confusion for the mothers and put them in a situation in which they had to choose whom to believe. Carmen, a 26-year-old mother of four describes what occurred in the clinic: "Whenever she (my daughter) went to see the doctor, he checked her, they give her vaccines and the doctor didn't say nothing. He tells me she was fine. When she went to WIC, they made me aware she was overweight."

Lidia expressed confusion regarding food served in the school cafeteria: "Maybe I'm confused because the doctor is telling me one thing, WIC is telling me one thing, and then the school is giving them something completely different." Olivia explained that she was told by her four-year-old son's provider that he was fine because of his height, but she received a letter regarding his weight from Head Start. She described her experiences with the WIC office, where she was also told that he was overweight. She concluded,

"You kind of have to trust the doctor more…you kind of have more confidence in the doctor."

Disconnectedness: between the mother and the expert.

The majority of the mothers felt rushed at the providers' offices because of the volume of patients being seen by the provider. Often, there was little opportunity for questions. When instructions were given, they were non-specific or did not consider the family diet.

Teresa describes her experience at the office of her son's provider: "If you see a doctor . . . it's like you don't know whether you should ask or not because it seems like they're in a hurry to get out and go to the next patient." Graciela expressed feeling as though her input was not wanted or needed: "They never ask how I feel about my child's health. He (the provider) didn't tell me anything. Sometimes I go and unless I ask, they won't tell me anything."

When receiving instructions from a provider, there was a disconnect between what the family normally eats and what the provider says the child should eat. Some of the mothers stated that the children disliked the recommended foods and preferred the traditional foods. Lidia explained: "I always use eggs, beans, Mexican style food. So now WIC give me a list of vegetables and the kids don't like them because they're used to me serving the other." Ana was told by her daughter's provider to limit the amount of meat and beans, but Ana finds this difficult because, "You know us being Hispanic, that's what we eat a lot of, like on a daily basis." For Ana, following these instructions was not easy: "It's kinda hard to make food just for her--like her own meal." In reality, Ana did not need to prepare a separate meal, but needed to understand how to limit the amount of

food. Ana also expressed confusion when discussing instructions she received: "Well, (the provider) said something about starches are not good, but like I don't know what a starch is." Carmen stated she was told by the WIC personnel to not put her child on a diet "because she's too young to be on a diet. They give me a paper of what to feed her and what not to feed her, but they didn't tell me how to feed her." Although the mothers looked to their healthcare providers for guidance, the mothers were left with more questions than answers.

Disconnectedness: between the parents.

Fathers were not always receptive to what the providers had told their wives. Several fathers challenged the opinion of the experts. Lidia spoke about her husband's reaction: "My husband got mad and said, 'You tell that doctor he's crazy because he is not fat.'" This sparked an argument between the parents. Lidia told her husband, "Well if the doctor says that, he knows he is bigger." To which her husband responded, "He's crazy, the doctor is crazy." Graciela had a similar experience: "He (the dad) thinks that was a lie, that it was not true. 'She is okay, she's not fat,' is what he says." On her kitchen counter was a large bowl, brimming with fresh fruits. She explained that she was trying her best to feed her child healthier foods. She tried to avoid going shopping with her spouse as she did not always approve of his food choices, which include snack foods. She told her husband, "With that money, if you go to the Mexican store, you can get a pineapple for two dollars and spend less money. It's a lot better for her."

The children can become aware of the disconnection between the parents which can make one of the parents appear to be the "bad guy." Graciela's husband chose to spend more money to buy Cheetos instead of the pineapple. Veronica said her husband

will buy their daughter cookies when she asks, saying, “It’s only one time.” When the participant and her daughter are at the grocers, the mother refuses to give in to her child, and tells her daughter the cookie is not good for her. She summed it up by saying, “I can’t. I’m not going to buy something like that” even if she is crying.

Disconnectedness: between the mother and other family members.

Several of the mothers discussed conflicts they encountered when dealing with other family members outside of the nuclear family. Ana describes her interaction with the extended family: “Like, it'll become a discussion--they'll sit here and attack me about ‘you feed her every time she wants to be fed’ and I'm like, ‘you know, well, whenever you're hungry, you eat.’ I feel like they don’t understand.” She then spoke about her mother-in-law, who expressed concern about the two-and-one–half-year-old girl’s weight but then goes to the store and buys the child chips because the child asks for them.

Graciela and Lidia discussed having relatives who were overweight. Graciela sees her in-laws as not worrying about the health of their own children because they never prepare vegetables in their homes. Resistance is met when the mothers attempt to share what they had learned with the family members. Lidia described her mother-in-law feeding her “heavy, heavy overweight” brother-in-law pizza pockets and soda and “everything in the icebox.” Lidia says she told her mother-in-law, “You’re giving him that stuff and that’s what’s making him big.” “Oh no, he’s not big, he’s fine,” was the response she received.

Theme 5: Being together: support through connectedness.

Connectedness: between mothers and the experts.

Being supported in their efforts to "give the children the right nutrition so they won't get sick" was important to the participants. Several of the mothers found the advice they had received from the WIC office to be valuable. Elvira, the mother of three preschool children, said she received a DVD about exercise, useful recipes, and instructions on how to make fruits and vegetables fun for the children. Olivia described the value of the WIC program to her family, finding the recipes useful. From her perspective "the WIC office, they're probably the only place nutrition-wise where I get more information from."

I was used as an expert during many of the interviews. While I was in the homes, many of the mothers used the visit to ask questions about how to measure portions, choose foods at the store, and make vegetables more appealing to the children. They asked what books or websites were helpful. They wanted to be able to do everything they could--to do the best for their children.

Connectedness: between the parents

For many of the participants, having a united front helped them to care for their overweight children. The future benefits convinced Elvira's husband to support his wife's efforts. She said her husband felt that following the WIC personnel's advice would keep the child from having to go to the doctor. In the future, their daughter "is not going to develop high blood pressure, diabetes and cholesterol. So he is happy with it."

Some mothers had spoken about their husbands giving the children sweets despite the mothers' disapproval. For Teresa, that was not a problem: "If I say no, he doesn't

like to, how you call it, undermine me . . . yeah, we don't do that. I don't undermine him so he doesn't like to do that." Maricela also spoke about the importance of parents being united: "He is together with me because before we had children, we talked about when we had children; we were going to raise them healthy and buy the good food that they need to eat." Having a united front as parents facilitated the mothers' ability to provide a healthier lifestyle for their children.

Connectedness: with neighbors

Elvira describes how she and three of her neighbors worked together to supervise children so they get outdoor play time. It was important to her that the children "go outside and play and socialize with the rest of the neighbors' children." The mothers "take care of each other." Neighbors also assisted Vivian, whose child was no longer eligible for WIC. "They get a lot of food from WIC because they have three or four children on WIC and I don't anymore. They bring me help and bring me cereal because their little children don't want cereal." Whatever is then left, she sends to Mexico.

Theme 6: Protecting the future: lessons learned from the past and present.

Anticipated suffering from untoward social consequences.

Graciela, who had seen the effect of teasing on her overweight nephew, stated she was trying everything she could to prevent this from happening to her daughter. Ana recalled her sister's experiences and was concerned about her daughter's future in school. Her sister was overweight and "she said she would suffer a lot at school." This memory prompted Ana to say that she was afraid of what would happen when her daughter went to school, "because kids are mean . . . that's my biggest fear."

Preventing untoward physical consequences.

The majority of the participants had family histories of weight-related chronic illness. They spoke about their concerns regarding the risk for their children in the future and what actions were needed now. Ana was apprehensive about her daughter developing diabetes, like her grandfather. She recalled asking her daughter's provider to test her "just because I don't want her to get it." Olivia felt being proactive was important. Her own mother had developed hypertension and dyslipidemia. She did not want her children to follow that path: "I don't want them to have high blood pressure or cholesterol or diabetes or anything [where] they have to take care of what they eat because they didn't eat healthier when they should have." She felt that it was important for parents to lead by example by exercising and eating healthier foods because if "we try, they will also do it."

In the attempt to influence children's food preferences and prevent future problems, mothers monitored television viewing carefully. Yanely, a 37-year-old mother of six, allowed her two-year-old to watch a children's show that encourages healthful eating. After watching the show, the daughter will ask her mother for fruit. Watching Popeye inspired Maricela's son to eat spinach. Several mothers described making decisions that may not be popular with their children, but that were choices to protect their health. Maricela brought the children's water jugs with her to family parties and discouraged friends and relatives from giving her children soda. Graciela refused to give her child other foods if vegetables were not eaten during a meal: "I don't give her a choice."

All of the participants voiced a need for more useful information, and the mothers even expressed interest in bringing their child to me as a provider. As Leticia said, mothers needed more help "learning how to break those bad habits." Their hope was that

the children had a better life than their own. They expressed a desire that their children got a good education, had good jobs, and, most of all were healthy.

Phenomenological Reflection

Van Manen (1990) recommends that the four existentials (*lived space, lived time, lived body, and lived other*) serve as useful guides for the process of phenomenological reflection. These existentials were incorporated into the review and analysis of the transcripts and field notes. *Lived space* is felt space; the space in which we find ourselves affects the way we feel. The participants were given options as to where the interview would take place. All of the participants invited me into their homes and this is where all interviews occurred. *Lived body* refers to the fact that we are always bodily in the world, in our bodily presence. Being "big" was often a family norm. *Lived time* is subjective time and our temporal way of being in the world. The mothers reflected on their past lives in Mexico. Their childhood experiences influenced their perception of the present. Most saw more opportunity in Texas for a better life for their children than in Mexico. *Lived other* is the lived relationship we maintain with others in an interpersonal space. The participants were warm and welcoming. Relationships were very important and were needed for support.

Discussion

The study illuminated maternal perceptions and how those perceptions shaped caring practices for their overweight pre-school aged children. Six themes captured these perceptions through the mothers' reported lived experiences.

Theme 1: Being Mexican: There and Here, Then and Now

The bond with their heritage has remained strong and is a major influence on the mothers' lived experiences. All of the mothers were fluent in Spanish and for most, it remained their primary language. A picture of Our Lady of Guadalupe, a recognized symbol of Mexican Catholics, hung in many of the homes. Most of the participants lived in trailer parks or neighborhoods with other families who came from Mexico. Traditional foods remained the mainstay of the family diet. Ingredients were readily available in Mexican specialty markets located in the area.

Childhood experiences in Mexico influenced their perceptions of their experiences in Texas. When comparing life in Mexico with life in the U.S., many mothers believed it was easier to be healthy in Mexico because of the availability of fresh produce and the necessity of walking as the primary mode of transportation. This perception was consistent with findings by Guendelman, Fernald, Neufeld, and Fuentes-Afflick (2010). The mothers' assessment was not without merit. Rosas et al. (2011), in a bi-national study, found a greater prevalence of childhood obesity in children of Mexican heritage living in the US than in Mexico.

The majority of the mothers reported having adequate financial resources to purchase healthful foods. Choosing healthful foods was challenging for some because they were unsure of what to buy. Being resourceful by shopping for sale items helped to stretch family budgets. Many experienced past food insecurities and now see the opportunity to have more by living in the United States, leading to increased food consumption. This is consistent with findings by Kuyper et al. (2006) and Guendelman et al. (2010). Kuyper et al. (2006) observed previous food insecurity leads to less maternal monitoring of sweets and snack foods.

Theme 2: Seeing the Child Through Many Eyes

In discussions about their children's weights, the participants often used comparisons with other family members to rationalize perceived normalcy. Health and weight were mutually exclusive. They equated being big with being "strong." Further, all participants viewed their child as being healthy because being overweight is "not a disease." Maternal perceptions and attitudes related to their children's body size are seen as a major influence on feeding practices for this population in other studies (Chaidez, Townsend, & Kaiser, 2011; Rosas et al., 2011). Frank discussions with healthcare professionals, reinforced with concrete evidence such as growth charts, enabled some of the participants to acknowledge that weight was becoming problematic. For Mexican-heritage mothers, health care providers' assessments were an important influence on maternal perceptions of a child's overweight status (Guerrero, Slusser, Barreto, Rosales, & Kuo, 2011). When examining parental recall of physician communication of weight status, Perrin, Skinner, and Steiner (2011) reported that fewer than 25% of parents of overweight children report having been told that their child was overweight. There was a tendency to minimize the weight issue by both healthcare professionals and other family members in this study. This in turn appeared to diminish the importance of the issue to the participants. As one mother stated, hearing "a little bit (overweight)" led to seeing "the smallest" degree of being overweight. This minimizing may be fed by the use of outdated BMI classifications, which can lead to confusion (Ogden & Flegal, 2010). What was once called "at risk for overweight" is now classified as "overweight" (85th to < 95th percentiles). Pre-2007 classification of "overweight" is now called "obese" (≥ 95th percentile). The manner in which health care providers communicate with families may

be further tempered by the 2007 recommendations. Ogden and Flegal (2010) note that the American Medical Association expert committee recommended using the clinical terms of "overweight" and "obesity" for documentation purposes but non-pejorative terms should be used when working with families.

Most of the participants were dissatisfied with their relationship with the experts, and especially with the providers. There were inconsistencies between their child's provider and the nutritionist at WIC in the identification of the child's BMI. This contradiction exists despite the fact that WIC and providers use the same criteria to assess BMI and provide nutritional counseling as required by the Texas Department of State Health Services to (Health and Human Services Commission, 2011). Schools were identified as sending mixed messages.

Theme 3: Bearing the Emotional Burden

The overwhelming weight of emotional burden was evident during the interviews. Participants expressed feelings such as worry, fear, guilt, helplessness, and a lack of control. Kaplan, Kiernan and James (2006) reported emotions of anguish by parents and grandparents of preteens due to their inability to control the child's diet. However, Kersey, Lipton, Quinn & Lantos (2010) observed high levels of perceived control by Latino preschoolers regardless of BMI. Their concerns were for their own children, members of their extended families, and their people as a whole. Time constraints added to the burden carried by working mothers in this study because of the difficulty of meeting family obligations. Buzzanell, Waymer, Tagle, and Liu (2007) reported similar findings in that Hispanic mothers experienced pain, guilt, and anxiety when trying to prioritize family over work responsibilities.

Theme 4: Feeding the Issue: Disconnectedness

There is an expectation that providers be warm and friendly by exhibiting *personalismo* and using *educado*. This means the provider should take a personal interest in the Mexican- heritage family (Management Services for Health, 2006; Sobralske, 2006), and be "attentive and attuned to the emotional components of social relationships and respectful behavior" (Howes and Obregon, 2009, p. 273). At providers' offices, mothers felt rushed and questions from the mothers were often not solicited or adequately answered. Maternal input was not requested. Instructions were frequently perceived as not being useful because cultural traditions were often not considered.

Theme 5: Being Together: Support Through Connectedness

Being supported by others was crucial. Connecting with the experts, family members, and neighbors was valued by the participants. Supportive relationships provide Mexican-heritage mothers with strength even when confronted with very stressful and challenging circumstances (Buzzanell et al., 2007; Marsiglia, Kulis, Perez, & Bermudez-Parsai, 2011). In the Mexican culture, *familismo, simpatía,* and *respeto* are three important values which may explain why spousal support and avoidance of conflict were so important to the participants in this study. The concept of familismo (familism) is a strong sense of family care and obligation (Warda, 2000; Hancock, 2004; Padilla & Villalobos, 2007). The mothers in this study repeatedly said that they were trying to do their best for their children. Consistency between the parents assisted the mothers in their quest to provide a more healthful diet. This harmony assures simpatía is maintained. This is a cultural value that encourages avoiding interpersonal conflict. It is important for the well-being of a relationship (Gamble & Modry-Mandell, 2008). Marital conflict

sometimes arose when spouses challenged the experts, and mothers' efforts to adhere to recommendations were undermined. Maintaining respectful hierarchical relationships is determined by age, gender, and social status and is called respeto (Antshel, 2002; Harwood, Layendecker, Carlson, Asencio, & Miller, 2002). Yu et al. (2008) found the influence of respeto on relationship adjustment may vary depending on gender. The outcomes vary depending on who adheres to respeto, mothers or fathers. Power differentials within Mexican culture may influence associations between the value of respeto and parenting outcomes. Mothers in this study quickly seized the opportunity to connect with the provider-researcher to learn more about how to better care for their children, having not had the occasion to do so on previous provider visits. Overall, WIC personnel were seen as the most consistent experts in identifying the children's weight as being a problematic issue. The advice provided by WIC was viewed as the most constructive and useful to the mothers.

Theme 6: Protecting the Future: Lessons Learned From the Past and Present

The influences of the past, present, and future were integral to the mothers' caring practices. Past familial experiences helped the mothers recognize potential risks of developing untoward consequences from being overweight. This finding is in contrast to a study that found parents of Latino preschoolers acknowledged obesity health risks but they did not believe these risks applied to their children (Kersey et al., 2010). However, recognition of the problem of obesity has been shown to motivate mothers to enforce better eating habits (Webber, Hill, Cooke, Carnell, & Wardle, 2010). Parental role-modeling was another proactive measure practiced by the mothers, and has been recommended for promoting positive child behaviors (Dave, Evans, Pfeiffer, Watkins, &

Saunders, 2010; Kaplan et al., 2006; Moore et al., 2010). They discussed their hopes and dreams, wanting a better life for their children. As I listened to the mothers' stories, it was as though one could see their arms enfolding their children, holding them close to protect them. They looked at the past, were living in the present, and trying to protect the future.

Limitations

Limitations of this study include several issues. Generalizability is limited because the population encompassed residents in only three counties of East Texas. No medical records were obtained even though the mothers understood that they were eligible if they were told by a health care provider that their child was overweight or obese. Language barriers, even with the use of an interpreter, may have affected the richness and depth of the interviews. Further research will be needed to ascertain if the results can be useful when working with Mexican-heritage mothers in other locales.

Implications for Nursing Practice and Research

Munhall (2007) states the final narrative and descriptive piece of a study must have relevance for the nursing profession. In order to do this, the following questions must be addressed. What meaning do the findings have for nursing practice and theory? Does the final narrative contain implications that critique current nursing practice and introduce new ways of understanding experience? Does it free us from pre-existing suppositions?

The need to treat clients holistically is a major practice implication of this study. The nurse must examine the derivation of both the clients' and one's own perceptions of a phenomenon. Cultural influences, social support, past experiences, available resources,

and emotional status all play integral roles in a mother's ability to partner with nurses in developing a working plan to effectively care for overweight children.

The participants identified what they wanted from nurses and other health professionals. Communication is essential, and maternal input is key when developing a plan of care. The need to discuss weight and potential health risks in an open and frank manner is critical for health professionals to do in working with this population. Questions must be encouraged and answered in a manner understandable to the client. Clear, useful information should be given, such as incorporating cultural traditions into economical and time-saving recipes with specific portion recommendations. Most importantly, health professionals must validate that the mothers have understood what has been discussed during the visit. By showing personal interest and respecting the patient's culture, nurses can expect to win a patient's *confianza* (trust) (Management for Health, 2006).

A crucial pre-existing supposition for this researcher was strongly dispelled. This was that an educational deficit would not be an issue in this study. This assumption was based on the fact that many of these children were on WIC where the mothers received nutritional education. They also had Medicaid and the children received an annual Texas Health Step (well exam) where education is a key component. The participants demonstrated otherwise --knowledge deficits in this population were profound. Even if they received education, it was not understood or feasible. Knowledge deficits in this population were profound. Even if they received education, it was not understood or feasible. Nurses can use information from this study to be better advocates for their clients in both the practice setting and health policy arena. These findings also lead to the

need for further scientific inquiry, including assessing the perceptions of fathers and the experts for this population. Interventional studies that incorporate recommendations from study participants (mothers, fathers, providers, experts) should be tested to provide evidence-based practice guidelines to positively impact the serious problem of childhood obesity in the Mexican-heritage community.

Conclusions

This study reflects an exploration of the lived experiences of Mexican-heritage mothers caring for overweight preschool children. Understanding maternal perception is key to this study. What the mothers see through their own eyes and the eyes of others is viewed through the lens of their personal experiences. Their understanding of the phenomena shapes their caring practices. Major findings reveal significant issues with lack of knowledge and lack of support from experts and families when the mothers are attempting to address the problem through diet and activity. Implications for health care providers highlight the importance of acknowledging cultural influences and ensuring that accurate, understandable, and useful information is disseminated to parents, families, and other experts, such as schools, daycares and WIC. Addressing this problem now with early intervention will impact the rising health care expenditures and co-morbidities associated with obesity.

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Appendix A

Table 1

Demographic Characteristics of Participants (n=12)

Characteristic	Mean	Range
Maternal age	32	19-49
Family Income	25,033.33	10,000-50,000
Household Residents	4.83	3-8
Years in the U.S.	12.17	5-23
Characteristic	*n*	%
Place of birth		
Unites States	1	8.3
Mexico	11	91.7
Maternal Education		
elementary	3	25.0
some high school	2	16.7
high school graduate	3	25.0
some college	4	33.3
Marital Status		
married	11	91.7
separated	1	8.3
Primary Language		
English	1	8.3
Spanish	9	75.0
Both	2	16.7
Gender of Study Child		
Male	5	41.7
Female	7	58.3
Age of Study Child		
2	1	8.3
2.5	1	8.3
3	1	8.3
4	6	50.0
5	3	25.0

Appendix B

Interview Guide

Grant tour question:

"Tell me about your last visit to the doctor - what did the doctor say about (child's name) health?

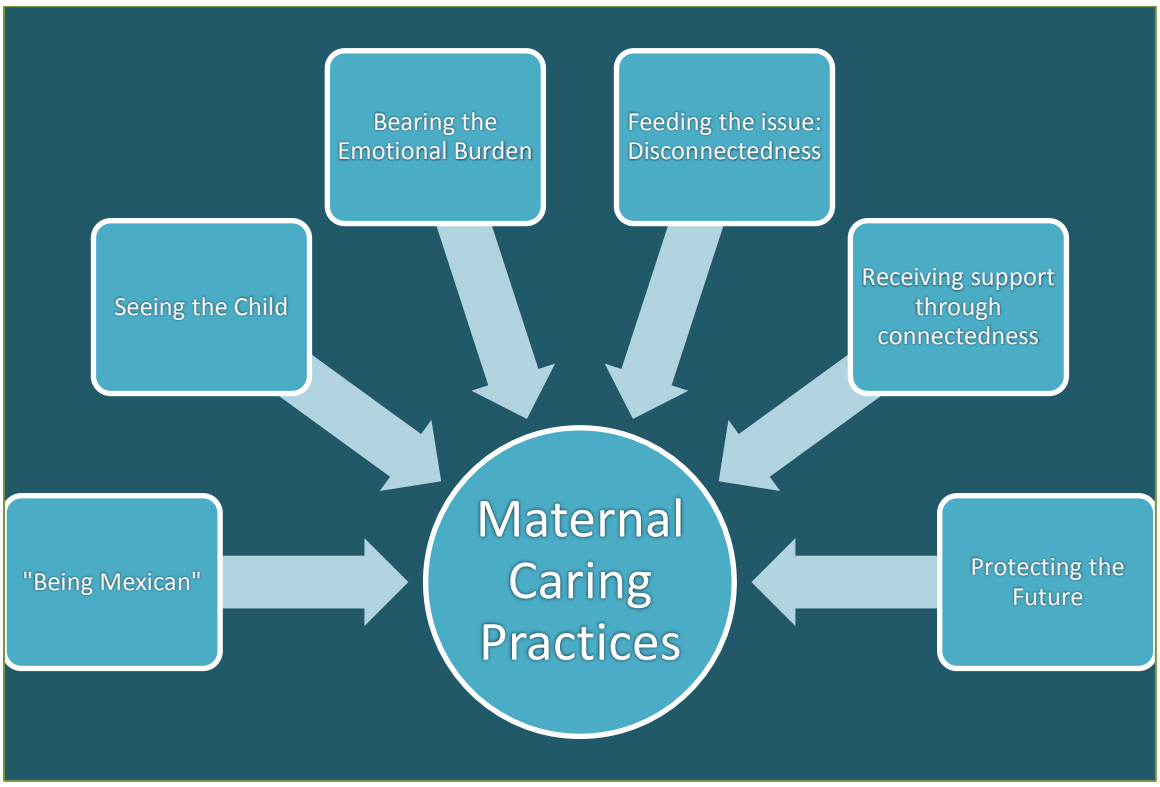
Follow up probes:

- Description of child's health
- Mother's perception of child's health and weight and if it is problematic
- What others (family, friends, health care providers, media) say or advise about child's weight and mom's perception of what is told
- Mom's selection of CDC picture most like her child
- What does mom do for child's weight, if any?
- Other influential factors for how mom cares for child

Appendix C

Figure 1

Maternal Perceptions Shaping Caring Practices



Chapter 4
Summary and Conclusion

Evaluation of the Project

The goal of this research was to explore the lived experiences of Mexican-heritage mothers caring for overweight preschool children. One of the strengths of this study was the development of an operational definition of perception. When examining this concept, the complexity of perception formation was revealed. Understanding clients' perceptions has been found to be crucial when teaching effective self-care activities (Sultan, Attali, Gilberg, Zenasni, & Hartemann , 2011). More importantly, a voice was given to those who usually did not have the opportunity to describe their experiences to a health care provider. Six themes and 16 subthemes emerged from the data. Maternal caring practices were influenced by their Mexican heritage, emotional burdens, perceptions of child's weight status, disconnectedness and connectedness with family and health care professionals, and the linking of past family history and practices with present needs in order to protect children from untoward consequences of overweight. During the interviews, there was an exchange of information between the participants and the researcher. While the researcher gained insight into the challenges faced by the mothers, the participants had an opportunity to gain knowledge about how best to care for their children.

Limitations of this study include several issues. Generalizability is limited because the population encompassed residents in only three counties of East Texas. No medical records were obtained even though the mothers understood that they were eligible if they were told by a health care provider that their child was overweight or

obese. Language barriers, even with the use of an interpreter, may have affected the richness and depth of the interviews.

Recommendations Based on the Findings

The need to treat clients holistically is a major practice implication of this study. The nurse must examine the derivation of both the clients' and one's own perceptions of a phenomenon. Cultural influences, social support, past experiences, available resources, and emotional status all play integral roles in a mother's ability to partner with nurses in developing a working plan to effectively care for overweight children.

The participants identified what they wanted from nurses and other health professionals. Communication is essential, and maternal input is vital when developing a plan of care. The need to discuss weight and potential health risks in an open and frank manner is critical for health professionals in working with this population. Questions must be encouraged and answered in a manner understandable to the client. Clear, useful information should be given, such as incorporating cultural traditions into economical and time-saving recipes with specific portion recommendations. Most importantly, health professionals must validate that the mothers have understood what has been discussed during the visit. Being seen as cold and impersonal can cause Mexican-heritage clients to lack confidence in health care providers (Horwitz, Roberts, & Warner, 2008; Zoucha, 2000). By showing personal interest and respecting the client's culture, nurses can expect to win a client's trust.

Conclusion

This research reflects an exploration of the lived experiences of Mexican-heritage mothers caring for overweight preschool children. Understanding maternal perception is a key element of this study. What the mothers see through their own eyes and the eyes of

others is viewed through the lens of their personal experiences. Their understanding of the phenomena shapes their caring practices. Major findings reveal significant issues with lack of knowledge and lack of support from experts and families when the mothers are attempting to address the problem through diet and activity. Implications for health care providers highlight the importance of acknowledging cultural influences and ensuring that accurate, understandable, and useful information is disseminated to parents, families, and other experts, such as schools, daycares and WIC. Addressing this problem now with early intervention will impact the rising health care expenditures and co-morbidities associated with obesity.

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Appendix A

Demographic Information

Participant Number_____

Maternal Information

Maternal Age: _____

Marital Status: ____Single ____Married _____Separated ____Divorced ____Widowed ____Other (describe:_____)

Maternal education in yrs.: _____ Family annual income: _____

Place of birth: ___U.S. ___Mexico

If U.S., parent born in Mexico: ____ Mother ___Father

If Mexico, number of years in U.S. _____

Primary Language: _____ English _____ Spanish _____ Both

Enrolled in WIC: ____ Yes _____No

Household Information

Number of people residing in the home: _____

Adult Household members: _____ mother ___ father _____grandmother _____grandfather _____other (describe :_____)

Child Information

Number of children in family: _____

Age and gender of child 1: _____ age _____male _____female

Age and gender of child 2: _____ age _____male _____female

Age and gender of child 3: _____ age _____male _____female

Age and gender of child 4: _____ age _____male _____female

Preschool child 1: Daycare/preschool ____Yes _____No

Preschool child 2: Daycare/preschool ____Yes _____No

Appendix B
Consent

THE UNIVERSITY OF TEXAS AT TYLER

Informed Consent to Participate in Research

Institutional Review Board # F2011-11

Approval Date: 10/4/11

1. **Project Title**: Lived Experiences of Mexican Mothers With Overweight Preschoolers

2. **Principal Investigator:** Susan McDonald

3. **Participant's Name:**

To the Participant:

You are being asked to take part in this study at The University of Texas at Tyler (UT Tyler). This permission form explains:

- Why this research study is being done.
- What you will be doing if you take part in the study.

This form also talks about the risks that may happen with this study. After talking with the person who asks you to take part in the study, you should be able to:

- Understand what the study is about.
- Choose to take part in this study because you understand what will happen

4. Description of Project

The purpose of this study is to ask mothers about how they care for their preschoolers after the nurse or doctor tells them their child weighs too much. Nurses and doctors can use your story to help other mothers who have children who weigh too much.

Appendix B (Continued)

5. Research Procedures

If you agree to be in this study, we will ask you to do the following things:

- You will be asked to set up a meeting with the researcher to talk about how you care for
  your child in your home.

- You may be asked to meet again if more information is needed.

6. Side Effects/Risks

You may become slightly upset when discussing your child's health, though we do not expect this to be a common problem. Should you become upset, the researcher, as a nurse practitioner, can help you if needed.

7. Potential Benefits

Nurses and doctors can help other families of overweight children by learning about how mothers care for their children.

Understanding of Participants

8. I have been given a chance to ask any questions about this research study. The researcher has answered my questions.

9. If I sign this consent form I know it means that:

- I am taking part in this study because I want to. I chose to take part in this study after having been told about the study and how it will affect me.

- I know that I am free to not be in this study. If I choose to not take part in the study, then nothing will happen to me as a result of my choice.

- I know that I have been told that if I choose to be in the study, then I can stop at any time. I know that if I do stop being a part of the study, then nothing will happen to me.

- I will be told about any new information that may affect my wanting to continue to be part of this study.

- The study may be changed or stopped at any time by the researcher or by The University of Texas at Tyler.

- The researcher will get my written permission for any changes that may affect me.

10. I have been promised that that my name will not be in any reports about this study unless I give my permission.

11. I also understand that any information collected during this study may be shared as long as no identifying information such as my name, address, or other contact information is provided). This information can include health information. Information may be shared with:

- Organization giving money to be able to conduct this study
- Other researchers interested in putting together your information with information from other studies
- Information shared through presentations or publications

12. I understand The UT Tyler Institutional Review Board (the group that makes sure that research is done correctly and that procedures are in place to protect the safety of research participants) may look at the research documents. These documents may have information that identifies me on them. This is a part of their monitoring procedure. I also understand that my personal information will not be shared with anyone.

13. I have been told about any possible risks that can happen with my taking part in this research project.

14. I also understand that I will not be given money for any patents or discoveries that may result from my taking part in this research.

15. If I have any questions concerning my participation in this project, I will contact the principal researcher: Susan McDonald at (936) 468-7725 or email her at mcdonaldsm@sfasu.edu

17. If I have any questions concerning my rights as a research subject, I will contact Dr. Gloria Duke, Chair of the IRB, at (903) 566-7023, gduke@uttyler.edu,
or the University's Office of Sponsored Research:

The University of Texas at Tyler
c/o Office of Sponsored Research
3900 University Blvd
Tyler, TX 75799

I understand that I may contact Dr. Duke with questions about research-related injuries.

18. CONSENT/PERMISSION FOR PARTICIPATION IN THIS RESEARCH STUDY

I have read and understood what has been explained to me. I give my permission to take part in this study as it is explained to me. I give the study researcher permission to register me in this study. I have received a signed copy of this consent form.

_____ _____

Signature of Participant Date

_____ _____

Signature of Person Responsible Relationship to participant

(e.g., legal guardian)

_____

Witness to Signature

19. I have discussed this project with the participant, using language that is understandable and appropriate. I believe that I have fully informed this participant of the nature of this study and its possible benefits and risks. I believe the participant understood this explanation.

_____ _____

Researcher/Principal Investigator Date

Appendix C
IRB Approval

The University of Texas at Tyler
Institutional Review Board

September 29, 2011

Dear Ms.McDonald:

Your request to conduct the study entitled *Lived Experiences of Mexican Mothers With Overweight Preschoolers* is approved as an expedited study, IRB #F2011-11 by The University of Texas at Tyler Institutional Review Board. This approval includes the use of the written informed consent that is attached to this approval letter. Please use this form for all persons, and ensure that each participant is able to repeat the purpose of the study, the voluntary nature of it, any risks involved, and who to contact other than you as the PI. In addition, ensure that any research assistants or co-investigators have completed human protection training, and have forwarded their certificates to the IRB office (G. Duke).

Please review the UT Tyler IRB Principal Investigator Responsibilities, and acknowledge your understanding of these responsibilities and the following through return of this email to the IRB Chair within one week after receipt of this approval letter:

- This approval is for one year, as of the date of the approval letter
- Request for Continuing Review must be completed for projects extending past one year
- Prompt reporting to the UT Tyler IRB of any proposed changes to this research activity
- Prompt reporting to the UT Tyler IRB and academic department administration will be done of any unanticipated problems involving risks to subjects or others
- Suspension or termination of approval may be done if there is evidence of any serious or continuing noncompliance with Federal Regulations or any aberrations in original proposal.
- Any change in proposal procedures must be promptly reported to the IRB prior to implementing any changes except when necessary to eliminate apparent immediate hazards to the subject.

Best of luck in your research, and do not hesitate to contact me if you need any further assistance.

Sincerely,

Dennis Combs, PhD
Designated Reviewer, UT Tyler IRB

Appendix D

Permission to Use Article

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Appendix E

The Mothers Speak

Hello Nurse Researcher,

We are the mothers in your study. You came to us, seeking insight into our lives as we raise our preschool children who have been labeled as overweight. We span a range of ages- from 19 to 49. We have spent part of our lives in Mexico and have lived in the United States for as few as five years or as many as twenty-three years. More than half of us have three or more children and have graduated from high school. Some have even gone to college. We are all married and all but one lives with her spouse. Many of us live in trailer parks or neighborhoods with other families who came from Mexico. Our homes are not big or fancy. Most are old and need some repairs. But these are our homes- this is where we are raising our children.

When we look at our sons and daughters, we know they are healthy. They are happy and can play and run like all of the other children. They don't get sick very often. Most of our children like their fruits and vegetables as much as they like their sweets.

Some of our children were big babies-this is just the way they are. We compare our children to people we know. In our children, we see our other family members. One of us called her child her grandfather's "Mini- Me". This is the way our families looks, so it could be genetics. Several of us have had experience with our other children, nieces and nephews, and other family members who were big when they were this young. It was temporary and they outgrew it. Some of us have seen some signs that our children are getting bigger. They are heavy when we pick them up. They are outgrowing their clothes so quickly and wearing many sizes larger than other children their age. We have

seen the charts at the doctors' offices and are told they are not where they should be on the chart.

There are those among us whose family members have expressed their concern about our children's weight. They have been blunt and told us that our children are fat. They tell us we need to watch what we are feeding them. Sometimes, our families say they are concerned but when the children ask for the fries, the cookie, and other treats, they give in to keep them happy.

You ask about the experience of being told our child was overweight. Some of us heard this news from both WIC and our child's primary care provider and some received the news just from WIC. We wondered why our child's provider said little about this but are very appreciative of WIC and their concern for our children's nutritional status.

Not all of our husbands do believe what we have been told and say the doctor is crazy or is lying to us. But we are supposed to believe the doctor, aren't we? Perhaps the weight is not really so bad because some of the doctors, friends, and family members say our children are big, they have the height for the weight, or they are just a little overweight, but not much. It's not like this is a disease.

When we were told, we had many reactions. It made us sad that we may not be doing something right, because we love our children. We feed our children fruits and vegetables and the 2% milk the WIC gives to us. We don't understand why this is happening. We felt as though this was our fault. Many of us became worried about our children when we heard this news. We worry about their future health because we have diseases in our family histories like diabetes, high blood pressure, and high cholesterol.

We know these diseases can happen because a person is overweight. We worry that our children will be teased at school because they are bigger than the other children. We worry that they will eat enough of the right foods. One of us became upset and angry because her child does not look fat. There are children who are bigger than hers and no one told them they are fat!

We like taking our children outdoors especially to the park or to the zoo. Some of us believe that the children in Mexico are healthier because they walk a lot. With our families, usually both parents get to go on outings but sometimes the fathers don't participate. Soccer is a sport that several of our families enjoy and we are trying to get the children involved.

When we feed our children, we remember our childhoods in Mexico and how little we had. There is so much here and we get to eat all of the things we never could as children. So, we want to be able to give our children all of those things.

Although we now live in the United States, we still prepare our traditional dishes. The ingredients are easy to buy at our local Mexican markets. Our families like tortillas, which you can use as an edible spoon and we serve these with our meals. We don't use lard when preparing our dishes, but are using oils that are lower in fat.

Many of our parents grew fruits and vegetables when we were children, so we enjoy these foods and give them to our children. We believe the children in Mexico are healthy because they are eating these foods. We feel we should show our children how good these foods are. This is how they will learn to eat right. When our husbands support us, we both try to keep the children away from the sweets.

However, not all of our husbands support our efforts to feed the children properly. These husbands do not like vegetables and tell the children about this. They like cookies, chips, candy, and cokes and the children see this. The children cry and ask their fathers for sweets and soda. The fathers want the children to be happy and not become angry with them, so they give these things to the children. When this happens, we mothers become very upset with our husbands and quarrel.

Buying food can be hard. We are grateful for WIC and food stamps. With these resources, we buy most of the groceries we need. Many of us have learned to spend the money we have on the fruits and vegetables and other foods that are good for the children. There are so many foods to choose from here. We look for sales so we can stretch our money. There are a few who have children who are now five years old and no longer receive help from WIC. This makes it hard to buy what is needed with the money we have. Thankfully, we have neighbors who will share the extra they have with us. There are those among us who do like other foods like chips, hotdogs, and cookies. We will spend some of our money on those items, too. We make choices on how to spend our resources.

If we are working mothers, it is very hard to care for our children. If the grandparents watch the children while we work, we cannot control what they are giving them to eat.

It makes us feel bad because we are too busy, too tired, and just don't have enough time. We don't prepare the foods we know should. We fix whatever is the fastest or buy fast foods. They are so easy- they are already cooked. Children in Mexico are too poor to buy

fast foods, so they may be healthier than the children here in the United States. If our children are fat, it is our fault.

When we send our children to Head Start or pre-kindergarten, the schools feed our children. We believe it is the schools responsibility to keep our children healthy and teach them good habits. Many of us are upset with the schools. They tell the children if they don't want what is on the tray, to throw it away. We think of all of the hungry children in Mexico and cannot understand why a school would teach a child to throw away good food. They feed our children

pizza- sometimes four times a month! They give them burgers. They let them drink juice. Our children come home and ask for these foods. WIC tells us that pizza, burgers, and lots of juice are not good, so why are the schools serving them? If the schools say these are ok, maybe they are.

On television, several of us have seen programs that teach about healthier cooking and have found these helpful. Television for the children is limited to channels that are specifically for preschool children. These channels don't advertise the sweets and junk foods. When the children see someone on their channel eating fruits and vegetables, they often ask us to buy these foods for them. We try not to allow the children to see the advertisements for the burgers that are the size of a 52" television because when our families see these commercials, everyone wants a burger.

When we bring our children in for checkups, there are so many children in the waiting room. The healthcare provider doesn't have a lot of time to spend with us. Often, no one asks if we have questions. They don't ask if we are having problems or what we

think about our children's health. They don't explain things to us well. Sometimes, they use words we don't understand but they don't ask if we understood them. If they say everything with a child is fine, we suppose there are no questions to ask.

You ask us what can someone who cares for the health of our children do better to help us. Since we have you here in our homes, we would like you to answer some questions for us. We want to know how to choose the healthier foods. When we fix our child's plate, how much should we put on it? We would like to know ways to fix the vegetables so our children will like them more. How can we find faster ways to fix the good foods?

We do have suggestions for the people at WIC and our providers' offices. Please ask us about our child. We live with them. Please take the time to teach us. Give us more information about which food to buy, how to prepare it, and how much to serve. We want to know how to prepare our Mexican dishes differently. Give us easy to use recipes that we can fix after coming home from work. Please say what you mean when you tell us about our children- if you say something is "little", we may not think it is important. Mothers may not understand what is unhealthy and what can happen to the children. Give us information that tells us about these things. Have classes in Spanish that our spouses and parents can attend. Make sure we understand what you tell us. We have dreams about the future for our children. We want them to get a good education, have good jobs, and most of all, to be healthy.

Thank you for caring about our people; we hope what we have told you will help.

Your Mothers

Biosketch

BIOGRAPHICAL SKETCH

NAME Susan Mary McDonald	POSITION TITLE Doctoral Candidate, University of Texas at Tyler Clinical Instructor, Stephen F. Austin State University
eRA COMMONS USER NAME (credential, e.g., agency login) smcdonald	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	MM/YY	FIELD OF STUDY
Herbert H. Lehman College, Bronx NY	BSN	06/76	Nursing
Pace University, Pleasantville, NY	MS	06/87	Nursing
University of Texas Medical Branch, Galveston TX	Post-Masters PNP	12/97	Nursing
University of Texas at Tyler, Tyler, TX	PhD	05/12	Nursing

A. Personal Statement

The goal of this study is to gain insight into the lived experiences of Mexican mothers caring for overweight or obese preschool children. A hermeneutic phenomenological approach influenced by van Manen will be utilized to capture these experiences. The aim is to use this insight to foster collaboration between mothers and nurses when developing a plan of care. I have worked for 15 years as a pediatric nurse practitioner with this population and other medically underserved children which make me well suited to be the PI in this study. I have had experience as a nurse manager. As a result of this previous experience, I am aware of the importance of frequent communication among group members and of constructing a realistic plan, timeline, and budget. In summary, I have a demonstrated record of caring for medically underserved children, and my expertise and experience have prepared me to lead the proposed project.

B. Positions and Honors

Positions and Employment

2005-	Clinical Nursing Instructor, Stephen F. Austin State University, Nacogdoches, TX
2005-2011	Pediatric Nurse Practitioner, East Texas Community Health Services, Nacogdoches TX

1999-2005	Pediatric Nurse Practitioner, Beaumont Pediatric Center, Beaumont, TX
1992-1999	Advanced Practice Nurse, Christus St Elizabeth Hospital, Beaumont, TX
1988-1992	Perinatal Nursing Staff Nurse, Christus St Elizabeth Hospital, Beaumont, TX
1988-1990	Clinical Nursing Instructor, Lamar University, Beaumont, TX
1985-1988	Maternal Child Nursing Director, St. Francis Hospital, Beacon , NY
1983-1985	Assistant Head Nurse OB/GYN, Northern Westchester Medical Center, Mt. Kisco, NY
1979-1983	Perinatal Staff Nurse, Julia L. Butterfield Hospital, Cold Spring, NY
1978-1979	Assistant Nursing Care Coordinator, Morningside House, Bronx, NY
1976-1978	Staff Nurse Montefiore Hospital and Medical Center, Bronx, NY

Other Experience and Professional Memberships

1997-	National Association of Pediatric Nurse Practitioners
1986-	Sigma Theta Tau International

C. Selected Peer-reviewed Publications

McDonald, S. M. (2012). Perception: A concept analysis. International Journal of Nursing Knowledge, 23(1), 2-9.