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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. Despite this, 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 to enhance nurses' ability to effectively care for these children. A qualitative, hermeneutic design was selected for this study guided by the phenomenological approach of Max van Manen. Saturation was achieved after interviewing 12 mothers of Mexican heritage. Seven themes and 11 subthemes emerged from the data. Maternal caring practices were influenced by their Mexican heritage, emotional burdens, and perceptions of child's weight status, disconnectedness and connectedness with family and health care professionals, and being resourceful. To protect their children from the untoward consequences of overweight, the mothers linked past family history and practices with present needs. 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 holistic effective plan to care for overweight children. Keywords: Mexican-Heritage Mothers, Caring, Lived Experience, Preschool, Obesity, Phenomenology, van Manen

In children, ages 2 to 5 years, the rate of obesity has more than doubled in the past 30 years (Ogden & Carroll, 2010). When examining Body Mass Index (BMI) data from preschool children enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), this trend may be slowing. In high-risk populations, the Institute of Medicine (IOM) observed a flattening in the rate of children, ages 2 to 5 years, classified as obese (IOM, 2014).

Despite this trend, Hispanic children classified as overweight ($\geq 85^{th}$ percentile for BMI) or obese ($\geq 95^{th}$ percentile for BMI) continue to outpace their non-Hispanic peers. When examining the NHANES 2010-2011 data, 29.8% of Hispanic children were at or above the 85th percentile for BMI and 16.7% were at or above the 95th percentile (Ogden, Carroll, Kit, & Flegal, 2014).

Among the states, Texas has the 6th highest rate of childhood obesity (IOM, 2009). Of the low-income preschool aged children enrolled in the Texas WIC Program, 30% were overweight or obese (Texas Interagency Obesity Council, 2011). 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. To be successful as nurses, it is important for us to understand what is happening in the lives of the families for whom we care. This study utilized a hermeneutic phenomenological approach guided by the phenomenological approach of Max van Manen 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 Centers for Disease Control and Prevention (2014), 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 since obese children are more likely to become obese adults (Texas Department of State Health Services, 2011).

Hispanic children are significantly at 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 et al., 2007). Multiple factors have been identified including socioeconomic status, parental education and perception, sweetened beverage intake, and nutrition in the home.

In Texas, 25.8% of the population of East Texas 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; Reineke, 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). Low parental education was cited as associated with the development of childhood obesity (Dubois et al., 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 with low education were also more likely to misclassify their children (Hackie & Bowles, 2007; Warschburger & Kroeller, 2009). Hispanic parents were less likely to recognize their child as overweight (Hackie & Bowles, 2007; Small, Melnyk, Anderson-Gifford, & Hampel, 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; Reineke, 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 there was a higher overall Kool-Aid© intake in obese Mexican American children (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, they may not be providing it at home. For Hispanic children, child care outside of the home was protective against the development of overweight, while 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 often does not differentiate the country of origin and identifies samples as Hispanic or Latino rather than Mexican, Columbian, Puerto Rican, and so forth. There are few studies exploring how mothers caring for Mexican American preschool children manage their children's health when they are told their child is overweight or obese. How does the mother care for this child at home after a healthcare provider tells her that her preschooler has a weight problem? There appears to be a "disconnect" between the plan of care discussed in the healthcare setting and what happens at home. 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. A search of the literature reveals no studies have been done to examine this phenomenon. I choose hermeneutic phenomenology as influenced by Max van Manen (1990) to explore the lived experiences of Mexican-heritage mothers caring for overweight preschool children.

Methods

Hermeneutic Phenomenological Approach

van Manen (1990) stated that hermeneutic phenomenology is a human science that studies persons. In defining the term, van Manen explained 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 saw his approach to research as an active and ongoing interplay among six research activities: turning to a phenomenon of particular interest to the researcher; investigating experience as we live it 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. van Manen (2014) explained that phenomenological research is the writing. There is an "inseparableness of phenomenological inquiry or research from phenomenological writing or textual reflection" (p. 389).

Anecdotal evidence by healthcare practitioners indicated that there appears to be a disconnect between the plan of care discussed in the healthcare setting and what mothers do at home when caring for Mexican American preschoolers with BMIs exceeding the 85th percentile. The phenomenon of interest for this study is Mexican-heritage mothers caring for their preschool children who are overweight. van Manen (1990) observed 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). It is easy to pin the label "non-compliant" on mothers of children with weight problems, but healthcare providers need to understand what is going on in the lives of the families for whom they care. "Perception of experience is what matters, not what in reality may appear to be contrary or more *truthful*" (Munhall, 2007, p. 161).

As a nurse practitioner, the only perception the researcher was privy to was her own. In a 15 minute office visit, there is little or no time to gain insight into the mother's perception of her child or the feasibility of the treatment plan. Other than some demographic notations in the medical record, a provider does not know what families experience in their everyday lives. What is the mother's experience of caring for her children and what does it mean to them? van Manen (1999) stated "To understand people's experience we would need to get really close to them so that their hopes become our hopes, their pain becomes our pain-we would need to listen and speak, read and write in a manner that is attentive to the things of the world that are ultimately unnamable" (p. 19).

Because of my interest in looking at both the descriptive and interpretive aspects of the phenomenon, hermeneutic phenomenology was a way to explore the lived experiences of Mexican-heritage mothers caring for overweight preschooler children. The question studied was: What are the lived experiences of Mexican-heritage mothers caring for overweight or obese preschool children?

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 daycare centers. Print advertisements were placed in the both the local Spanish and local daily newspapers. The researcher 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. Recruitment continued until the achievement of data saturation. 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 2 to 5 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.

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, the researcher made an appointment with the participant at the location of the participant's choice. Mothers received a $25 gift card honorarium and a book for their child for participation.

A total of 12 participants were recruited for the study (Table 1). All participants spent part of their lives in Mexico. One mother was born in the United States, but moved to Mexico as a child. More than half have three or more children and have at least graduated from high school. Many live in trailer parks or neighborhoods with other families who came from Mexico. Their residences were located in three counties in East Texas.

Protection of Human Subjects

This proposal was approved by the University of Texas at Tyler Institutional Review Board (IRB) before implementation. After an appointment was set during the initial contact, written informed consent from each participant was obtained prior to data collection. A translator was available for both obtaining consent and the interview process to assure that participants had a clear understanding. The participants retained a copy of the consent.

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

Data Collection Procedures

Data collection began in December 2011. In preparation for interviewing the participants, I decentered myself by reflecting on my own beliefs and preconceptions. These reflections were recorded in a journal. This step was important to be able to listen as openly as possible. Openness is facilitated by having an "unknowing" state of mind (Munhall, 2007).

The criterion for place of interview was 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. During the appointment, consent was obtained prior to data collection.

Demographical information was then obtained. Individual interviews were conducted by the researcher, 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. When describing the interview process, van Manen (2011) suggested that the interview style should be conversational and oriented toward making sense of and interpreting the lived experiences. When interviewing the mothers, I acknowledged that I did not know what their lives were like but I wanted them to share their experiences with me to increase my understanding.

Data Management and Analysis

The analysis process began during the interview as the researcher 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, the researcher solicited frequent feedback to assure understanding of the participants' answers. 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 the researcher to again place herself in that time and place where the interview took place. A combination of sententious and highlighting approaches was used to help isolate themes. When using a sententious approach, van Manen (1990) focused on looking at the text in a wholistic manner searching for a key phrase that may capture the fundamental meaning of the text as a whole. When highlighting is used, statements or phrases that are essential or revealing about the phenomenon are singled out (van Manen, 1990).

Phenomenological Reflection

During the process of phenomenological reflection, the four existentials (*lived space, lived time, lived body,* and *lived other*) served as useful guides for reflection as recommended by van Manen (1990). An awareness of these existentials was incorporated into the review of the transcripts and field notes. Each will be discussed.

Lived space is felt space; the space in which one finds oneself affects the way one feels (van Manen, 1990). The participants were given options as to where the interview would take place. All of the participants invited the researcher into their homes. Some living quarters were substandard trailer homes in a subdivision outside of the city limits with poor roads and roaming dogs. This invoked a feeling of depression and despair for the researcher. But this was their space- where they and their children lived. Children's toys and pictures decorated their living space - it was their home.

Lived body refers to the fact that we are always bodily in the world; in our bodily presence (van Manen, 1990). Mothers were welcoming and open. Being "big" was often a family norm. Some mothers were aware of their children's weight issue before being told by health professionals. Some stated that they, too, weighed too much but were aware of this.

Lived time is subjective time and our temporal way of being in the world (van Manen, 1990). The mothers reflected on their past. These mothers were either born or raised 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. They were cognizant of the possible effects of past family history on their children's future health and well-being, and understood that changes needed to be made in the present.

Lived other is the lived relationship we maintain with others in an interpersonal space (van Manen, 1990). The participants were warm and welcoming. Participants valued relationships which were seen as important elements of their support system. Mothers and fathers were not always in agreement about the existence of a problem or how to feed the child. This also was seen with grandparents and other relatives. The mothers were dependent on experts such as healthcare providers and schools to provide guidance but were often left confused, wondering who they should trust.

Credibility

Interviews were conducted until there was data saturation. Accuracy of the data was validated with the participants during interviews and with the translator. The researcher spent between 45 to 75 minutes with each participant. A fellow qualitative researcher conducted a peer review of the data and thematic analysis. An expert qualitative researcher had access to a data trail, including field notes, transcribed interviews, and coding themes for audit review.

Results

Thematic Analysis

Seven essential themes with 11 subthemes evolved from the data. Themes and subthemes are depicted in the following section. The names of the participants have been changed to maintain their anonymity.

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. They were described as their "fork or spoon" and "the worst thing to eat. They're good. I love them."

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 5-year-old daughter, 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 both a sense of wonder as well as concern. Olivia, a 25-year-old college student and mother of three children described her experiences and observations:

> Because in Mexico, well I remember, I was six, and I remember we didn't have much to eat, so just whatever and we would get full, I guess. I remembered when we come (sic) over here and we see a table full of food and 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. I don't know…Because in Mexico, I mean people are healthier. I mean the only reason they're getting sick is because they can't afford to go to a doctor, but people are always walking around over there. They can. Someone can live here and walk to the Brookshire Brothers and come back and that's okay. Over there, they don't have enough money to buy food, so they eat what they crop or what they

> already have or their farm animals they have. That's where we come from —a really small town. Well, that wasn't much. It was whatever we could grow or the item that we had. I remember that we had chickens in our yard. So, it's just whatever we could have there and we couldn't afford good —we couldn't afford meat. I'm guessing that something and everything I remember eating a lot of was beans and tortillas and that's something other people make fun of, but that is true.

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 you have money. If you work, you have money, but it's not natural here. All our fruit, it's natural, but here they put in more for growing —put in more stuff (chemicals)." Food quality was also a concern for Lidia, a 25-year-old mother of two living in Texas for ten years:

> 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 cooking, already made, let's do it. It's right there. It's done. It's more convenient. Yeah. That's part of the problem.

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, mothers discussed their children's weights. Their descriptions incorporated their own observations as well as those of their family members and the experts (providers, WIC personnel, and school officials). Three subthemes emerged: normalcy, acknowledging excessive weight, and softening the blow by experts and family members.

Normalcy. According to Merriam-Webster (2012), normalcy is defined as the state or fact of being normal. Being healthy, looking like other family members, having a "strong build", and being a temporary phase were descriptions used to rationalize their children's weights. 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 "Mini-me," Ana, the mother of a 3-year -old girl said:

> They're just kids and it's not a disease…If you look at her, she's very active, she runs like any, you know, like any normal, skinny baby…I feel like 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 4-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. I don't know. He's going to be built probably, so that's the kind of heavy he is."

For several mothers, this was not their first child who had been classified as overweight. These mothers viewed "being chunky" as a phase. "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.

Acknowledging excessive weight. For several of the mothers, there was concrete evidence that the child's weight was a problem. Clothing size was one factor that made the issue clear: "Almost 50 pounds one of the times before the last time (her daughter went to the provider). Size 6 didn't fit. She was wearing size 8 and 10 for a 5-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." The use of growth charts had a powerful impact on Maricela, a 38-year-old mother of three who expressed concern about her two-and-one-half- year-old son: "Because 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."

Softening the blow. While speaking with the mothers, there was a sense that there was 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 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 be…she actually told me don't worry too much about it right now because he is too tall for his age. She 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 the researcher 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."

Theme 3: Bearing the emotional burden. During the interviews, the weight of emotional burden was palpable. The researcher could see it in the mothers' eyes and in their hand gestures; it could be heard in their emphatic speech. 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 4-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 explained. 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, because he has problems with other children that make fun of him. Yeah and 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.

She continued with: "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.

They described feeling as though they could not control what was happening. 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.” Ana expressed fear of being blamed for the inability to control the situation:

> 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.

Another summed up her feelings with “I don’t know how I can help her.”

Working as well as stay-at-home mothers discussed the plight of working mothers. The description of being “too busy, too tired” with “not enough time” led mothers to feel guilty and embarrassed for not being able to give what was needed to the child. Lidia relayed what happened when her friend came for a visit. The children were playing in the living room and being disruptive, so Lidia told the children to play in their 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.”

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 hoped 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.

Theme 4: Feeding the issue: Disconnectedness. One of the intents of this study was to explore any disconnect between the plan of care discussed in the healthcare setting and what happened at home after a mother has been told that her child was overweight. When looking at the individual interview transcripts separately and as a whole, there were indeed disconnects. 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. Carmen, a 26-year-old mother of four described her experience:

> The doctor didn’t say anything. The only person that told me she was overweight was at WIC. Whenever she 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.

This can cause some confusion for the mothers and put them in a situation where they have to choose whom to believe. Olivia explained that she was told by her 4-year-old son’s provider that he was fine because of his height:

> But at the Head Start, whenever they do his weight, his height and all that they sent me a letter that he's overweight. When I take him to the WIC office, it's

> also that he's overweight. You kind of have to trust the doctor more…you kind of have more confidence in the doctor.

The disconnectedness among the experts was also illustrated by Lidia when she spoke about her frustration:

> School is supposed to be taking care of the children that they eat healthy, so maybe they are healthy - the hamburger and the pizza. Maybe I'm feeding them right. 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.

Disconnectedness: Between the mother and the expert. The majority of the mothers said they 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 4-year-old son's provider:

> She just goes in there, checks them and that's it. If you see a doctor in a hurry, 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:

> Whenever they (family members) come over to grandma's house, we'll make them their soup and their meat and their beans. You know (the provider) is like, *they're not supposed to eat a lot of that.* You know us being Hispanic, that's what we eat a lot of, like on a daily basis. Like right now, we just had soup. Yeah, we had soup and menudo and stuff. It's kinda hard to make food just for her —like her own meal.

Some of the mothers stated that the children disliked the recommended foods and preferred the traditional foods, as 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."

The mothers looked to their healthcare providers for guidance, but often felt the instructions were not clear. Ana expressed confusion when discussing instructions she received: "Well, she said something about starches are not good, but like I don't know what a starch is."

Carmen shared this:

> They (WIC) told me just don't put her 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.

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.* I argued with my husband and said, *well if the doctor says that, he knows he is bigger.* My husband says that he's crazy, the doctor is crazy.

Graciela described her 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:

> Sometimes the father comes with a big old bag of $2.99 Cheetos or whatever and I say, *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." 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 even if she is crying—telling 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."

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 described 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 attempting 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." The response she received was, "Oh no, he's not big, he's fine."

Theme 5: Receiving support through connectedness. The importance the mothers placed on having positive interpersonal connections became evident as I was reflecting on the existential concept of lived other during the interviews and reviewing the transcripts. The mothers appreciated good relationships with persons they saw as essential to assist them to provide the best care for their children.

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 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:

> I know I like the WIC office, like I guess their food. They give us recipes of how to prepare healthier food. I think the recipes from the WIC office help me cook them (her children) something better…I mean because the WIC office, they're probably the only place nutrition-wise where I get more information from.

The researcher was used as an expert during many of the interviews. While the researcher 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 "being together":

> He (dad) 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. So, we're together on that.

Theme 6: Being resourceful. Resourcefulness was a valuable tool that enabled the mothers in caring for their children. Elvira described how she and three of her neighbors worked together to supervise children so they get outdoor play time. Neighbors also assisted Vivian, whose child had turned 5 and was no longer eligible for WIC, by sharing whatever cereal their children could not eat.

Most of the mothers stated that they did not find it difficult to purchase healthful foods. All of the fathers were employed, as were four of the mothers. Most of the mothers received assistance from WIC if their child was less than five years of age. 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, especially organic foods. The mothers considered these foods better than the less expensive alternatives.

Veronica discussed planning quick, healthful meals after coming home from work. 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, not the WIC cheese, the natural cheese, they have the cheese in there." Opening her refrigerator, she lifted out a package to show the researcher. "It's not fat."

Theme 7: Looking at the past, living in the present, protecting the future. Elements from the past, the present, and the future were interwoven in the caring practices of the mothers. Olivia described how these elements were important and influenced her being an active participant in her son's life:

> Last year, when I wasn't pregnant, I was at the Head Start like every time they had parties or something, participating. Just being there - for him to know that I was there -involved. Because I know that's one thing, my parents weren't involved with me and I want him to know that I am there. And [my husband] will tell me *why are you there? You don't need to go.* And I'm like *one day I'm going to start working and I'm not going to be able to go any more.*

The mothers were cognizant of the potential untoward psychosocial and physical consequences of being overweight. 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:

> That even makes me scared for her to go to school because kids are mean…I don't want her to be like my sister. She was a bit bigger and she said she would suffer a lot at school, you know, and that's my biggest fear.

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 expressed her apprehension:

> I am scared of her getting diabetes and stuff, but you know she doesn't eat a lot of junk food. Her grandpa has diabetes…I asked Dr. S. if we could test her for that 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."

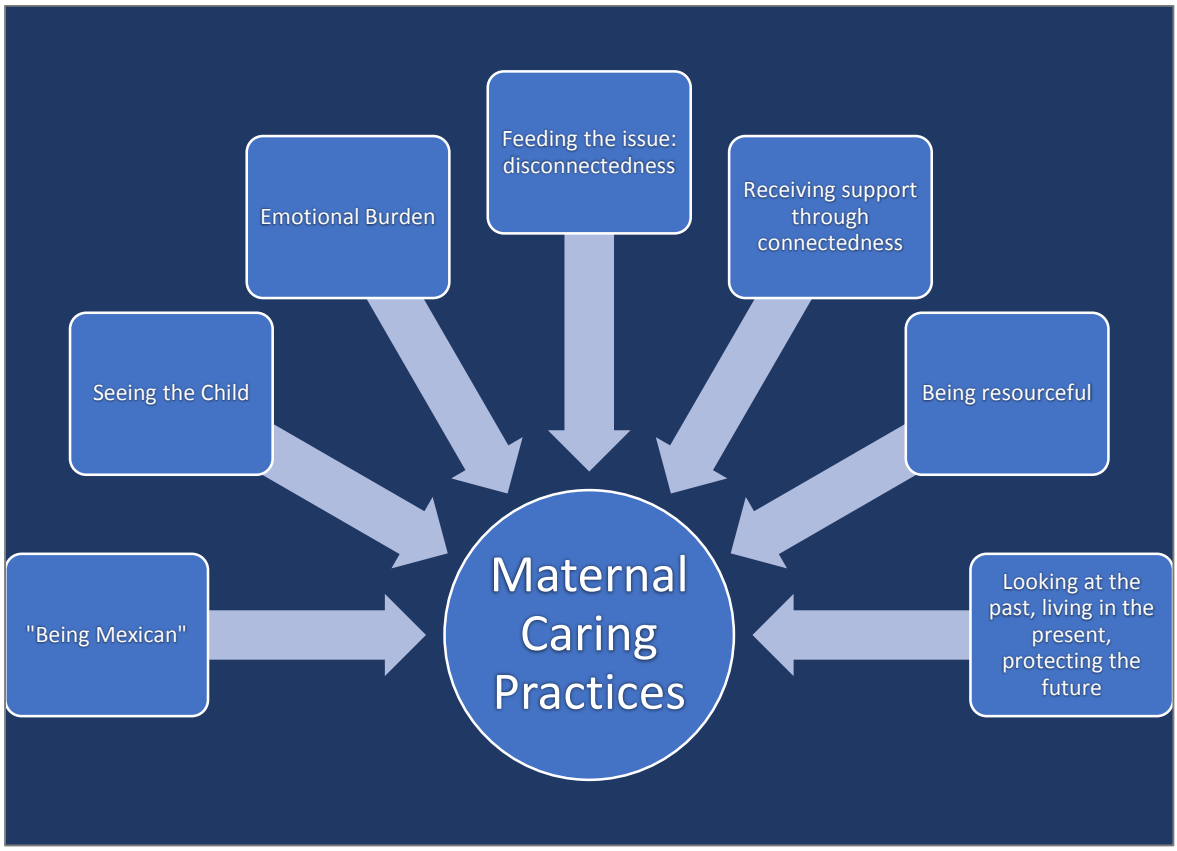
All of the participants voiced a need for more useful information. As Leticia said, mothers needed more help "learning how to break those bad habits." Their hope was that the children had a better life than their own. They expressed a desire that their children got a good education, had good jobs, and most of all, were healthy.

Discussion

With this study, the researcher attempted to explore the lived experiences of Mexican-heritage mothers caring for overweight preschool children. Through thematic analysis, caring

practice influences for this group of mothers were identified (see Figure 1). Understanding maternal perception was key to this study. What the mothers saw through their own eyes and the eyes of others was viewed through the lens of their personal experiences. Their understanding of the phenomena shaped their caring practices.

Figure 1. Influences on Maternal Caring Practices



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 lives in Texas. When comparing life in Mexico with life in the United States, 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 was similar to findings by Guendelman, Fernald, Neufeld, and Fuentes-Afflick (2010).

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 living in the United States, to have more, leading to increased food consumption. This finding is consistent with research by Kuyper et al. (2006) and Guendelman et al. (2006). The former observed previous food insecurity also led to less maternal monitoring of sweets and snack foods.

Maternal perceptions and attitudes related to their children's body size is seen as a major influence on feeding practices for this population in other studies (Chaidez, Townsend, & Kaiser, 2011). In discussions about their children's weights, mothers often use comparison to other family members to rationalize perceived normalcy. For Mexican-heritage mothers, health care providers' assessments are an important influence on their own perception of a child's overweight status (Guerrero, Slusser, Barreto, Rosales, & Kuo, 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. There was a tendency to minimalize the issue by both healthcare professionals and other family members. This in turn appeared to minimize the issue to the mothers. As one participant stated, hearing "a little bit" led to seeing "the smallest."

Most of the participants were dissatisfied with their relationship with the experts. There were inconsistencies between their child's provider and from the nutritionist at WIC. Schools were identified as sending mixed messages. At providers' offices, questions from the mothers were often not solicited or adequately answered. Maternal input was not requested. Instructions were frequently perceived as not being useful since cultural traditions were often not considered. Overall, WIC personnel were the most consistent health care professionals identifying the children's weight as being an issue and giving useful advice. Statements from the participants support Howes and Obregon (2009) recommendation for healthcare professionals working with Mexican-heritage mothers. Professionals should focus on the cultural values of *educado*, "building on the notions of the importance of being attentive and attuned to the emotional components of social relationships and respectful behavior" (p. 273).

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. Their concerns were not only for their own children, but members of their extended families, and their people as a whole. Time constraints added to the burden carried by working mothers. Being supported by others was crucial. Participants valued connecting with experts, family members, and neighbors. Supportive relationships provide Mexican-heritage mothers with strength even when confronted with very stressful and challenging circumstances (Marsiglia, Kulis, Perez, & Bermudez-Parsai, 2011). Support from their spouses was important. Consistency between the parents assisted the mothers in their quest to provide a more healthful diet. Marital conflict sometimes arose when spouses challenged the experts and mothers' efforts to adhere to recommendations were undermined.

The influences of the past, the present, and the future were integral to the caring practices. Potential risks based on past family experiences were acknowledged. Proactive measures identified included choosing healthful foods and parental role-modeling. They discussed their hopes and dreams, wanting a better life for their children. As the researcher 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.

Study Strengths and Limitations

Many studies looked at the demographics of the childhood obesity problem. No previous studies addressed the impact having a child with weight issues had on the lives of the mothers caring for these children. This study allowed mothers to tell their stories - the voices behind the numbers.

There are limitations to this study. The population was limited to residents in three counties of East Texas. Mothers were self-identified as having overweight children. No

medical records were obtained. 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 Theory

Munhall (2007) stated the nursing profession has a moral and/or ethical imperative. In the final narrative and descriptive piece of a study, its relevance for the profession must be examined. She posed the following questions. What does this meaning 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 results of this study reinforce nursing's stance that clients be treated in a holistic manner. It is important for the nurse to 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 was essential. It was felt that health professionals needed to discuss weight in an open and frank manner. Questions should be encouraged and answered. Maternal input should be solicited when developing a plan of care. An explanation of the potential health risks needed to be emphasized. Clear, useful information should be given. Culture traditions need to be incorporated in recipes. These recipes also needed to be quick and easy, with specific portion recommendations. Most importantly, health professionals must validate that the mothers have understood what has been discussed during the visit.

A crucial pre-existing supposition for this researcher was strongly dispelled. This was that an educational deficit should not be an issue. 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 proved otherwise - there was a deficit.

The NHANES data continues to show an increase in the incidence of obesity in preschool children of Hispanic descent (Fryar, Carroll, & Ogden, 2014). Concepts gleaned from this study can help nurses and other professionals design interventions that meet the unique needs of this population and be better advocates for their clients in both the practice setting and health policy arena. These findings also lead to further questions, including the perceptions of the health care professionals caring for this population.

Conclusions

Overweight and obesity have a major impact on the lives of Mexican heritage families. Mothers relied on advice from experts to guide them when caring for their children. The message they received was mixed and often the advice was confusing or inadequate.

What was clear in this study was the voices of the mothers. They were knowledgeable about the impact weight had on their families as they acknowledged the myriad of problems it has created within their extended families. They wanted to do the best for their children, they recognized the hurdles, and they expected guidance from health care professionals to make them successful in keeping their children healthier than previous generations. How will nurses and other healthcare professional know how to assist these mothers? Asking the mothers what they need would be a good first step.

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