

MOTHERS' PERCEPTIONS OF OVERWEIGHT AND OBESITY IN THEIR CHILDREN

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Accepted for publication May 2005

Key words: mothers, mother-blaming, childhood obesity, child health

ABSTRACT

Background:

Childhood obesity is a growing health concern and the literature implicates parents, particularly mothers.

Aim:

To develop understandings into the views of a group of mothers with an overweight or obese child, about their child's overweight or obesity.

Method:

A qualitative design informed by feminist insights. Eleven English speaking mothers of at least one overweight or obese child were drawn from a large urban community in metropolitan Australia to participate in this study.

Results:

Participants attributed their child's obesity to factors such as slow metabolism, sedentary lifestyle, familial or cultural factors, genetics, eating habits such as not drinking enough water, or not chewing food adequately. Participants were very concerned about their child's weight problems and their immediate concerns focussed on social problems associated with obesity/overweight.

Conclusion:

Understanding parental views about their children's overweight and obesity is a key step in forming effective liaisons between health professionals and parents.

BACKGROUND

Childhood obesity is a major international public health concern. Evidence from the United Kingdom (Reilly et al 2004), the United States (Hodges 2003), Canada (Anderson 2000; LeBlanc 2003), Australia (NHMRC 2003) and New Zealand (Gordon et al 2003) all raise concerns about childhood obesity in local populations.

Despite these global concerns, obesity in childhood is poorly defined, although most definitions do relate to measurements of body mass index (BMI). As Reilly et al (2003) point out, childhood obesity is regularly defined as a BMI exceeding the 85th or the 95th percentiles.

Childhood obesity occurs within a context of family life, and parents, especially mothers, have been implicated in the rapid growth of prevalence in childhood obesity (Golan and Crow 2004). Parental style is identified as influential in establishing children's eating patterns, with both over-controlling and under-controlling parental attitudes linked with undesirable child outcomes (Gable and Lutz 2000; Golan and Crow 2004).

A subtext of blame aimed at mothers is evident in the discourses around childhood obesity, particularly in the media (Mitchell 2002; Teutsch 2002). Mothers usually influence the nature, variety and quantity of food available to their young children (Baughcum et al 2000). They are instrumental in moulding the food related attitudes and behaviours children form; they create the family mealtime environment and influence rituals around eating (Gable and Lutz 2000; Golan and Crow 2004; Hodges 2003).

Hodges (2003) notes that parental recognition of obesity in children is a key factor in effecting change. Yet evidence suggests parents may have difficulties in

recognising weight problems in their own children (Myers and Vargas 2000). Myers and Vargas (2000) found that 35% of 200 socially disadvantaged parents of pre-school children did not recognise obesity in their own children. Baughcum et al (2000) found similarly, with only one in five (or 20%) of sampled mothers able to recognise overweight/obesity in their pre-school aged children. Furthermore, evidence also suggests that even where mothers recognise excessive weight, it may be viewed in a positive rather than a negative light. In a study involving mothers of infants aged 12-36 months Baughcum et al (1998) revealed maternal views suggesting that a large infant was a healthy infant and was therefore an indication of successful mothering.

Parental involvement is identified as crucial in obtaining favourable outcomes from interventions aimed at achieving sustained weight management in children (Golan and Crow 2004; Myers and Vargas 2000). Hodges (2003) highlights the importance of clarifying parental understandings and perceptions related to recognition of the problem. Given that obesity is an outcome of lifestyle factors over a period of time and not a sudden occurrence (Gable and Lutz 2000), it is also important to clarify factors that raise maternal concerns about obesity. In addition, maternal views and beliefs about causation are important because they will influence whether mothers feel they can do anything to resolve the problem, and will shape the actions they will take in response to the problem.

The aim of this study was to develop understandings into the views of a group of mothers with an overweight or obese child about their child's overweight or obesity. Specific aims were to: ascertain the length of time the mothers had perceived their child as having a weight problem; identify the catalyst for their concerns; and, discover mothers' perceptions of causative factors.

METHODS

Philosophical underpinnings of the study

Because of its concern with the insights and views of a group of women a feminist approach was selected as appropriate to inform this study. Feminist research principles identified by Cook and Fonow (1986) guided the project. These principles identify the need for continuous recognition of gender as basic to all social life; recognise consciousness-raising as an integral aspect of methodology; accept inter-subjectivity and personal knowing as legitimate sources of knowledge; acknowledge ethical responsibilities in research; and, understand the transformative and empowering aspects of feminist research (Cook and Fonow 1986).

Recruitment and procedure

Information about the study appeared in the media and women meeting the inclusion criteria were invited to contact the research team. Inclusion criteria were that

women: were mothers of at least one overweight or obese child currently residing with them; could speak and understand English; and, were willing to participate. The inclusion criteria did not include any reference to age of the child as it was not specifically relevant to the aims of the study. Upon contact with the research team, further information was given to the women and appointments made to meet.

Where mothers had more than one child who was overweight or obese they were asked to focus on one child only and this child was referred to as the 'focus child'.

This study recruited parents rather than children themselves and though we could have asked parents to record the weight of their children this procedure could have been distressing to children who may already be sensitive about their weight. Furthermore, potential problems related to inter-rater reliability would render such information meaningless. Therefore, participants were asked to provide a recent photograph and information about the height and clothing size of the focus child. Clothing size worn by the focus child was sought by the researchers as an objective measure of the child's size in relation to their age. This information enabled researchers to establish each focus child as being either overweight or obese without needing to have any direct contact with the child.

Following recruitment into the study and procedures of informed consent, women participated in in-depth conversations about their perceptions of their child's obesity. During the conversations, three trigger questions were asked:

- How long have you perceived your focus child as having a weight problem?
- What initially raised your concerns?
- What do you consider to be causative factors to your focus child's weight problems?

Each of the conversations lasted for between one to two hours. Conversations were audio-taped and transcribed, with silences, periods of tearfulness, or other notable events indicated in text. Following transcription narratives were analysed taking an approach that involved using the research questions as a guide to question the text (Jackson et al 2003). The narrative was then clustered into key points that addressed the research questions (Mannix 1998).

Ethics approval

The relevant institutional ethics committee granted ethics approval. Pseudonyms are used to ensure participant confidentiality.

Participants

Eleven women meeting the inclusion criteria participated in the study. See table 1 for information about

the age and clothing size of the focus child, and family type of each participant.

Table 1: Pseudonym, age, clothing size and family composition

Pseudonym of participant	Age of focus child	Child's clothing size	Family composition
Barbara	14 months	1-2	F1
Kathy	5 yrs	8-10	F3
Fiona	5 yrs	8-10	F3
Donna	6 yrs	12-14	F1
Vicki	7 yrs	12	F1
Rose	7 yrs	14 (children) 10 (ladies)	F1
Julie	9 yrs	12-14	F2
Anne	9 yrs	10-12	F1
Sheryl	11 yrs	12-14	F1
Trish	12 yrs	16	F1
Wendy	15 yrs	22 (ladies)	F3

Key: F1 = mother and father of focus child (traditional married couple); F2 = mother of focus child with new partner; F3 = sole parent family (focus child lives with mother)

FINDINGS

Participants expressed great concerns about their child's weight problems. They reported experiencing difficulties obtaining age-appropriate clothing for their focus children. Mothers were anxious about their children experiencing social problems related to their weight, and all but one of the participants described various forms of social rejection experienced by their children. These included uninvited remarks by strangers or family members, mockery, bullying, unkind nicknames, and for some children, exclusion from certain social activities. The findings of the study are presented to reflect responses to the research questions.

How long had they perceived the problem?

None of the participants viewed their children's overweight or obesity as a short-term problem. All participants described having concerns about their child's weight for considerable periods. Most reported concerns for between two to five years, with one mother of a 15-year-old daughter having concerns for 10 years, and the mother of a 14-month-old son being concerned for approximately one year.

Factors that raised maternal concerns about obesity

Various factors were identified as raising maternal concerns. For some mothers, concerns became more intense when their children could no longer fit into age appropriate clothing:

'It never worried me for about the first three years. When he was about four, I think, then I started to worry because he wasn't fitting in clothes that my daughter would fit into, you know, she was quite consistent with her development... So now he's six and he's in clothes size 14, and that worries me.' (Donna)

'When she started school she was already a big girl. We had to get uniforms made for her, she just kept getting bigger. And in high school, we had to try to find uniforms that fitted her.' (Wendy)

Other events that triggered concerns were events such as negative comments from friends and relatives, and seeing their child in a class photo and noticing their child was larger than peers were, or being told that their child was outside centile charts by a health professional. Two participants could not link their concerns with any particular event. Rather, they described a gradual realisation that the focus child's weight was a matter for concern.

Maternal perceptions of causative factors

All participants could identify factors that they viewed as contributing to the problem and these included slow metabolism, sedentary lifestyle, familial or cultural factors, genetics, eating habits such as not drinking enough water, not chewing food adequately, or a combination of these factors. Sheryl took a fatalistic approach in that she felt that 'this is how God made' her daughter. Kathy did not consider her daughter's weight problems had anything to do with her diet. Rather, she considered lack of exercise was the main problem:

'I know good nutrition. I know what causes obesity and I don't think that has happened to my daughter. I think she doesn't do enough activity. I don't think it's her diet. It's her metabolism, it needs to be increased. I feel that is what the problem is with her, so I never even look at it from another perspective.' (Kathy)

And later Kathy commented that:

'She doesn't get much opportunity to exercise. Personally I don't think she overeats.' (Kathy)

Lifestyle and environmental factors were identified as impacting on the activities of their children. Participants reported a feeling that the focus children had a tendency to be naturally sedentary, with preferences for sedentary activities such as drawing or craftwork:

'She tends to come home, sit down, put on a video or watch television and unless I closely supervise her and say "television's going off, go outside and play" she's quite happy just to sit and do nothing... I've noticed her very slow movement to even just get dressed.' (Fiona)

'Since she was a toddler, she has been a fairly sedentary child, she loved being inside doing craft with me or watching a bit of telly, she's never been an outside person, so that's always been a struggle with us to try to get her outdoors more.' (Vicki)

Participants reported that they had to be very inventive and continually encourage their children to move about more. Mothers discussed the tensions between wanting to encourage their children to be more active, and issues around child safety.

A number of mothers felt that walking to and from school would be good exercise for their children, however, felt it wasn't safe for their child to do this alone, and due to other commitments were not able to accompany their children. Therefore, they put child safety first and arranged for their children to be driven or bussed to school:

'It's close enough to walk but there's no footpath and it's too dangerous, so we actually drive to and from school' (Sheryl)

Several participants commented that the focus child seemed to have a different relationship to food than other family members. They felt the focus children enjoyed food and loved to eat more than their other children. Where this was the case, mothers felt there was a need to monitor the dietary intake of the focus child, whereas their other children were able to self monitor food intake. Rose and Sheryl felt that their focus children had a lack of self-control where food was concerned. Other participants also noticed that their focus children ate more than their siblings and peers and would hover around food when it was available:

'She will just eat. We notice a lot when she goes to parties or there's lots of food around. If there's food around she can't not eat it, even if it's nibble food or whatever, she's got to be eating it all the time. You know, other kids might be off running around but she would be sitting eating. Probably not so much now but when she was little bit younger, I'd notice that when I'd stay at the parties.' (Vicki)

'If there's a plate of biscuits, she will have three whereas my other daughter would only have the one, and that daughter is always on the go, where she (focus child) is a bit more slow.' (Sheryl)

Wendy attributed her daughter's longstanding weight problem to a genetic predisposition, and commented that the extended family are a 'big' family. Other participants also linked their current concerns about the weight of the focus child to family issues describing longstanding and entrenched intergenerational obesity among grandparents, parents, aunts, uncles and cousins:

'I look at her dad and his side of the family and they are all naturally as wide as they are tall! They're like squares. Because the grandmother is obese isn't she.' (Julie)

'He was born big, he was 4.7 kgs born, and a lot of people say he's like my mother, and if you look at genes, you know, she's very broad.' (Barbara)

Participants from some minority groups identified cultural heritage as an issue that contributed to their child's weight problem, both because of the feeling that to be large was viewed positively in some cultures, or because of the role of food in family gatherings.

Donna felt that her son's cultural minority background had an effect on his weight and his relationship with food. However, though Donna viewed the role of culture and heritage as contributing to her son's weight problems, she felt that other factors also played a part. Donna's focus child is the youngest child and Donna thinks he may have been 'spoilt' and fussed over by his much older siblings. She felt that his position in the family meant that he was subject to lower parental expectations in general, and she acknowledged that he had been permitted to eat certain 'junk' type foods, which her older children had not been permitted to eat. Donna attributed her child's initial obesity to feeding practices as a baby in that he was given extra bottles to comfort him when he was distressed or unsettled:

'I think the way he was fed up until he was four years old. Not that he wasn't fed healthily, but maybe over-indulged. I think that was the cause, not just genetic. He was predisposed to it definitely, but I think we helped him along the way too.' (Donna)

DISCUSSION

The findings of this study give insights into the views of a group of mothers of overweight or obese children about their child's overweight or obesity. Findings reveal participants were greatly concerned about their children's weight and expressed awareness of the social ramifications of excessive weight for their children. There was less of an awareness of the physical ramifications of obesity.

Parents had been concerned about the weight of their children for considerable periods of time, and with the exception of Barbara who was mother of an infant, children had entrenched weight problems before their mothers became concerned. Prior to specific events that triggered their concerns mothers indicated that they did not feel particularly concerned about their children's weight.

Parents are not the only ones who have difficulties in recognising obesity in children. Myers and Vargas (2000) found that 18.7% of health centre staff did not recognise obesity in children who were clinically obese and they cite other research evidence to suggest that only 20% of obese children are recognised and offered treatment for their obesity (Myers and Vargas 2000). Paradoxically, Story et al (2002) conducted a mailed survey to ascertain paediatric health professionals' attitudes and knowledge about childhood obesity and found that up to 93% of respondents were concerned about childhood obesity, viewed it as a threat to health and well-being, and felt intervention was warranted (Story et al 2002).

Despite mounting concern about childhood obesity in the health community, much about this phenomenon remains unresolved in the professional discourses. Even defining and measuring obesity in children is contested (Fruhbeck 2000; Kimm and Obarzanek 2002), though common measures currently available include body fat distribution measures, BMI, and weight-height indices (Hodges 2003). Kimm and Obarzanek (2002) highlight a need to re-examine definitions of obesity in relation to children. They assert that the accepted BMI measures are arbitrary and are not linked to known adverse outcomes (Kimm and Obarzanek 2002). Ideas about causation held by health professionals (Blasi 2003; Kimm and Obarzanek 2002; Myers and Vargus 2000; Reilly et al 2004) were similar to those held by the participants in this current study.

In this current study, participants also linked eating habits such as not drinking enough water and not chewing food adequately to their children's weight problems. It is important to understand parental beliefs about causation of obesity and overweight because it influenced whether the women felt that they could do anything to resolve the problem, and what actions they could take. For example, where parents perceived the problem was primarily linked to sedentary lifestyle; efforts were made to provide opportunities and encouragement to participate in physical activity.

To be effective, any intervention designed to either prevent or manage overweight or obesity in young children is dependent on the involvement and support of parents (Anderson 2000; Baughcum et al 2000; Golan and Crow 2004). Parents tread a fine line between being over controlling and too laid back when it comes to monitoring their children's food intake. Some participants noted differences between their obese/overweight child and other children in that some children seemed better able to self-monitor their intake. Parental over-control of food and mealtimes is linked to children being unable to self monitor food intake as are overly laissez-faire parents (Gable and Lutz 2000).

IMPLICATIONS FOR PRACTICE

Nurses are ideally placed to support parents and families who are trying to manage overweight or obesity in their children. The literature provides guidance on the needs of parents of children with long-term health challenges and these include a requirement for information, and, a need to form caring partnerships with health professionals (Fisher 2001). However, the evidence suggests that health professionals themselves have difficulties in recognising childhood obesity (Myers and Vargus 2000), and this is an area to be addressed if mothers and families are to be assisted effectively. Studies looking at parental involvement identify the importance of ensuring shared perceptions and views of a situation (Simons et al 2001).

A key step in forming effective liaisons between health professionals and parents is ensuring shared perceptions - that is, both parents and professionals understand what childhood obesity is and understand its full social, emotional and health ramifications.

Mothers and their children are frequent users of health services and though a child's weight may not be a primary reason for the presentation to a health professional, recording weight and height are normal and routine aspects of paediatric health assessment. However, despite collecting height/weight information, it may not be fed back to mothers in such a way that they can fully understand where their child sits in relation to ideal height/weight ratio.

Effectively communicating with parents about growth concerns means that any presentation for health care can provide opportunities to give mothers timely information about child's weight and general health regardless of the catalyst for the contact. Notwithstanding the current debates about the applicability of common measures (Fruhbeck 2000; Kimm and Obarzanek 2002), working with mothers and families to help them start to have an awareness of their children's weight patterns, and how they develop in relation to general growth could be a good beginning in helping families to develop a heightened awareness of weight related issues.

Though participants attributed their children's weight problem to a range of factors, there was acknowledgement that a sedentary lifestyle had contributed to the situation. Mothers described children who were reluctant to exercise, and also described feeling unable to let children walk to school or play outside because of safety concerns. Nurses in the community have a role in working with parents, schools and other agencies to promote child and family health and acting to ensure safe places for children to play and participate in a whole range of physical activity.

LIMITATIONS TO THE STUDY

The self selected nature of the group of participants means that respondents already had awareness of and concern about the weight problems of the focus child.

CONCLUSION

The involvement and support of parents is essential to the success of any intervention aimed at the prevention and management of overweight or obesity in young children. A window of opportunity exists for nurses to recognise childhood overweight or obesity as a preventable chronic health problem. By doing so nurses can work on preventative strategies in partnership with families to manage this major health problem. While findings are not able to be generalised, they provide insights that can help guide the development of preventative strategies and practice initiatives.

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