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PARENTAL PERCEPTIONS OF HEALTHY BODY WEIGHT IN PRESCHOOL CHILDREN

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Abstract

This qualitative study examined parental perceptions of healthy body weight in preschool children. Parents answered two open-ended questions regarding their definitions of health body weight and weight problems in children age 2 to 5 years. The researcher utilized a convenience sampling approach, and there were 115 participants. Content analysis revealed three overarching themes regarding how parents knew children were at a healthy weight or developing a weight problem. These themes were: 1) expressions of parental uncertainty and/or lack of knowledge regarding how to determine the appropriateness of body weight in children, 2) parental reliance on subjective observations and feelings regarding the child to determine appropriateness of body weight, and 3) parents referring to objective data sources to determine when a child was at an appropriate weight. The themes that emerged can provide direction for future nursing practice and research.

Keywords: Qualitative, Parental Perceptions, Preschool Child, Body Weight

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Obesity rates have increased among children of all ages and have reached near epidemic levels.¹⁻⁷ Weight problems in preschoolers (e.g., children ages 2 to 5 years) have increased rapidly in the last decade, with a reported 40% increase in obesity in this age group since 1994,⁸ and recent studies have noted obesity rates between 10-20% in the preschool population.⁸⁻¹² The current obesity rates for preschool children point to an emerging health crisis for children, their families and for society. In an attempt to understand the large increases in weight problems in young children, previous studies have focused on parental perceptions of overweight and obesity in children. This body of research has repeatedly shown that parents have problems understanding weight problems, such as obesity. But a clear understanding of how parents determine that a preschool child has a healthy body weight has not been explored.

Review of Literature

Several past studies utilized qualitative phenomenological methods to examine parental perception of their child's weight, with a focus on overweight and obese children.¹³⁻¹⁷ A synthesis of findings revealed three main issues across the studies. Common themes included the difficulty of defining childhood weight problems, the etiology of childhood weight problems, and barriers to managing weight problems.¹³⁻¹⁷

Previous findings indicate that caregivers often do not share the healthcare system's definition of childhood obesity. Children who could participate in activities, looked and felt good, and had good relationships with peers were not considered obese, even if they fell within the criteria for a medical diagnosis of obesity.^{14,16} Parents have also used terms such as "big boned" or "solid" rather than "overweight" and "obese" to describe their children.¹³⁻¹⁷ Mothers in these studies did not define obesity in a numerical sense and avoided labeling their children. Based on the review of literature it seems that parents, especially mothers, are more concerned about their child being underweight rather than overweight/obese and that having an appropriate or healthy weight was not the focus.^{13,14,16,17}

A second finding from the literature relates to the perceived etiology of weight problems in children. Parents commonly viewed childhood obesity as related to genetic makeup and that children are typically comparative in size to their parents and other relatives.¹³⁻¹⁷ It was interesting to note that having a sedentary lifestyle is not often seen as a cause of childhood obesity.

Studies addressing parental perception of child body weight frequently mention barriers to managing weight problems in a child. When caregivers had conflicting ideas regarding the child's dietary patterns, management of obesity was more

difficult.^{13,16,17} Also, several authors mentioned the need for easily understandable education related to what obesity means and its consequences.^{13,14,16,17} Crawford and associates¹⁴ found that mothers wanted more age specific anticipatory guidance related to nutrition and weight issues. Parents voiced a need for more education on how to determine satiety in children, what a healthy weight is for a child at various ages and how to develop positive eating habits from an early age.^{13,14,16,17}

From this review, it is clear that further examination of parental perceptions of child weight and how parents come to the determination that children have a healthy body weight is crucial. Several recent studies noted the existence of a link between successful prevention and treatment of childhood obesity to parental awareness of appropriate body weight and involvement.^{11,18-22} Further, Maynard, Galuska, Blanck, and Serdula²³ noted that there may be difficulty in the implementation of programs targeting children who are at risk for obesity, or are already obese, if parents do not recognize that the condition exists and/or the risk it poses to the child's future health. Based on these findings, promoting an understanding of what constitutes a healthy and appropriate body weight for a preschool child may be the first step in improving outcomes through prevention or early intervention.

Purpose

The purpose of this research study was to describe parental perceptions of appropriate, healthy body weights in young children and to determine what parents view as indicators of the development of a weight problem (either underweight or overweight) for children age 2 to 5 years. By understanding the parent's perception of healthy versus unhealthy body weight, it is anticipated that nurses and other providers can work more effectively with parents to address the burgeoning childhood obesity epidemic and to intervene earlier to prevent or treat preschool child weight problems.²⁵

Methodology

The study utilized a qualitative design. The researcher approached data analysis from a descriptive phenomenological perspective, which involves three basic steps including immersion in the phenomenon, analysis of the essence of the data, and description of themes.²⁴ Parents completed a demographic questionnaire and responded to two open-ended questions regarding their thoughts on healthy body weight and weight problems in preschool children. The responses to these questions were audiotaped for coding and content analysis.

Measures

Demographic Questionnaire

Each participant answered a demographic questionnaire. Information collected on the questionnaire included gender, age, race/ethnicity, education level, family income, and number of persons living in the home. Parents also provided demographic information on their child.

Open-Ended Questions

The researcher posed two-open ended questions to each participant: 1) How do you know when a preschool child is at a healthy weight? and 2) What are the signs that a preschool child is developing a weight problem (either underweight or overweight)?²⁵ Two members of the researcher's dissertation committee who were experienced in conducting research with children and families assisted the researcher in developing the open-ended questions. In addition, the questions were based on focus group and interview questions used in previous studies.¹³⁻¹⁷ The two questions were pilot tested with five mothers of preschool children to determine face validity prior to use in the current study.

Setting and Sample

Data were collected at two sites: a health department in south central Kentucky, and a private pediatrician's office in the same county. Participants at the health department were solicited via the Women, Infant, and Children Supplemental Nutrition Program and the Well Child Program. The pediatrician's office served both lower- and middle-income families and accepted Medicaid, private insurances, and self-pay patients.²⁵

The study utilized a convenience sampling strategy. Participants who met the following criteria were invited to participate in the study: 1) parent of a preschool age child (2 to 5 years), 2) stated ability to read and understand English, and 3) had a child with no chronic illnesses. The sample included those who were biological, adoptive, or foster parents.²⁵

The sample was composed of 115 parents of children age 2 to 5 years who sought services at one of the data collection sites.²⁵ Over 80% of participants were Caucasian, and 93% of total participants were mothers, or female fulfilling the maternal role (See Table 1). There were no statistically significant differences between groups from the health department and private office sites in parental or child gender, parental education level, marital status, or employment status ($p > .05$). There were statistically significant differences between the racial/ethnic makeup of the samples of each site, as well as total family income per year, and socioeconomic status, using Hollingshead's Two Factor Index of Social Position ($p < .05$). The sample from the private pediatrician's office was comprised of more Caucasian participants with higher total family income levels and parental social position ratings.²⁵

Data Collection

The Institutional Review Board for Protection of Human Subjects and both data collection sites approved the study. The researcher approached parents of preschool children at both sites and offered information on the study. To ensure privacy the researcher escorted consenting parents to a private room or section of the lobby and conducted the interview. Responses were recorded on audio cassettes for subsequent transcription and content analysis. The researcher transcribed the participants' responses to the open-ended questions. Responses were transcribed using a word processing program and secured on a password-protected computer in the researcher's private office.²⁵ Each interview was replayed multiple times and checked with the transcript to ensure accurate transcription.

Data Analysis

The open-ended question responses were submitted to content analysis. The researcher utilized an adaptation of Hickey and Kipping's²⁶ flexible approach to content analysis of open-ended responses. The steps taken in this content analysis were 1) immersion and identification of preliminary categories, 2) reaching consensus on categories, 3) allocating category and code details, 4) dealing with rogue responses, and 5) merging and reallocating details.²⁶

Immersion in the data began as an independent process with the researcher carefully transcribing the interviews and then repeatedly reading the transcripts to develop a sense of what the data indicated as a whole. While reading the transcripts the researcher made notes in the margins and highlighted key words and phrases. The researcher worked with her dissertation chair, who had experience in qualitative data analysis and researching childhood obesity, during the content analysis process. First, each researcher examined a random selection of 15% (n=21) of the transcripts in order to develop preliminary categories for the data. Each researcher then worked independently to develop preliminary categories for the data. Discussion of the emerging coding structure and consensus on the categories to code the remaining data were done by email and telephone calls. The researcher worked independently to code the full data set (N=115) using the established coding structure. In addition to allocating data to categories, detail codes were added to responses. The coding strategy was then sent back to the dissertation chair for review, who checked the full data set using the detailed codes developed by the primary researcher. After identifying and discussing rogue responses with the dissertation chair, the researcher finalized the coding structure and revised detail codes. The dissertation chair reviewed and confirmed the narrative summary of the qualitative analysis.²⁵

Results

Content analysis revealed three overarching themes regarding how parents knew preschool children had healthy body weights or were developing a weight problem.

Theme 1. Expressions of Parental Uncertainty and Lack of Knowledge

Parents were often unsure of how to determine the appropriateness of body weight in children. Subthemes included: 1) some parents did not know or were not sure how to determine appropriate body weights in children, and 2) some parents said there was no definite way to tell if a child had a healthy body weight or was developing a weight problem.²⁵

Parents were not sure how to determine an appropriate body weight in children. Several parents expressed bewilderment when asked how they would determine the appropriateness of a child's weight. For example, one mother stated, "Good Lord, I don't know... I don't know." Another mother reported that the question left her confused in regards to formulating an answer. Her response, "I don't know. I have no idea how to answer that one," echoed the sense of confusion. Several parents reported that considering weight problems in children, especially preschoolers, was a new concept for them. A mother talked about her lack of experience with children with weight problems, especially at a young age:

In a child, I don't know. I don't really have any experience in that area. My experience is with the way that older kids, but I don't, I don't have, I don't know. I don't know the answer to that question.

Parents said there was no way to tell about appropriate body weight in children. Some parents had difficulty formulating a clear definition of appropriate body weight or weight problems. Others responded that there was not a definite way to tell if a child's body weight was appropriate or not. One mother said, "There's no true way to define it." Another mother expressed how difficult it is to know the appropriateness of a child's weight status, stating, "Yeah, because, I mean, it's really, it would kind of be really hard to know, really, you know what I'm saying." Another mother indicated ambivalence about determining the appropriateness of a child's weight by reporting, "There is a way to tell, but then there isn't a way to tell."

Theme 2. Parental Reliance on Subjective Parental Observations and Feelings

Parents used subjective observations about children to determine if a child's weight was appropriate and healthy. Subjective parameters included assessments of activity or energy level, mood, behavior, and physical appearance. Parents also relied on their feelings or sense of a child's weight to determine appropriateness, made comparisons between children, and considered the length of time that a child had a weight alteration in determining the seriousness of a weight problem.²⁵

Activity and energy levels. Parents felt it was very important to note a child's activity and energy level in relation to his or her weight status. The appropriateness of a child's body weight depended, in large part, on its effect on ability to be active, play, and do things that peers could do, and not being tired and weak. One parent expressed, "Um, you can, I can kind of, when they're not complaining of a lot of things, of being tired all the time and when they're playing." This thought was apparent throughout many transcripts, including the thoughts voiced by a mother who said, "If they're active and not fatigued and tired all the time," as her key component for determining appropriateness of body weight for any child. Parents saw the desire and ability to be active as a sign of health regardless of the actual body weight, feeling that weight was not a problem if it did not affect activity and energy in a negative way.

Child mood and behavior. Some parents expressed the idea that children with weight problems would have different moods and behaviors. One parent said that negative mood changes were seen in children who were underweight and overweight, stating, "There's mood changes. I know with the weight loss, especially if they're not eating right, their hair and their eyes will look different when they're losing weight. And, overweight they'll be grouchy." By contrast, parents saw children as having appropriate weight if their moods and behaviors were positive and appropriate. One mother reported that she knew her child was at a good weight when her daughter was able to maintain her mood in a positive manner. She stated, "You know, pretty much stay in a good mood. Well, I mean, just all around delightful child. You know."

Just by looking at the child. Parents commonly expressed that they could just look at a child and tell if his or her weight was appropriate. This related in most cases to a perception that the child's body size appeared healthy and/or normal to the parent. A parent stated, "I just know if they look normal." Parents also expressed that children would be appropriate if they did not look too big or too small, and the parents used a variety of descriptive words to designate what they meant by these terms. The terms used included skinny, bony, fat, and chubby. One mother used her own child as an example of how a person could just look at a child and see that he or she was an appropriate size:

Well, um, like with [child name], you know you can tell, I mean she's got; I mean she's not too skinny, she's not too fat. You know, she's not like, you can tell she's healthy. She's got enough body weight on her. She doesn't, she doesn't look like I have starved her to death. I mean, she look like any other average child.

Parents trusted their own visual cues and interpretation of children's weight status, as summed up by one mother from the private pediatrician's office who said, "Yeah. Just by looking. That's the way you can tell."

Physical attributes. In addition to looking at a child's general appearance, parents also mentioned several distinct physical characteristics associated with

weight problems for children. One mother said, "You can tell by their face if they're appropriate or you know, overweight. Just by looking." For other parents, the face was an area that could be examined to determine underweight, as with the parent who reported, "If they're underweight, then they, um, you would see it in their face. Their eyes are sunken in a little bit." Extremities and trunk were other body areas where mothers and fathers looked to see if children were too big or small. One parent commented, "Yeah. When they start getting fat instead of muscle in places, like, you know, their arms, their legs, their stomach," that one could tell a child had a weight problem. Another parent verbalized the following, "I think, um, I don't think a child should ever have, like a big gut or huge, you know, arms and legs. You can tell when a child is overweight." Many parents looked for physical attributes that are seen in larger adults as signs that the child had a weight problem. Several parents commented on cellulite, rolls, and skin dimpling. One mother stated, "Um, if their belly sticks out and they have little cellulite, literally, have cellulite on their legs. And these little dimples and little fat rolls. I mean that's what indicates if they're overweight. That's it."

Parental feelings about child body weight. Some parents thought they would just be able to feel within themselves if a child had a healthy body weight or not. They did not rely on external cues, but instead looked to an inner intuition. One parent stated, "I usually go, I mean, you know by what I feel. I could always be wrong." One parent summed up this theme when she was asked how to determine if a child had a weight problem, stating the following, "No I can't see, but I can tell. It's a feeling, but I don't know how to say what I mean."

Comparisons to other children. Participants often based feelings about the appropriateness of a child's body weight on comparisons to their perceptions of other children's weight and eating habits. One parent compared the sizes of her own children in discussing what was appropriate for a child's body weight:

But, like [child name], like I said, he was nine pounds and he's skinny. And, [child name], he was seven pounds but he's starting to get love handles and the little boy boobs, I guess. My seven year old, he's overly tall for his age, and he has the boobs and he's got a big stomach and hips. But, his legs and everything are normal.

The desire to use comparisons between children's weight status also was expressed by the mother who stated:

Like I said, in my case, I mean, you got some who wants to lay around. Don't want to do anything except watch TV. But, this kindly how it works in my family, we got a bunch of them. Five or six years old, and I'm talking about two hundred pounds. Way over weight. And, it is because their mother let them eat hot dogs and bologna constantly. It's not good for them. But, being miserable, and you can tell the difference between him and them. He's always wanting to go out and run and hunt for something. Just keeps you busy.

Parents easily identified problems in other children and used that as a measure of how their own child was progressing in terms of weight development.

Length of time weight is considered a problem. For some parents, the length of time that a child had a weight problem was important. Brief periods during infancy or one visit to the healthcare provider where the child's weight was not appropriate were not as big of a concern as when the child's weight stayed elevated or lowered. As one parent described:

Um, if they didn't lose it in a few years. You know sometimes it's baby weight, but if it sticks on you as you get older and older, and you continue to get bigger and bigger or smaller and smaller, then you can tell there is a problem there. Because you know, usually if you start out overweight, because you know he was really overweight when he was younger, but as he got older it started to drop off a little bit. The more activities he started doing. If he continued to pick up weight instead of losing, I would have thought that he had a weight problem.

Such parents had an optimistic viewpoint about child body weight. They did not feel that being underweight or overweight in childhood was something the child could not overcome in the future. They saw the problem as being temporary as long as it did not affect health at the present time. One parent summed this up, stating, "The way I look at it is, just as long as they're healthy, I hope they'll grow out of it at some point in time."

Theme 3. Parents Referring to Objective Data Sources

Many parents wanted objective sources and measures to examine the issue. Objective data sources or measures included information from the child's healthcare provider, books and internet resources, and clothing sizes. In addition, signs of physical distress or poor health were important benchmarks related to healthy body weight in childhood. ²⁵

Physician or other medical provider's advice. Several parents reported looking to the pediatrician or other healthcare provider to give guidance about the appropriateness of child body weight. One mother stated:

Well, of course, we do routine yearly check-ups. And ah, of course, he gives us the percentile of weight. We determine off of that, like he was ninety percent today for his age. We go off that, plus he's around a lot of other kids. You can pretty much determine by, with help from the doctor.

Parents seemed to depend on and trust the medical provider to give accurate information about the child's weight. Another parent stated, "I guess a lot of that depends. You rely on your medical professional to tell you...Yes. I really rely on that. For the doctor to let me know." This sentiment was echoed by the mother

who said, "You always need to go by what the doctor says. Because he's a doctor."

Books/internet resources. Although some parents were content to base their view of appropriate body weight for children on the information provided by the medical professional, others voiced the desire to find information from other sources. These sources included books on child health and the use of internet sources. One mother reported that weighing a child was important but that she also consulted books as a means of interpreting the scale measurement. She reported, "It's in their weight. They have a scale here that I guess would tell you. You know, like their body weight and stuff. I've got books and stuff at the house that I go by." Still another parent reported that the internet could provide useful information for determining the appropriateness of child body weight. She stated, "I could go to the internet and check it out. If I had their weight and their height, I could go to the internet and check out to see if they were in their right range."

Clothing size. Parents used clothing size as an objective measure of appropriateness of child body weight. The parents reported that children should fit into the appropriate size clothing for their age, and if the child could not wear an age appropriate size clothing, a weight problem might be developing. An example of this mindset was expressed by the parent who said, "To me it's, you know, like their age and their clothes size. That's the way I look at it. Like if they're in the right clothes size for their age group normally." A similar opinion was stated by the mother who reported that you could use clothing size as a warning sign for a developing weight problem. "And, maybe a drastic change in the size of clothes." Another mother expressed that if a child could get into a size of clothing that was appropriate for children younger than they were, it was a sign of healthy weight status. She stated, "Um, he is two years old, he's 24 months old. He can still fit in clothing that is 18 months old so I know he can still fit in clothing fitted at an age range."

Objective physical distress/poor health status. Parents recognized the relationship between body weight and several signs of physical distress or poor health. Many parents clearly articulated the link between respiratory difficulty and weight problems. They saw being overweight as a cause of breathing problems. A parent reported signs of respiratory distress in her own daughter including "heavy breathing. Can't breathe when they lay down, because she does that . . . when she runs, she gets out of breath quicker." Another parent said, "when kids start running, and then they start breathing hard." Parents also linked illness and decreased immunity to inappropriate weight in children. One mother reported that she saw a strong relationship between weight and immunity, commenting, "they'll be sick, they'll stay, their immune system is weakened if they're overweight or underweight." Another parent associated being over or underweight with "being ill all the time." Parents also noted the weight problems could lead to mobility problems. This was expressed by one parent who said, "I think, I've noticed young kids before where their walking is really slow to develop, underdeveloped

when they're really large. And their feet might even curve in or things like that." Another parent reported that walking problems and other health-related issues could be brought on by excessive weight, stating, "I see a lot of kids that have problems walking. Or, you know, breathing. You know, if they can't take care of themselves, there's something wrong." A final objective sign that parents saw in some children with weight problems was the development of concurrent diagnosed health problems. Problems mentioned included asthma, high cholesterol, and heart problems. The development of health problems was specifically mentioned as related to being overweight. As one concerned mother voiced that problems begin "when they're too heavy, I think when they're too heavy it cause more like heart problems and um, high cholesterol. I think it can lead to more problems if they're heavy.

Discussion

Parents in the study felt that they could determine the appropriateness of a child's body weight by using subjective observations of child characteristics. It was reported that active, happy children would have an appropriate body weight, which is consistent with the findings of previous studies where a healthy weight was defined as the ability to participate in desired activity, not being teased, acting happy, and looking healthy.^{13,14,16} Parents did not want to define a child's weight in a numerical sense, but used appearance and behavior as markers of health and appropriateness of body weight in the preschool aged child.²⁵

In addition, many parents had trouble identifying signs that signaled the initial development of weight problems.²⁵ Previous qualitative studies on this phenomenon noted similar confusion about what signifies a weight problem in a young child.¹³⁻¹⁷ Nurses are in a strategic position to intervene to help parents develop more accurate perceptions of what constitutes an appropriate body weight for their child.

This study also provided new information about objective measures parents use when assessing the appropriateness of their child's body weight. Parents listed the pediatrician or other healthcare providers as important sources of data regarding their child's weight status. Parents defined and based understanding of their child's weight status on objective parameters such as clothing sizes and print and internet resources, among others. In contrast to findings from other studies in which parents expressed distrust for growth charts and medical advice, this study found reliance on these sources.^{14,16,27} This new finding provides nurses with a better understanding of potential avenues for teaching parents about how to determine when a preschool child either has an appropriate body weight or a weight problem is developing.²⁵

Limitations and Strengths

The researcher noted limitations related to the collection and analysis of the qualitative data obtained using the open-ended questions. Interviews were generally brief and conducted at the time the parent was in clinic for the child's healthcare. It is possible that this was not the best time or setting to interview parents about perceptions because of the stress of seeking care for their child and the immediate feedback they had regarding the child's weight. In addition, conventional content analysis does not allow for generation of theory, which limited the researcher to the development of a conceptual description of parental perceptions of appropriate body weight and signs of weight problems in preschool children. It should be noted that there has been limited qualitative study on parental perceptions of body weight in preschoolers and earlier samples were not representative of the general population. In addition, the purpose of this study was to provide description and explore relationships among concepts, not to generate theory. More research is needed on how parental perceptions of child body weight are formed and change over time, and this may be an area suitable for future grounded theory studies. The homogenous nature of the sample may limit the transferability of the findings to other parents of preschool children.

Credibility of the findings is enhanced due by use of data triangulation via the prolonged engagement in the data collection (time triangulation) and the use of two data collection sites (space triangulation).²⁴ Confirmability of the findings was enhanced by having two researchers analyze and code the data. In addition, the primary researcher kept an audit trail to allow other researchers to see the decision making process related to data analysis, which enhances confirmability.²⁵

Summary

Understanding parental perceptions of healthy body weight in early childhood is an important aspect of managing the rapidly increasing obesity rates in preschool children. Previous literature points out that parents often misperceive or underestimate body weight in young children.¹⁸ The study provides a view of what parents perceive as a healthy body weight in preschool children and how they determine a weight problem exists in a young child. Nurses can use this information to tailor education on nutrition issues for parents. If parents do not understand healthy body weight levels in preschool children, they may not recognize potential weight problems or be willing to participate fully in the treatment plan.

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Table 1. Demographic characteristics of the overall study sample and by data collection site

	Private Clinic (n=57)	Health Dept (n=58)	Overall (N=115)
Parent			
Gender			
Female	52 (91.2%)	55 (94.8%)	107 (93.0%)
Male	5(8.8%)	3(5.2%)	8 (7.0%)
Race/Ethnicity			
Caucasian	53 (93.0%)	40 (69.0%)	93 (80.9%)

Hispanic	0 (0.0%)	4 (6.9%)	4 (3.5%)
African-American	4 (7.0%)	9 (15.5%)	13 (11.3%)
Other	0 (0.0%)	5 (8.6%)	5 (4.3%)
Education Level			
< H.S.	11 (19.3%)	15 (25.9%)	26 (22.6%)
H.S.	20 (35.1%)	25 (43.1%)	45 (39.1%)
Some college	21 (36.8%)	14 (24.1%)	35 (30.4%)
B.S. degree	4 (7.0%)	4 (6.9%)	8 (7.0%)
> B.S. degree	1 (1.8%)	0 (0.0%)	1 (0.9%)
Family Income			
< \$20,000	18 (31.6%)	36 (62.1%)	54 (47.0%)
\$20,000-\$49,999	20 (35.1%)	16 (27.6%)	36 (31.3%)
≥\$50,000	10 (17.5%)	2 (3.4%)	12 (10.4%)
Did not respond	9 (15.8%)	4 (6.9%)	13 (11.3%)
Child			
Gender			
Female	24 (42.1%)	28 (48.3%)	52 (45.2%)
Male	33 (57.9%)	30 (51.7%)	63 (54.8%)
Race/Ethnicity			
Caucasian	49 (86.0%)	33 (56.9%)	82 (71.3%)
Hispanic	1 (1.7%)	6 (10.3%)	7 (6.1%)
African American	3 (5.3%)	9 (15.5%)	12 (10.4%)
Other	4 (7.0%)	10 (17.2%)	14 (12.2%)