Published in final edited form as:

Public Health Nurs. 2016 September ; 33(5): 421–429. doi:10.1111/phn.12263.

The Meaning of Weight: A Big Way of Life for Rural Mexican-American Adolescent Men and Caregivers

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Abstract

Objective—Describe the meaning of body weight among rural Mexican American adolescents (RMAA) and an influential person (IP) of their social network.

Design—This is qualitative descriptive study. Convenience sampling was used to recruit RMAA seeking care at a rural primary care-based clinic. Content analysis was used to identify categories and subcategories.

Sample—Fifteen male adolescents and fourteen IPs were interviewed (n=29).

Measurements—Individual interviews were conducted using a semi-structured questionnaire.

Results—Participants described body weight through family norms, body size, and history of heart disease or diabetes. Cultural scripts were used to describe weight gain, judgment of size and resource limitations.

Conclusions—Healthcare providers must evaluate cultural scripts associated with body size to develop interventions that are derived from the meaning ascribed to weight status rather than simply based on evidence-based standards.

Keywords

adolescent; body weight; perception; family; qualitative research

Background

Evidence that provides context for understanding obesity in rural Mexican American male adolescent populations is needed. Obesity prevalence in Mexican American adolescents has doubled over the last twenty years with higher prevalence noted in rural versus urban populations (Joens-Matre et al., 2008; Ogden & Carroll, 2010). Obesity prevalence for

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[ClinicalTrials.gov](https://clinicaltrials.gov/ct2/show/study/NCT01387646) Identifier: NCT01387646

The authors J.C., D.O., or J.D.C. report no conflicts of interest.

Mexican American adolescents has been widely described (Champion & Collins, 2012; Ogden & Carroll, 2010). However, the perception of body weight for ethnic minority males, particularly those living in rural areas requires further examination in order to provide a stronger basis for intervention (Flynn et al., 2006). Differences have been found between male and female adolescents with respect to perceptions of body weight with males having greater self-esteem and less anxiety about weight (Huang, Norman, Zabinski, Calfas, & Patrick, 2007). Findings indicate parents perceive boys as more physically active and at less risk to develop obesity than young women (Glassman, Figueroa, & Irigoyen, 2011). Evidence that male adolescents and their parents are not concerned about obesity is concerning. A retrospective chart review of rural Mexican American adolescents seeking primary care-based services revealed that more males (55.1%) than females (46.35) were overweight, obese or severely obese (Champion & Collins, 2012). Therefore, an understanding of how rural Mexican American adolescent males and members of their social network perceive weight is important for identification of conceptual and empirical targets for prevention of obesity among these adolescents. This qualitative study addresses this critical need by assessing the meaning of body weight for rural Mexican American adolescent males and an influential person in their lives.

Methods

A qualitative descriptive study design was used as explained by Sandelowski (2000). This approach was used to develop broad interview questions concerning perceptions of obesity among rural Mexican American adolescent males and an influential person in their lives. Convenience sampling was conducted in the same community in which the retrospective chart review was completed. Content analysis was used to complete data analysis.

Sample and Participant Selection

Appropriate Institutional Review Board approval was obtained. The study was conducted in a rural health clinic located along the Texas-Mexico border in southwest Texas. A convenience sample of adolescents and an individual who they named as influencing their weight was recruited during routine visits at the rural health clinic. Inclusion criteria for male participants was English speaking, self-reported Mexican American ethnicity, aged 12 to 18 years with parental or guardian consent for adolescent participation. Inclusion criteria for an influential person in their social network (IP) included identification by the male participant as someone who influenced his health and weight and was aged 12 years or older. Written consent from a parent or guardian was obtained if the IP was aged 12 to 17 years. Written consent was obtained if the IP was aged 18 years or older.

Spanish-speaking only participants were excluded from the study. The rural Mexican-American community in which the study was conducted is bilingual, English-Spanish speaking and potential participants had attended public school and were proficient in English. The IPs were also proficient in English. All study participants received \$25 compensation for study participation.

Data Collection

Participants were interviewed individually for one hour in a quiet room in the rural health clinic. A semi-structured questionnaire consisting of demographic information and 5 open-ended questions about the meaning of body weight was used to interview participants. The meaning of body weight questions were developed based on a review of related literature and on clinical expertise of the investigators with the target population (see Table 1). Questions included basic demographic information concerning age, self-reported height and weight, phone number, address, and annual income.

Interviews were recorded, transcribed and compared to audio-tapes for accuracy and clarification of context clues. Data management and integration of analysis were facilitated by use of NVivo 10 (QSR International NVivo 10).

Basic demographic information including age, self-reported height and weight, phone number, address, and annual income (if known) was collected. In this study we did not have access to data contained in participant health care records and chose to use self-report of height and weight in order to approximate the basal metabolic index (BMI) for participants. The BMI served as a context reference for participant discussion of the meaning of body weight.

Participant self-reported height and weight were used to calculate body mass index (BMI). Weight categories were classified differently for adults versus adolescents per Centers for Disease Control and Prevention guidelines (Centers for Disease Control and Prevention, 2011). Weight categories for adults were classified using the National Heart, Lung and Blood Institute (NHLBI) (National Heart, Lung and Blood Institute, n.d.) BMI categories (underweight= <18.5; normal weight =18.5–24.9; overweight=25–29.9; obesity=BMI of 30 or greater). (See Table 3)

Centers for Disease Control and Prevention (2011) Excel spreadsheet for BMI calculations and guidelines for interpreting BMI in children and adolescents 2 to 20 years of age were followed to evaluate weight status of male adolescents (less than 5th percentile=underweight; 5th percentile to less than 85th percentile = healthy weight; 85th percentile to less than 95th percentile = overweight; equal to or greater than the 95th percentile = obese) (See Table 3).

Data Analysis

Content analysis using conventional and summative approaches as described by Hsieh and Shannon (2005) was used to retrospectively analyze transcripts. Analysis began with a conventional approach to content analysis as described by Hsieh and Shannon (2005). Researchers read the transcripts multiple times to gain a sense of meaning and used text data to identify codes and broad categories. Researchers chose to code male adolescent and IP transcripts separately given potential differences in life experience and access to resources based on developmental stage. During initial coding we noted that the adolescent males were less verbal than the IPs. Therefore we decided to code the adolescent males first to clearly examine their views and developed an initial coding structure based on their choice of words. During open coding of the IPs we again allowed the words of the IP to guide the naming of codes. It became clear that there was overlap in the meaning of the codes between

the male adolescent and the IP. As we developed more interpretive categories to enhance our understanding of the meaning of participant statements we selected words/labels that were representative across the many of statements by the male adolescent or IP. This allowed us to create a coding structure for both RMAA and IP data. We used this coding structure to code all data from male adolescents and IPs. New codes were added if the segment appeared to be distinctly different from existing codes. Consensus for coding was reached through discussion by all researchers for the coding and categories. Although member checks were not part of this study design, the uniqueness and relevance of the coding labels to the population was examined in discussions with one of the investigators who had provided care as a nurse practitioner for twenty years in this rural health clinic.

Elements of summative content analysis as described by Hsieh and Shannon (2005) were also used to analyze text. Examination of open-coded categories led to the identification of the consistent use of key words by male adolescents and IPs when they talked about or attempted to explain body weight. These key words included: bad, fat, big, overweight, family, in shape, skinny, lose, diabetes, and weight. Frequency of these key words by each male participant and IP were counted and compared between male adolescents, between IPs, between adolescents and IPs as a whole, and within each adolescent-IP pair and subsequently interpreted for meaning and context. Use of these key words helped to consolidate coding categories, aided in the broader interpretation of the meaning of body weight to study participants, and facilitated the elucidation of the final coding structure (see Table 2).

Results

Study Sample

Fifteen male adolescents living in a rural county and of Mexican American ethnicity and 14 IPs were interviewed. One male adolescent and his IP were excluded from analysis for language difficulties. The range of ages for 14 males in the sample was 12–18 years of age, mean age 15.4 years of age ($SD = 1.8$). The range of ages for 13 influential others (11 mothers, 1 grandmother and 1 father) in the sample was 32 to 63 years of age, mean age 42 years of age ($SD = 7.8$).

Ten male adolescents were considered obese and three were considered overweight given self-reported height and weight. One male adolescent reported not knowing his weight. Seven influential persons were considered obese, four were considered overweight, and one was considered normal weight given self-reported height and weight. One influential person reported not knowing her weight.

Understanding the Meaning of Body Weight

The Mexican American community in this study described body weight through a cultural script that included their beliefs and language about self and family. This script included a description of family size and disease history, food reduction and exercise as solutions to weight gain, judgment and desire for change, and decisions made based on resource limitations. Embedded in this script were key words identified by male adolescents and IPs

when talking about body weight. Consideration of the words bad, fat, big, overweight, family, in shape, skinny, lose, diabetes, and weight helped clarify the meaning and categorization of body weight.

The following four categories provided a summative description of the meaning of body weight in this sample: 1) All in the family; 2) What we say and believe; 3) Sizing you up; 4) You can't help it; were supported by data across all the adolescent males and the influential others. Twelve subcategories were identified (see Table 2).

All in the Family

The size of family members provided context for individual size. IPs and males suggested that knowing the meaning of one's weight included knowing the size of one's family, likeness to one's father and potential to inherit family disease history.

I come from a really big, heavy set family—One subcategory was about knowing individual weight based on family weight. Size of family members was described by weight classifications, and numerical weight of family members. “My mom, she has a weight problem...everybody in my mom's side is obese, and they're big. She just lost, she lost a brother not too long ago, because of his weight. He was big” (Male 6).

I come from a really big, heavysset family...a lot of our relatives are 300 or 400 pounds I think we've had three members in the family who've had gastric bypass surgery. So ever since I was younger, I've always been weight conscious... (IP-2)

Like father, like son—Influential persons and male adolescents' described body weight as opportunity to be like one's father. Influential others used the father's size to explain the size of the son. “He does eat a lot, but he just doesn't gain the weight. ... But his dad was the same way as he was when he was his age” (IP-1). “My dad was like 215, only like 17, 15% body fat when he was in high school... I think I, I really want to, I've been trying to do that” (Male 4).

It could happen to me—IPs and males described body weight through the history of diabetes and heart disease in the family. Alertness to family history and body size were necessary. “I really want to lose weight...Being close to diabetes, I want, I want to be, stay healthy... My grandma, my grandpa...died of diabetes.” [Asked if this scared him and young man nodded head in agreement.] (Male 8)

My grandfather was diabetic and he was a big man. And heart disease... because you hear all about your genes, it's in your genes, it's in your blood, it's in your family if you're going to get this or not. (IP-5)

What We Say and Believe

IPs and males used certain language to describe the meaning of being overweight. Cutting back on how much food was eaten and doing any form of exercise were methods that could be used, that they had used, or that they suggested be used. Any reduction in the amount of food one ate and any movement identified as exercise were responses to weight gain.

Lay off the tortillas—This subcategory represents participants' response to weight gain. Consuming less food than one normally eats was often mentioned in response to weight gain. "If I see that he looks like he's gaining a little bit of weight, I might say, "Ah, Mijo, you need to lay off on the tortillas...Ah Mijo, don't eat so many bowls of cereal" (IP-5). "I think I gain more weight is whenever I drink a lot of sugar, I drink a lot of soda. Because I noticed I stopped drinking soda, and I lost weight, no matter what I ate" (Male 6).

Let's go to the track—Language used to describe body weight included movement or exercise to lose or gain weight. Running, weight lifting, working out, and going to the local stadium were included. "Because there is sports and I know they do plenty during the year, and I know they'll lose the weight during the school year ...it's just during the summer where they're gaining maybe a little bit of weight" (IP-1). "... If I feel fat I...I would like do something about it...I'd be like, "Oh dang, got to work out," and I'll go and hit the weight room or my room, my weight set" (Male 5).

Sizing You Up

Both IPs and males reported judgment of size. These judgments were associated with desire to lose weight yet feeling unable to do so; acceptance of current weight; desire not to be judgmental about size or weight; and desire to lose weight based on comparison to others.

Putting it off until tomorrow—Both IPs and participants judged described being overweight. Both IP and participant wanted to lose weight, yet believed losing weight was difficult.

You stop the dieting, you stop the exercising, and there it started piling up again. ... If you don't have discipline, you're not going to do it. You know? If you just lay back and say, "Later. There's always tomorrow." But for me, tomorrow never comes. [Laughs] (IP 5)

"I hate being overweight. I gained about 60–80 pounds... It's just when you get fat, you know it's hhhhaard. Like I didn't realize how hard it is to get back to being skinny after you're fat" (Male 14).

I think he's fine right now—Acceptance of body size was another way participants described body weight. Being big was used to describe size acceptance. IP and males indicated that current size was expected for them. "I think he's fine right now. He's just a big boy. He's tall, too, so I think that helps em out a lot" (IP1). "I'm a big guy... It's like in my genes I'm always going to be naturally big" (Male 4).

Don't be down on yourself—Being overweight was a negative experience. Participants shared the negative personal experiences of being overweight and being told they were overweight. "I don't do negativity to make him feel bad cause I grew up chubby or whatever, and it wasn't a very good life to grow up like that" (IP5). "Being told, all that stuff... being like, "Oh, you're overweight," and all that. Like it takes away confidence" (Male 3).

I want to be like them—Participants described body weight through comparisons to others. IPs and males indicated that they became aware of size or weight based on

comparisons they made with others. “I’m not happy with everything that, you know, your body has...you still look at the women on TV and say, oh, you know, you wish you had those kind of arms” (IP2).

I kind of like judge myself in a way. ... I think I should be, since I’m in basketball, like there’s a lot of people in shape and...I’m in shape, kind of, but not as much as they are. I’m just, I don’t know, like it’s a race and I’m trying to catch up to them, but I can’t. (Male 7)

You can’t help it

Body weight was described as feeling limited to make decisions about weight. Weight increases were connected to limited food sources and type of food available by some. Constraints on time, food purchases and preparation were explained as something brought about by finances, employment and lack of knowledge.

You take what you get—Access to food was limited by who provided the food. The types of food eaten based on this dependence was described as a problem. “he goes to visit his dad... that’s the problem... his dad’s a single dad and doesn’t cook, so it’s McDonald’s, pizza, whatever, pickup and everything and that’s where my little one is gaining the weight” (IP13). “I eat that what’s around the house...there’s too much junk” (Male 3).

I have to pay for it—Body weight was described through limitations with resources such as time and money. Participants described how limitations led to choices to forego certain foods, services with health professionals and activities. “We’ve talked about ... exercising, like both of us together...but... we’re lacking that time right there” (IP1).

I have to pay for it. And my family is struggling with money. I want ... to go to a gym for free, able to go to a gym work out for free. ... something for free I mean for like poor kids like me. (Male 4)

It cost me a lot—Events were used to describe body weight, specifically those that resulted in weight gain. Participants explained that these events were directly connected to weight gain. “...used to be three hundred and twenty pounds.... I was really depressed and went through a divorce, so food was my companion” (IP-13). “I’ve gained so much weight since I got out of athletics...soccer, swimming, played football....for 8th grade, freshman, sophomore, and then after that I haven’t been doing nothing....Because...like my grades, like I’m down like two or three credits” (Male 14).

Discussion

Participants in this study offered a rich description of the meaning of body weight for themselves and their family within the context of their ethnic and community background. An explanation of the need to know the family in order to know the individual, included having knowledge of size, diabetes or heart disease. This knowledge provided both an explanation and expectation of size. Alertness to familial histories of diabetes and heart disease added to a sense of vulnerability to genetic heritage with respect to body size. Being like one’s father was also a way for IPs and males to explain body weight and may have

been a positive way to explain size. The relationship between family history of cardiovascular illness, diabetes and obesity has been supported in some studies of adults (Lindsay, Sussner, Greaney, & Peterson, 2011; Towns & D'Auria, 2009). Yet, associations between illness and family history was not identified by adults in others (Towns & D'Auria, 2009).

Participants' responses to weight gain included language about food reduction and movement named as exercise. Certain language was used to resolve the issue of weight gain for themselves and their children. One IP, for example, justified body size based on her son's participation in team sports and felt confident in the assured protection of exercise for future weight loss. Responses to weight gain that included language about food reduction and movement appeared to be protective. This language appeared to be protective because despite suggestions that weight was lost in the past through food reduction and movement, for the majority of this population, these solutions did not translate into weight loss. Here one wonders about the impact of the cultural script being created and reinforced in the choice of language by parents and their children. This cultural script may offer an opportunity to strengthen communication between health care provider and client about a sensitive and challenging topic such as obesity.

Language used regarding oversight and recommendations for food and exercise may also reflect a caregiver's role. Parents in other studies described the freedom to allow children to eat as they wished, the use of authoritative practices to feed children, and the father's deference to mothers in overseeing feeding practices (Tschann et al., 2013; Turner, Navuluri, Winkler, Vale, & Finley, 2014). Parents also reported oversight of food intake via attempts to persuade children to eat a certain way (Glassman, Figueroa, & Irigoyen, 2011; Martinez, Rhee, Blanco, & Boutelle, 2014; Tschann et al., 2013). Parents, particularly mothers, found that feeding their children was an important part of their parenting role (Lindsay et al., 2011). This evidence is consistent with our study as adolescents in our study described eating what grandmothers and mothers made or had available at home. Other family members' influence on child feeding practices was also noted, with some parents perceiving their children's interaction with other family members as leading to barriers to healthy eating (Glassman et al., 2011; Lindsay et al., 2011). IPs in our studies explained how time with single fathers and extended family often resulted in adolescents eating food that resulted in weight gain.

IPs and male participants described body weight through judgment and reflection about their own or others' size. Both IPs and males reported wanting to lose weight yet felt incapable of doing so. IPs and young men also normalized body size with language suggestive of developmental stage (i.e. "he's a growing boy") as well as genetic inheritance. Normalizing weight status has been found to be consistent with misperception of weight and associated with ethnicity, income, parent weight, gender, age of the child, and ability to address resource limitations (Towns & D'Auria, 2009). Both may have unintentionally misperceived weight status to avoid harming others given the vulnerability and negativity associated with being overweight. The variability in this sample of perception of being overweight may be suggestive of levels of readiness. Towns and D'Auria (2009) found that readiness to address overweight and obesity in children was related multiple factors. These factors included

parental perceptions that a child had a health problem, a child or sibling was overweight or parental self-perceptions of being overweight. This evidence also relates to the final sub-category, in that judgment of weight was motivated in some cases by comparison to others.

Access to resources and life events had influence on weight in this population. Other evidence suggests that resource limitations, lack of time, cost, transportation, safety issues, and lack of knowledge about healthy diets are barriers to dietary habits, physical activity and achieving overall health (Glassman et al., 2011; Turner et al., 2014). The meaning of body weight was also described through events that resulted in weight gain, specifically pregnancy. This is consistent with previous study in which Latino mothers, 23 to 44 years of age, with preschool children noted that weight gain started for them during and after pregnancy (Lindsay et al., 2011).

Limitations

These study findings represent only adolescents who are accessing primary care-based services in a rural health clinic thereby excluding representation of those who do not have this access. Additionally, convenience sampling limits application of study findings to other rural Mexican American communities. Additional research needs to be completed with participants similar to those identified in this study as negative cases; specifically, influential others of normal weight and those who report having adequate resources to address weight.

Implications

Inheritance of size and disease from family, weight gain, size judgment, and resource limitations characterize the description of body weight for this sample. Participants used terms such as 'big' and 'solid' to describe individuals' size. IPs and young men's use of words such as 'big' and 'solid' with mention of the harm of naming someone 'obese' suggests that some language used by healthcare providers (i.e. BMI, obesity) may be inconsistent with this community's norms. Sensitivity to the meaning of language may give healthcare providers entrée into discussions regarding weight.

Family size and specifically father's size, family history of illness and related size, and size or ability of peers were mentioned as points of comparison by participants in this study. Using members of one's social network such as family and peers as a reference for size and shape are useful targets for healthcare providers to explore. Willingness to name size or weight as a problem did not appear to be related to actual changes in weight based on self-reported weight. Self-reported BMI (see Table 3) suggests a congruence between naming oneself overweight yet rarely obese, as some participants were. Healthcare providers will need to engage with this community over time to create interventions that converge with the norms and meaning this population assigns to size.

IPs and male adolescents suggested that a lack of resources influenced the decisions made regarding food and exercise yet rarely challenged the lack of resources as a social problem and instead presented these issues as individual choice. The discourse of individual decision is similar to other evidence. Chaufan, Constantino, and Davis (2013) found a focus among clinic staff and low-income Mexican American participants on personal responsibility for diabetes prevention despite mention of resource limitations. Most staff and clients proposed

a solution to preventing diabetes as a need for more educational programs and personal knowledge (Chaufan, et al., 2013). Assessment and modification of sociopolitical and environmental influences on the achievement of body weight will be necessary to support individual change.

Healthcare providers must develop interventions based on the meaning ascribed to weight status as inferred by language rather than simply based on evidence-based standards. Wierzbicka (1994) suggests that examination of language patterns of a population, or cultural scripts, can be used to understand the meaning behind words, including cultural attitudes and norms. Findings in this study suggested that cultural scripts drove the discussion of body weight by both parents and adolescents. Healthcare providers can use scripts to explore the meaning of weight that is inferred by the presence or absence of certain language. Perception of family weight and perception of the use of the term 'obese' and the congruency between being named and accepting the characterization of being obese is critical. Assessment of what individuals do or believe in response to being named obese and addressing the motivation that inclines clients to consider their weight or other's weight is necessary. Perception of resource availability to address weight is a consideration all healthcare providers must evaluate for patient populations with regards to weight. Future studies should examine the role of cultural scripts as the basis of interventions in this population.

Acknowledgments

Funding: National Institute on Drug Abuse R01DA19180

We would like to also acknowledge funding from the TTUHSC School of Nursing F. Marie Hall Fund.

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Table 1

Questions for participants

<i>Questions for adolescent males</i>	
1	What comes to mind when you think about your weight?
2	What do you think changes weight for males in general?
3	What do you think makes your weight change?
4	Do you accept your body as it is?
5	What have you heard others say about weight?
6	What do you think about your own weight?
<i>Questions for IPs</i>	
1	What do you do when it comes to his weight?
2	What things do you think about when it comes to his weight?
3	What do you think causes changes to his body weight?
4	Do you accept his weight as it is?
5	Do you accept your own weight?
6	What have you heard others say about weight?
7	What do you think about your own weight?

Table 2

Coding structure

Category	Subcategory
All in the family	I come from a really big, heavy set family
	Like father, like son
	It could happen to me
What we say and believe	Lay off the tortillas
	Let's go to the track
Sizing you up	Putting it off until tomorrow
	I think he's fine right now
	Don't be down on yourself
	I want to be like them
You can't help it	You take what you get
	I have to pay for it
	It cost me a lot

Table 3

Male adolescents' weight percentile and category and IPs BMI and weight category

<u>Adolescent male</u>	<u>Percentile</u>	<u>Weight category</u>
1	98.8	Obese
2	99.1	Obese
3	99.1	Obese
4	99.4	Obese
5	99.3	Obese
6	89.2	Overweight
7		didn't report
8	99.5	Obese
10	99.4	Obese
11	96.3	Obese
12	93.3	Overweight
13	99.5	Obese
14	98.6	Obese
15	92.4	overweight
<u>IP</u>	<u>BMI</u>	<u>Weight category</u>
1		didn't report
2	25.4	Overweight
3	30.6	Obese
4	23.4	Normal
5	43.9	Obese
7	37.5	Obese
8	25.1	Overweight
10	25.6	Overweight
11	35	Obese
12	31.9	Obese
13	31	Obese
14	37	Obese
15	28	Overweight