



## Experience and expectations of the primary caregiver of obese children

Vivência e expectativas do cuidador principal de criança obesa

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**Objective:** to understand the experience and expectations of the primary caregiver of obese children. **Methods:** a qualitative research based on the Social Phenomenology of Alfred Schütz with 16 caregivers of obese children through interviews. **Results:** two categories were identified regarding the “reasons why”: Knowledge about childhood obesity and Experience with the child’s obesity. As for the “reasons for”, three categories were found: What is expected for the obese child; What is expected for yourself; and Expectations regarding health and school services. **Conclusion:** it was evidenced that the group of caregivers studied has knowledge about the phenomenon of obesity and its consequences, as well as about the inadequate diet and body weight of the children. Nevertheless when facing it, they do not accept the condition of obesity of their children.

**Descriptors:** Child Health; Obesity; Child Nutrition Disorders; Caregivers; Qualitative Research.

**Objetivo:** compreender a vivência e expectativas do cuidador principal de criança obesa. **Métodos:** pesquisa qualitativa fundamentada na Fenomenologia Social de Alfred Schütz com 16 cuidadores de crianças obesas por meio de entrevistas. **Resultados:** identificaram-se duas categorias referentes aos “motivos por que”: Conhecimento sobre a obesidade infantil e Vivência com a obesidade do(a) filho(a). Quanto aos “motivos para”, constataram-se três categorias: O que espera para a criança obesa; O que espera para si mesmo; e Expectativas perante os serviços de saúde e escolar. **Conclusão:** evidenciou-se que o grupo de cuidadores estudados possui conhecimentos sobre o fenômeno obesidade e suas consequências, como também a respeito da inadequação da alimentação e peso dos filhos, porém, ao vivenciá-la, não aceita a condição de obesidade dos seus filhos.

**Descritores:** Saúde da Criança; Obesidade; Transtornos da Nutrição Infantil; Cuidadores; Pesquisa Qualitativa.

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## Introduction

Obesity and overweight occur due to abnormal accumulation of body fat. Both conditions have adverse metabolic effects on blood pressure and cholesterol and triglyceride concentrations, contributing to the increase of cardiovascular diseases, ischemic cerebrovascular accidents, type two diabetes mellitus or some cancers<sup>(1)</sup>. It is a public health problem, a preventable, chronic disease, caused by the association of multiple factors, such as behavior, environment and genetics, affecting the population worldwide with rates that indicate a triple increase since 1975. In 2016, about 1.9 billion adults 18 years old and older were overweight, of these 650 million were obese<sup>(1-2)</sup>.

Globally speaking, children are also part of this overweight and obese population group, reaching 40 million in 2010, according to World Health Organization data. By 2025, if appropriate measures are not taken, the number of obese children could reach 75 million. In Brazil, 50.0% of the population is obese, whereas 21.7% of the male population between 10 and 19 years are overweight and 5.7% are obese. The female population in this age group shows a lower rate, 19.4% overweight and 4.0% with obesity<sup>(3-4)</sup>.

With regard to childhood obesity and its relationship to feeding, the family has an important role and may transmit to the child values, knowledge and habits that can promote health or disease with regard to healthy eating habits. It is known that the behavior of parents and family members in the provision and consumption of special meals such as sweets interferes directly with childhood overweight<sup>(4)</sup>. In order to change the behavior of parents or caregivers regarding the unhealthy eating practice, it is necessary to encourage them through individual or group educational activities to support the development of knowledge to obtain results that promote healthy eating and, consequently, better results in obesity control<sup>(5-6)</sup>.

In 2012, the Intersectoral Plan for the Prevention and Control of Obesity was created to prevent and control obesity from various angles, with actions

to promote adequate and healthy eating and physical activity<sup>(7)</sup>. In addition, factors such as the home environment, including improper healthy eating and lack of physical activity, are determinant for the risk of obesity. Therefore, the family as a social group may influence the habits of its members, contributing to their nutrition, as well as determine the overweight and obesity conditions of each family member<sup>(8)</sup>.

Given the evidence presented, this research starts from the following concern: How do the main caregivers experience and consider the childhood obesity situation? Accordingly, the aim of this study was to understand the experience and expectations of the primary caregiver of obese children.

## Methods

This is a qualitative research focusing on the Social Phenomenology of Alfred Schütz. It is concerned with human phenomena and involves the relationship and social action of individuals<sup>(9)</sup>. The research was conducted in two neighborhoods, one in the southern region and one in the northern region, in the city of Cascavel, Paraná, Brazil. These neighborhoods were chosen because they are neighborhoods with distinct socioeconomic characteristics. In contrast, families living in the southern region have more favorable social conditions. These contrasting situations enhanced the quality of the data. The selection of participants took place through a survey of the enrollment in the Health at School Program, having as inclusion criteria: being 18 years old or older; being the primary caregiver of the obese child regardless of whether he/she was a parent, family member or other. The main caregivers of obese children who were not part of such program, and those who sporadically cared for the obese children were excluded.

Contacts were made by phone to schedule the date and hour and to explain the research and the informed consent form. Eighteen caregivers were invited; of these, 2 were not present on the day of the interview. Thus, the total final sample was composed

of 16 participants. All were linked to the Basic Health Unit or Family Health Strategy unit, married, female, mothers of obese children, with family income between one and three minimum wages, all dedicated to housekeeping and child care.

Data collection took place from April 2017 to March 2018, through semi-structured, audio-recorded interviews. The interviews were focused on two main topics; “reasons why”, that is, the participants’ experiences, and “reasons for”, i.e., the expectations of the participants regarding the obese child, the services and professionals. The interviews lasted on average 20 minutes each. Two interviews were conducted in the pilot test mode of the instrument. There was no need to change the instrument, as there were reports with sufficient content for analysis. The reports were obtained at the participants’ homes, without interference from third parties.

These were questions related to “Reasons why”: Tell me about your perception of obesity; What is your understanding of childhood obesity (focus turned to causes, lifestyle, eating habits)? Comment on your experience of having and caring for an obese child. Regarding the “Reasons for”, the participants answered the following questions: What do you expect regarding the child’s obese condition? What do you expect for yourself as caregiver of an obese child? What do you expect from services and from health and school professionals regarding child obesity activities?

The interviews were ended when the reports became repetitive and sufficient to analyze the concrete categories of the lived experiences of the main caregivers of obese children according to the adopted reference. After the interviews, the reports were fully transcribed by the researchers, and then, carefully and repetitively analyzed in order to identify the motivations - “reasons why” and “reasons for”. On that account, the “reasons why” are related to past and present experiences, explanations after the events occurred, and the “reasons for” refer to expectations<sup>(9)</sup>.

The reports were analyzed as recommended by researchers of the Social Phenomenology of Al-

fred Schütz. Step 1: carefully and judiciously reading of each report, seeking first to identify and grasp the global meaning of each participant’s social action; Step 2: rereading each statement in order to identify common aspects that express the contents related to the “reasons why” and “reasons for”; Step 3: grouping the common aspects according to the convergence of contents to the composition of concrete categories; Step 4: analysis of concrete categories for the understanding of social action; Step 5: constitution of the lived experience from the set of “reasons why” and “reasons for” expressed in the analysis of concrete categories; Step 6: discussion of the lived experience according to the Social Phenomenology of Alfred Schütz and other references related to the theme of this study<sup>(10)</sup>.

It is necessary to emphasize that the anonymity of the participants was preserved, they were identified with the Code PC (Primary Caregiver) followed by the number of each interview, from PC1 to PC16. The study complied with ethical precepts with research involving human beings and was approved by the Ethics and Research Committee of the State University of Western Paraná, under favorable opinion nº 1,872,666/2016.

## Results

The study participants were all married, housewives, nine had attended elementary school and seven high school. All were mothers of obese children, with family income between one and three minimum wages. The reports allowed the analysis in concrete categories of lived events, which include the experience lived in past and present time, “reasons why”, and the intentionality of the action, called “reasons for”.

Based on the analysis of the reports regarding the “reasons why”, which relate to the experiential context of the main caregivers of obese children from their knowledge background, two categories were identified, namely: “Knowledge about obesity childhood” and “Living with the child’s obesity”.

In the category “Knowledge about childhood

obesity”, obesity was considered as overweight in children, a disease that needs attention and which is related to eating and life habits. *It is a body weight off limits. So I think it's a serious problem (PC 3). Obesity is a disease because they can start to get fat when they are little and they can grow that way (PC 4). I know it is very bad for health. If you are obese, you have difficulty to walk, talk, breath (PC 6). Lack of healthy eating and exercise (PC 8).*

Caregivers add that children have inadequate diet and sedentary habits. This is what reveals the “Causes of obesity” category. *If she ate the way she was supposed to eat, she wouldn't be overweight. She has more anxiety, and this causes her to not eat well (PC 1). It is overeating, eating out of time, not eating right (PC 7). It is that the child eats a lot. We as mothers can control our diet, but we feel sorry (PC 5).*

In the category “Living with the child's obesity”, it was possible to understand that most caregivers feel responsible for the child's overweight and for not having a firm attitude towards feeding, showing difficulty in adopting a healthy diet for the child and adhering to physical activity habits. Others do not consider their child obese, even when overweight or obesity has been identified. *We take care within our limits, but she doesn't want those limits. She overeats. At school there is sports activity once a week. At home I turn off the TV and I send her to play outdoors (PC 2). I worry if she keeps growing like this. She will suffer prejudice (PC 9). But it's not just her fault, but mine too. I feel sorry for her and I give her the things she likes (PC 10).*

Given the complexity of the theme, the category “Eating Habits” stands out. In this category, the participants report on the breastfeeding process, the meals that the family and children have in the home environment, as well as the child's diet in school. It is noteworthy that only three children were breastfed until two years of age. Most had food introduction at six months of age. The reports spell out a nutrient poor diet. *It is very difficult for him to eat salad. He likes better when I do noodles. He eats a lot of sweets, he sucks lollipop, candy and bubble gum (PC 12). In the morning it's bread with butter, a fried egg or a sausage if we have it. At lunch and dinner, he eats meat, rice, beans, fried egg, sausage and salad. She was breastfed until she was two years and*

*seven months old (PC 11). From the age of six months, I started to give her “Danoninho”, baby food and bean soup with potatoes. When she would cry I would give her soup, “Danoninho” or crackers. And so she was growing (PC 14).*

It was evidenced that the participants of this study have a compromised dialogue regarding the food that the child gets at school. *She buys things at the market and takes them to school, she says the school snack tastes bad (PC 13). I find quite unusual the snack they get at school. It has no vitamins. Sometimes it is that sweet biscuit with juice or chocolate milk and sometimes sagu (PC 18).*

Regarding expectations, i.e., the “reasons for”, three categories were described: What is expected for the obese child; What is expected for yourself; and Expectations regarding health and school services.

In the “What is expected for the obese child” category, the participants' responses are related to changes in child's diet. It is believed that, through this change in eating habits, children will reach adolescence with the appropriate weight. *I think as he grows, he will become thinner (PC 16). I don't worry. I hope she lose weight because I was chubby and I lost weight (PC 3). We are trying to change habits, buy more fruits, these kinds of things. We are trying to motivate her to exercise more (PC 17).*

In the category “What is expected for yourself”, the participants hope their children may no longer be obese and, with changes in eating habits, they lose weight, minimizing the feeling of helplessness when facing and coping with the situation. Few reported about the need to change children's sedentary habits. *I hope she will not be obese in the future, because in my family and my husband's there is no one obese (PC 3). I have the feeling of helplessness, I hope to be able to stay focused and take care of my daughter's diet (PC 15). I hope I can take better care of my child's diet (PC 8).*

In the category “Expectations from Health and School Services”, the participants expect health services to provide care to their children in a resolute way, and that the school is able to control the amount of food by offering healthy food. *I hope that they (school and primary health care facility) will send us a list of what she can or can't eat so she can lose weight (PC 4). I hope the nutritionist recommends*

*us a better way of doing things so that she can eat healthy (PC 15). I hope school helps, I think they should always give them healthy food and not let the children repeat (PC 6).*

## Discussion

This study has limitations because it only takes into account the obesity phenomenon related to children who are taken care by caregivers. It is needed to broaden this horizon with new research focused on the considerations of children and adolescents, as well as the estimates of health and education professionals. It is noteworthy that these segments are being studied in other research clippings linked to the larger project that originated the present study.

The results obtained in this work contribute to the reflection on the daily life experienced by the main caregivers of obese children when facing their own anxieties and limitations related to obesity and surroundings, such as the incipient knowledge about aggravating childhood obesity, lifestyle and feeding. As it is a persistent phenomenon that is at the same time emerging, complex and challenging for society as a whole, childhood obesity deserves prominence in the public health agenda aiming at solving the problem, not only within the scope of reflection on the subject.

In the context of teaching and research, it is expected that the results found here may lead to further studies on childhood obesity. With regard to the care and experience of caregivers, this study may raise awareness and instigate the most effective care by the responsible bodies and that health and education professionals and main caregivers may find care strategies that are resolute for obese children.

It is necessary to sensitize both professionals and family members about the inadequate feeding and children's body weight and the consequences of obesity, demystifying the idea that overweight is resolved with the child's growth and development. This understanding becomes possible through experiences, as well as from the background of knowledge

acquired from predecessors, from people living together, such as family members experiencing the obesity of a child, or through school knowledge, studies, readings, among others<sup>(9)</sup>.

It is identified that the development of overweight and childhood obesity are not only related to socioeconomic aspects, as another study reveals<sup>(11)</sup>. Caregivers reveal poor perception of their children's nutritional status, which tends to underestimate obesity because it has no immediate harmful effect on children's health, in most cases<sup>(12)</sup>.

Although caregivers recognize obesity as a disease, it is noted that they do not recognize the obesity situation of their children because they believe that as they grow up, they will lose weight. Therefore, it is confirmed that overweight and childhood obesity are fraught with stigma, which poses a barrier to the discussion of the child's body weight inside the family. Health professionals are responsible for raising the discussion on the theme in order to guide and sensitize caregivers<sup>(13)</sup>.

In this context, health professionals can help them to accept child overweight and recognize the need to change family behavior regarding eating. Added to this is the need for social interventions through the strengthening of public policies and better use of primary care services, including psychological support<sup>(14)</sup>.

It takes motivation to reach the desired ideal, which is characterized by the "reasons why", that is, all the knowledge acquired so far about obesity and its importance, as well as the "reasons for", to project for the future when taking care to reduce obesity and its health consequences<sup>(9-10)</sup>.

Caregivers point out to expectations regarding health and school services to improve the nutritional aspects of children's diet, in quality and quantity. However, it is emphasized that parents are the main formers of healthy eating habits in early childhood, mediators for children's healthy choices<sup>(15)</sup>.

Still, the school is considered an adequate spa-

ce for the development of interventions and encouragement of self-care. Educational practices related to physical activities and eating aspects should be encouraged. Above all, the performance of physical activity becomes essential in the fight against obesity when its practice becomes pleasurable for the child<sup>(16-17)</sup>.

School based actions are the foundation for a healthy education, but intersectoral practices have more strength to act in childhood obesity, as shown in a study conducted in a city of Greater São Paulo, with managers and health and education professionals. The study reveals the implementation of an intersectoral working group that enabled an action plan based on the local reality and the specificities of the basic health units and schools, planning actions in conjunction with the Health at School Program and the Family Health Care Center<sup>(18)</sup>.

It is essential that health professionals be aware of social organizations and their habits and, together, seek to qualify the assistance, which should be provided in a complete and individualized manner. Therefore, it is necessary to invest in continuing education of professionals from various areas that act in prevention and health promotion activities of children so that obesity is seen and thought by a multidisciplinary or interdisciplinary team, thus reaching the expected and advocated goals<sup>(18-19)</sup>.

In order to reverse the growing number of cases of childhood obesity, whether national, state, regional or local, it is necessary to adopt health actions by the interdisciplinary team and at a intersectoral level, involving school and community, as all the acquired knowledge and experiences make up what we are today as individuals, ie, the biographical situation of each one of us<sup>(9)</sup>.

To reverse the obesity even in childhood, it is necessary to renew the stock of knowledge about it, thus allowing it to be contemplated in a biographically different way. This will consequently be surrounded by changes in eating and living habits. It is noteworthy that overweight or obese children and adolescents

tend to maintain this nutritional condition at all stages of life, which keeps a high prevalence of nutritional alterations in adults and elderly<sup>(20)</sup>.

Within the scope of services, it is up to health professionals, in particular the Nursing team, to renew their knowledge about health education focused on the family and community, as well as developing actions aimed at planning and building strategies for monitoring obesity in its coverage area. Therefore, it is necessary to act in an objective and subjective manner. It is necessary to reach the subjectivity of people under professional care, this may be the key to adherence to treatment and care, aiming to acquire new stocks of knowledge and, especially, to change habits and lifestyles regarding health and disease process in the context of obesity.

## Conclusion

It was evidenced that the group of caregivers studied has knowledge about the obesity phenomenon and its consequences, as well as about the inadequate diet and body weight of the children, but, when experiencing it, they do not accept the obesity condition of their children.

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## Collaborations

Caldeira S, Damasceno L, Cavalheiro RF, Baggio MA and Oliveira TF contributed to the analysis and interpretation of data, writing of the article and relevant critical review of the intellectual content. Machineski GG contributed to the project design. All authors contributed to the final approval of the version to be published.

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