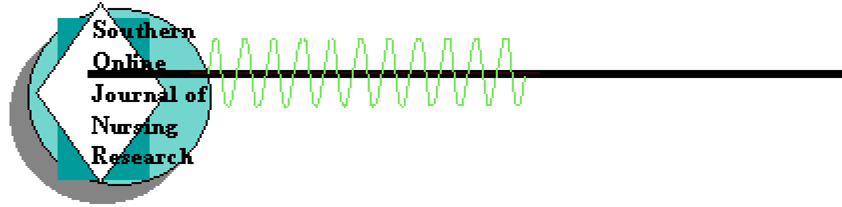

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Mi familia viene primero (My family comes first): Physical Activity Issues in Older Mexican American Women

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ABSTRACT

Despite the known benefits of regular physical activity, a significant proportion of ethnic, older women do not participate in sufficient physical activity necessary for health promotion. Research demonstrates that older adults, especially women, ethnic minorities, those with lower levels of income and education, and individuals living with disabilities and chronic illnesses are the least active population. In terms of cardiovascular disease (CVD), the mortality and morbidity rates show that minorities seem to suffer disproportionately.

Studies have focused on physical activity in older women; few studies have focused on older postmenopausal Mexican American women and their perceptions of the

enablers and barriers to their initiation and maintenance of physical activity. Focus groups were used to describe the experiences of 10 older, postmenopausal Mexican American women. Enablers to physical activity included a desire to be healthy for their families, to lose weight, to feel better, to improve body image, and physician recommendation. Barriers included family obligations and responsibilities, not enough time, lack of social support, laziness, fatigue, lack of motivation, and health problems. Further research is needed to determine if sedentary behavior is circumscribed by social and cultural values and not necessarily by personal choice.

Key Words: physical activity, Mexican American, women, qualitative research, sociocultural context, ecological model

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Introduction

Despite the proven benefits of physical activity, more than 60% of American adults do not get enough physical activity to provide health benefits. More than 25% are not active at all in their leisure time. Activity decreases with age and insufficient activity is more common among aging women than men and among those with lower incomes and less education. Four in 10 or 38% of adults reported no participation in leisure time physical activity and only 22% of adults engage in physical activity at sufficient frequency, intensity, and duration to reduce risks of chronic diseases.[1] Of those individuals who begin a physical activity program, maintenance is less than one-third.[2] Fifty percent of people who start an organized fitness or exercise program drop out within six months.[3,4] With a prevalence of at least 60%, physical inactivity is among the top three leading actual causes of death in the United States and is estimated to cause 250,000 deaths per year.[5,6] Physical inactivity is clearly a public health problem with clinical significance.

Literature Review

Minority groups are consistently found to have relatively lower physical activity levels than their majority counterparts; more specifically, minority women have been found to be among the least active subgroups in the U.S.[7]

The results of three national health surveys with indicators of level of participation of physical activity (National Health And Nutrition Examination Survey III [NHANES III] 1988-1991, National Health Interview Survey [NHIS] 1985, 1990, 1991, and Behavioral Risk Factor Surveillance System [BRFSS] 1986-1991, 1992, 1994) yielded similar findings. Non-Hispanic white men (87%) and women (77%) reported more leisure-time physical activity than non-Hispanic African-American men (76%) and women (60%). Similarly, non-Hispanic white men and women physical activity rates were higher than Mexican-American men (67%) and women (54%) after adjusting for age.[8]

Older Mexican American women have a prevalence of physical inactivity of 46%, greater than in the population as a whole.[9-10] In addition, Mexican American women whose main language is Spanish had a physical inactivity prevalence of 58%.[2] Prevalence of physical inactivity among Mexican Americans of any age group is greater than the prevalence of physical inactivity observed among non-Hispanic whites ages 70-79. [11]

Physical inactivity affects less-acculturated Mexican American women and generally mitigates the better health outcomes of first generation Mexican women immigrants.[10] Analysis of NHANES III data collected between 1988-1994 revealed that less-acculturated Mexican American women were more likely (58%) to report leisure time inactivity than their more acculturated counterparts whose preferred language was English (28%).[10] It is estimated that 20,000 fewer deaths each year would occur if half of those who are sedentary would engage in some kind of physical activity, such as walking, biking or dancing, at least a few times a week.[12]

For older Mexican American women, participation in physical inactivity during leisure time was prevalent during earlier periods in their adult lives.[2] This may be explained partially because they may engage in more manual occupations that require higher energy expenditures than non-Hispanic whites with the same education and income levels.[13] Sallis et al.[14] studied the physical activity levels of a group of non-Hispanic women and Mexican American women (mean age 30.8 and 31.2 respectfully) over 7 years and found that non-Hispanic women

reported more vigorous leisure time physical activity while Mexican American women reported more moderate work activity.

However, Crespo [2] found that regardless of their occupational status, the prevalence of physical inactivity continued to be highest among both non-Hispanic black and Mexican American women. Ransdell and Wells [15] reported that women of color, women over 40, and women without a college education had the lowest levels of participation in leisure time physical activity.

Some literature has speculated that part of the reason for the low levels of physical inactivity may be the difficulty in the quantification or the measurement of physical activity. Women tend to engage in activities such as child care and household activities that are hard to quantify.[16] However, Kriska and Rexroad [17] do not feel that the low levels in minority women are completely the results of measurement error because objective measures have replicated the subjective findings.

The purpose of this study was to explore the enablers and barriers of physical activity patterns among older postmenopausal Mexican American women and to describe their subjective interpretations of environmental constraints and opportunities. The ecological model provided a framework for this study in that physical activity within older Mexican American women's lifestyles is influenced by psychological and social factors and the subjective interpretation of environmental and cultural values.

Physical activity is defined as bodily movement produced by contraction of skeletal muscle that substantially increases energy expenditure.[6] Exercise is defined as planned, structured, and repetitive bodily movement undertaken to improve or maintain one or more components of physical fitness.[6] This includes activities such as deliberate walking for its exercise benefits, running, jogging, aerobic dance, etc. It also includes activities that are a part of one's daily living, such as occupational exercise, walking to and in the store, cleaning one's house, yard work, or climbing stairs in a building. Although exercise is considered a subcategory of physical activity, for the purposes of this study, we focused on planned and structured activities. Sedentary activity is defined as no sports or exercise

reported in the past two weeks or no increase in heart rate reported from any activities.[18]

The latest recommendations provided by the American College of Sports Medicine, the Centers for Disease Control, and the Surgeon General state that adults should have at least 30 minutes of moderate physical activity on most, if not all, days of the week. According to these guidelines, health benefits can be achieved by performing moderate-intensity leisure time physical activities such as walking, jogging, biking and/or physical activities of daily living such as house and yard work, as well as occupational-related physical activities.[19]

Conceptual Framework. More attention to predictors of physical inactivity and other health risk factors that are specific to ethnicity and/or culture could potentially improve program intervention design and implementation. Castro, Cota, and Vega [20] suggest that any health promotion program that is designed to serve minority populations should take a cultural relativist orientation toward the design and delivery of an intervention to ensure that it meets the needs of minority groups. In other words, identification and incorporation of culturally specific factors, such as ethnicity, level of acculturation, gender identification, and location of residence in the local community must be considered in tailoring the program to the unique needs of the targeted group. If this is not done, health promotion programs will continue to use similar programs that may result in continued low levels of physical activity in this population.[15] For instance, some investigators have reported that sociocultural factors, such as body size image, body size values, and the reluctance to engage in physical activity, may be instrumental in the influence of minority women to engage in risk reduction behaviors.[20]

There is acknowledgement in the field of physical activity that there is a need for health promotion models to recognize the importance of social context. Currently there is strong interest in the use of ecological models in the study of physical activity. The ecological model, which has evolved over decades in the fields of sociology, public health, education, and psychology, allows for conceptualization of the interdependence among people, their

behavior and environment (to include physical environment as well as public policies), and proposes that all impact on the range of behavior by promoting and sometimes demanding certain actions and by discouraging or prohibiting other behaviors.[21-24]

Two key ideas from an ecologic perspective assist in directing the identification of personal and environmental leverage points for health promotion and education interventions.[25] The first is that behavior is viewed as being affected by, and affecting, factors at multiple levels. Five levels of influence have been identified. They are 1) intrapersonal or individual factors, 2) interpersonal factors, 3) institutional or organizational factors, 4) community factors, and 5) public policy factors.[22] The second key idea relates to the possibility of reciprocal causation between individuals and their environment, i.e., behavior both influences and is influenced by the social environment.[26]

Interventions in risk reduction and health promotion take place in specified environments, and these environments influence the type and extent of involvement in the activity. Important intrapersonal, interpersonal, organizational, community and public policy factors affect a person's behavior.[22] Thus, the "behavioral setting" is an important part of the design of an intervention to increase health promotion or reduce risk for chronic illness.

It is imperative to have a thorough understanding of the basic cultural values that may affect the process and outcome of a given study. More attention to predictors of physical inactivity and other health risk factors that are specific to older Mexican American women may improve program intervention design and implementation. For instance, *familism,* a strong attachment and commitment to the family network in which the collective is of greater value than the individual, appears to be a core value in the Mexican American culture.[27] It also seems to cross varying levels of acculturation [28-30] and socioeconomic status,[31] with women demonstrating a strong sense of commitment and obligation to their family of creation defined as their children, spouses and partners. Family of origin is defined as the parental lineage, as well as extended

family.[28,32,33] Other well known Mexican American culture beliefs include a cultural script known as *simpatía,* which calls for positive, warm and accepting interpersonal relationships [34]; *personalismo*, or respect for personal relationships; provision of *botanas* (refreshments); *respeto* or use of formal title, such as *Señora* for a married and/or older woman, and *Usted*, a formal, second person pronoun and a personal greeting/handshake upon arrival to a group. Understanding how these possible mediators may influence experiences with physical activity and exercise are very important in determining older Mexican American women's physical activity behavior.

Methods

A naturalistic method was used to describe the enablers and barriers of physical activity among a group of 10 postmenopausal older Mexican American women. The purposive sample was recruited from a community center located in the *barrio* or neighborhood of the participants. Human rights protection was ensured as the study was approved through the local health science center's Institutional Review Board and all participants signed an informed consent for participating in focus groups. Narrative data was collected in three focus group sessions located at the community center, with four, three, and three participants in each focus group, respectively. The focus groups were conducted in the participants' preferred language, English or Spanish, the first two in English and the last in Spanish. All the focus groups were facilitated by the primary author. All the interviews were audiotaped and transcribed verbatim. Once the data was recorded on audiotape, they were transcribed by a bilingual assistant with expertise in Spanish to English translations and transcription of audiotapes. All focus group participants received a $25 gift certificate from a local store for participating.

Semi-structured interviews were used to explore the phenomenon of physical activity from an "emic," or subjective, perspective.[35] The participants were asked open-ended, descriptive questions about their perceived barriers and aids to engaging in physical activity. The questions asked during the focus groups were the following:

1. What factors do you perceive as facilitating physical activity and exercise in your lifestyle?
2. What factors do you perceive as barriers to physical activity and exercise in your lifestyle?

Demographic data were analyzed using descriptive statistics. Narrative data analysis was conducted through constant comparison methodology to analyze and assign related codes to clusters of similar narrative data to determine categories and their properties.[36] The primary author, who is bicultural and has personal as well as professional expertise in working with older Mexican American women, coded the data. The second author reviewed and agreed with the categories. The categories were also reviewed and agreed upon by a *promotora,* a bilingual lay health advisor, who has been involved in past studies examining physical activity in older Mexican American women. Most themes are labeled in English with a Spanish translation next to it. These translations were verified for accuracy by two, independent bilingual individuals fluent in "Tex-Mex" Spanish, which is the type of Spanish that is spoken by the majority of Mexican-Americans in San Antonio.

Credibility and auditability were augmented by verbatim transcriptions of all the participants' statements, the open coding format, and individualized coding verified by two parties. Several other steps were taken to address scientific adequacy and rigor of qualitative analysis, including reflexivity [37] and the use of self.[38] Because the primary author was familiar with the cultural and social norms of these participants in a group setting, this allowed for trust and rapport during data collection.

Sample. The authors used a nonprobability, purposive sample of 10 older postmenopausal Mexican American women. The sample was selected using the following criteria: 1) identify themselves as Mexican American; 2) postmenopausal for greater than six months, and 3) willingness to be interviewed. The sociodemographic characteristics of participants are displayed in Table 1. The age of the participants ranged from 48-65, with a median age of 54. In general, the participants were of low (37%) to middle (63%) income, married (80%), high school diploma (80%), with 20% having two years of college. All of

the women stated they were housewives. In addition, 40% of the women worked full-time outside the home.

Table 1.
Sociodemographic Characteristics of Participants

Characteristic	Frequency	Proportion (%)
Age distribution		
40-49 years	1	10%
50-64 years	8	80%
65-79 years	1	10%
Marital Status		
Married	8	80%
Divorced	1	10%
Widowed	1	10%
Grade Completed		
High School	10	100%
Some College	2	20%

Results

Perceived Barriers. A barrier is defined as the potential negative aspect of a particular health action that may act as an impediment to undertaking the recommended behavior.[39] Barriers could be personal or environmental. The barriers found to be most prevalent in this group were consistent with pervious literature, e.g., lack of time due to caregiving activities.[40-41]

Mi familia viene primero. All of the women reported family obligations, what we are calling "*mi familia viene primero"* (my family comes first), as the primary barrier to initiation and maintenance of regular physical activity. *Mi familia viene primero* is being used by us to describe the participants' decisions to choose their families or family obligations when deciding about time allotments in their lives. However, an interesting aspect of this phenomenon is that although these obligations were perceived as a barrier, their families were also a motivation or aid to being physically active as all of the women expressed a desire to be healthy for their families so that they could continue to be good caregivers. Their narratives indicated that they knew that to be healthy, they needed to be more physically active. Examples include the following:

- "I think my grandchildren is one. (things that keep me from exercising)
- "I walk 2, 3 miles. I was doing it…until about a month and a half ago…because my mom is sick and I've been coming and going to Corpus Christi and things like that,"
- "I put my children first. I would never be able to tell my family 'take responsibility' because I need time for myself…that's not me. They need me I put myself to the side and then I'll make time for myself,"
- "…and I'm not getting any younger, so I want to live to see my grandkids you know, grow up."
- "I don't want to give up you know. Because my kids, my grandchildren are very active. And I'm very involved with them and I don't want to be saying "I can't do it" because I'm sick. When I'm sick, I'm sick. But I want to be able to spend time with them."
- "I have a grandson…he is full of energy…and so it depresses me that I cannot keep up with him the way that he wants me to. But I can do it, it's just that I'm too heavy. That's when I said I'm going to do something about it."

Gran amiga. All of the women discussed the importance of having someone to exercise with a friend or family member who was a motivator and who would push the women or what we are calling the need for a *gran amiga* (great friend). Recent research suggests that among undeserved minority women, strong social networks can have positive effects on preventive health behavior, such as cancer screening participation.[42-43] Examples include the following:

- Sometimes I need someone to account to. If I don't have anyone, like my sister-in-law says, I use it as an excuse. Oh I have something to do, oh, I'm too tired... but if I have someone to answer to, I go and I like it. You need a little push!
- "I don't have a friend to exercise with, someone to push me"

- "I'm not afraid to go out there and walk, it's just trying to get somebody to go with me."
- "…I think having someone to motivate you really helps me, makes me feel motivated…"

However, the participants also described situations in which their *gran amiga* was a barrier to the initiation and maintenance of physical activity. Examples include:

- "My friend will try to talk me out of walking, instead wants me to go out to eat with her or if we do walk, she will want to go get a taquito after…"
- "You're always going to find somebody that will discourage you because they don't want to do it. They won't want to do it, let's do it later. They discourage you."

One participant identified both the neighborhood and friends as distractions. Latina culture promotes a cultural script known as *simpatía,* which calls for positive interpersonal relationships usually accompanied by the provision of *botanas* or snacks.

- "I walked for awhile, but you know what discouraged me? I've lived in the neighborhood for a long time…about 40 years. And so when people would see me…they'd go, what happened to your cart? And I would stop and talk to them! And instead of taking a half hour to maybe an hour, it would take me longer and I would come back with taquitos! I would stop and say good morning, how are you? And I would stop and talk and that would break my routine….Well it's rude not to accept and things like that. I figured I better start going by myself in another direction."

Pereza. Described as a barrier for all of the participants were feelings of *pereza* (laziness, fatigue). These, along with and body aches and pains, were listed as reasons for not exercising, as in the following examples:

- "…my feet hurt me, and I can walk a little but they just hurt me and I just stop. I'm all sore and I can't get started."
- "But anyway, what hold me back I have to admit it, I'm lazy sometimes. I don't want to get up. The bed is good and then things like that."

- "...I have not walked in the last month and a half and I could have gone back, but I get lazy sometimes."

Perceived Enablers

Porque el doctor me dijo. A facilitator to the initiation of physical activity that all the participants mentioned was their doctor, *porque el doctor me dijo* (because the doctor told me to). All the participants stated that their primary care provider encouraged an exercise program and all expressed a desire to abide by this or to do it because their doctor said to, as shown in the following:

- "I just need to exercise. That's what the doctor said."
- "Extremely overweight and the doctor recommended exercise for my high blood pressure. So that's why I started walking."
- "So I started walking and in a month I lost 30 pounds. In the diet and walking. I'm not on a diet. And the doctor said all you need is walk. That's your cure."

Body Image. A desire to change their body image was a facilitator to a significant number of the participants. They expressed a desire to not only feel better, but to look better for themselves and their spouses. Again, a perceived facilitator was embedded more in the family context rather for individual need. Examples include the following:

- "For one, I like to keep active. And also I'm very self-conscious of how I look."
- "And I'm not getting younger; I want to look better at my age. I've seen others that are much younger that look much older. I've seen people that are much older that look much younger. And I want to be one of those."
- "I have always been small. I have never really gained a lot of weight. And now that I am older and I have gained some weight, I'm very unhappy about it. Sometimes I don't want to take my clothes off in front

of my husband…cause I don't want him to see all my fat."

Sense of well-being. The participants also expressed the feeling that exercise and increased physical activity levels made them feel better and increased their self-esteem. They made statements such as "I feel good when I walk," "I have a lot of energy," or "I enjoy walking to mediate on problems…I don't want the family to know about it." Another interesting finding was that the participants expressed some past successes with walking or some other form of physical activity and they remember the sense of well-being received from it. Their thoughts included the following:

- "So that's what I did and I felt good,"
- "When my husband first retired, we stated walking after breakfast," or
- "I've done it, I walked 2, 3 miles until about a month ago when my mother got sick."

A summary of the enablers and barriers and a description of the narrative data that indicated each are outlin ed in Tables 2 & 3.

Table 2.
Enablers to Physical Activity

Perceived Enablers to Physical Activity	Description
mi familia viene primero/my family comes first	Remain healthy for family; for the future of children and family
g*ran amiga/* friends/family members	Someone to push me; to be accountable to
past successes	Provides encouragement; I have done it once, I can do it again
porque el doctor me dijo/ because my doctor told me to	As a treatment for chronic disease
change of body image, to be healthier	Motivator; to look better for myself, husband, family

Table 3.
Barriers to Physical Activity

Perceived Barriers to Physical Activity	Description
mi familia viene primero/my family comes first	Caregiving roles; don't have the time because of babysitting
no tiempo para mí/no time for myself	Won't take time for myself due to family obligations
g*ran amiga/* friends/family members	Someone that sabotages; discouragement
*mala salud/*poor health	Pain, hurting feet; it hurts me to walk
pereza/ fatigue/laziness	I don't want to get up; do it later, but then it gets too late

Discussion

Over the past two decades, scientific literature describing sedentary behavior among ethnic groups focused on differences based on socioeconomic status, environment, and acculturation. Subjective perceptions of physical activity among older, postmenopausal Mexican American women have not been described in depth. Findings that emerged from the narrative data generated from this study's focus groups indicate that despite their sedentary behavior, this group of older Mexican American women is very knowledgeable about the health promotion benefits of physical activity. These benefits were perceived within the context of family and improving their role as caregiver for their family. This seems to be more important than personal or individualistic gains as has been cited as enablers to physical activity in studies with African-Americans and non-Hispanic white women, who reported personal enjoyment, entertainment, and social interactions as primary benefits of physical activity.[44-45] This may have implications for health care providers in that it is possible that the touting of physical activity to older Mexican American women for its health promotion benefit may not have meaning unless it is framed in the context of how it can benefit their families by promoting their health.

The most frequently cited barrier by all of the participants to the initiation and maintenance of physical activity are family demands (*mi familia viene primero)*, either as a caregiver to children, grandchildren, spouses, or parents. Because of these demands, the participants had numerous time constraints and found it difficult to find time for themselves to exercise (*no tiempo para mí*, or no time for myself). This barrier is similar to those in other studies with ethnically diverse women.[40, 41, 46] Mendelson [47] reported that the Mexican American participants in her study viewed motherhood as their primary role and parenting as their primary responsibility. Although family support is seen as beneficial and as a source of strength, the resultant obligations and burdens must also be evaluated in the context of demands and distributions of time and resources.[32,47]

However, we noted conflicts that exist in this sample of older Mexican American women: the desire expressed by these participants to have a more physically active and therefore healthy lifestyle to enhance their role as for their family and the desire to be a good caregiver for the family. This "conflict of desires" may be the result of issues related to *familism.*[27] For instance, although their primary stated barrier to physical activity are their family and parenting obligations, the benefit to staying physically active will lead to a healthy lifestyle, which they acknowledge is important to maintain their role of primary caregiver and parent. Sedentary behavior for this group of women may be embedded in their perceived imbalance of the Latina cultural value of *familism*: being a good caregiver means that one cannot have a physically active lifestyle. Implications for further research are needed to fully understand the cognitive framing of this conflict and how its resolution leads to decisions regarding sedentary and physically active behavior.

This same "conflict of desires" emerged from the narrative data collected regarding social support or the need for a *gran amiga***.** The participants expressed a desire to have a friend or family member to exercise with and stated that this was very important for exercise initiation and maintenance; but yet also expressed knowledge that *gran amigas* or friends or family members could actually sabotage efforts at being physically active. *Personalismo,* a value describing the importance given to

interpersonal relationships in the Latino culture, may have influenced these participants to focus on the continuation of the interpersonal relationship with their family or friend, rather than on how disruptive the relationship could be to their goal of being more physically active.

Other than one participant's expression of the difficulty she has faced walking in the neighborhood in terms of having to stop and talk to neighbors, none of the women expressed a fear for their safety if they walked in their neighborhoods as cited in some studies.[46] All the women expressed either health concerns or lack of motivation or laziness as a barrier which is also detailed in some studies. [24,46] Finally, all of the participants were told by their physician, *porque el doctor me dijo,* to increase their level of physical activity; this was viewed as a motivator for each of them.

Further exploration needs to be undertaken to determine if in fact older Mexican American women do perceive a conflict when faced with decisions about behavior, specifically physical activity and sedentary behavior. Are older Mexican American women cognitively aware of the choice they make when faced with the desire to lead a healthier lifestyle through becoming more physically active yet are unable to due to the desire to be a good mother and caregiver and/or the desire to maintain an interpersonal relationship, even though that relationship is detrimental to initiating and maintaining a physically active lifestyle? If they are not cognitively aware of making this choice, then further exploration of how their sociocultural context forms their behavior and the degree to which it acts as a mediator to the engagement in a physically active lifestyle needs to be undertaken.

Further, it may be that sedentary behavior is intertwined and shaped by subjective interpretation of cultural values, such as *familism;* therefore it is important for researchers and health care providers to understand that the health consequences of sedentary behavior and other risky behaviors may be built into this group of women's daily lives.[48] Sedentary behavior, as an individual behavior, may be heavily circumscribed by social and cultural values and not necessarily by personal choice. Interventions designed to increase physical activity in this group of women without recognition of how

sedentary behavior is built into their lifestyles as determined by social and cultural expectations are doomed to fail.

Numerous past studies have reported that family obligations and responsibilities are the primary barrier for older Mexican American women in terms of increasing their levels of physical activity. However, many of these studies have stopped their investigations at this point and directed health care providers to design interventions with this barrier in mind. Although that is appropriate, we contend that unless researchers and health care providers go further to discover and understand the complexities of the choices and decisions that underpin the barrier of family obligations/responsibilities, *mi familia viene primero*, as well as other barriers in the older Mexican American women and how they direct their behavior, physical activity research will continue to be insufficiently complete in its usefulness to the reduction of their health disparities. Further development of the "conflict of desires" theme and its cognitive and sociocultural underpinnings will enhance this understanding.

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