**Childhood obesity: Investigating parental experience and family processes**

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**Abstract**

Childhood obesity is a serious and ongoing public health concern, with the many negative physical and psychological outcomes well documented in the literature. The experience of parenting an obese child however is less well researched, particularly in relation to overall family functioning (a factor related to the aetiology of childhood obesity). The current study aimed to explore family processes and the experience of parents in relation to childhood obesity. Ten semi-structured interviews were conducted with the parents of obese children, including six mothers, three fathers and one step-parent. Participants described several characteristics relating to the way in which they parented their child; characteristics of their children and how they appeared to interact with others (including themselves); as well as an account of how they have experienced their child’s weight status as a parent. Grounded theory analysis revealed that the bi-directional relationship between parent and child may contribute to a child’s weight status, and that the consequences of the child’s weight as experienced by both parent and child may also lead to its maintenance. The past experiences of parents and how these may influence parenting style was also found to be an important factor, influencing the overall emotional context of the family, the interactions between parent and child, and ultimately the child’s weight status. The current research highlights the importance of systemic and relational aspects in the aetiology and maintenance of childhood obesity.

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**Chapter 1: Introduction**

This chapter aims to contextualise the present research and establish the current understanding around the causes and consequences of childhood obesity. Within the literature, childhood obesity is referred to as ‘childhood obesity,’ ‘childhood overweight,’ and ‘childhood adiposity.’ To identify relevant work for inclusion in this review, these terms were used to identify research related to this group of children aged between 2-18 years old. These terms were used in conjunction with the key-words: ‘families,’ ‘experience,’ ‘factors,’ ‘interactions,’ ‘processes,’ ‘relationships,’ ‘causes,’ ‘consequences,’ ‘maintaining factors,’ ‘aetiology,’ ‘parents,’ ‘mothers,’ ‘fathers,’ maternal,’ and ‘paternal,’ ‘social factors,’ ‘environment,’ ‘parenting,’ and ‘parenting style’ in order to locate research about the parental experience and family factors related to childhood obesity. Literature searches were conducted using the following databases: EBSCO (including psycINFO, and psycARTICLES), Science Direct, Web of Science for ‘ANY’ text associated with the search terms. After identifying literature, full electronic journals and books were sourced where possible. In reviewing sourced literature, additional relevant literature was also identified from reference lists.

**Childhood obesity: The current picture**

Obesity can be defined as an excess of body fat, most commonly measured using a body mass index (BMI) calculation (Rudolf, 2004). According to the Royal College of Paediatric and Child Health (RCPCH, 2013) growth charts, cut-offs for overweight, obese and severely obese are the 91st, 98th and 99.9th centiles, for both male and female children aged between 2 and 18 years old. The World Health Organisation (WHO, 2015) has reported that childhood obesity is now one of the most serious public health challenges we face in the 21st century. Globally, it is estimated that there are nearly 43 million overweight children under the age of five (WHO, 2015). In England, data gathered by the National Child Measurement Programme (NCMP) reported that in 2013/2014, over a fifth of 4-5 year olds were overweight or obese and nearly a third of 10-11 year olds were overweight or obese (NCMP, 2014).

**The effects of childhood obesity**

Due to its high prevalence, much research has been conducted looking into the causes and consequences of childhood obesity. It is important to try to understand why some children may become overweight as it is highly associated with later adult obesity and other comorbid medical disorders (Daniels, 2009). Children with obesity have been reported to have a more than 50% risk of being obese in adulthood unless they receive an effective intervention (Whitlock, Williams, Gold, Smith, & Shipman, 2005). In 2012, just under a quarter of men (24%) and a quarter of women (25%) were obese in England, with predictions suggesting that by 2030, 41% to 48% of men and 35% to 43% of women could be obese if the current trends continue (The Health and Social Care Information Centre, 2014).

**Physical effects**

During their formative years, obese children have a higher risk of developing multiple comorbidities such as metabolic, cardiovascular and orthopaedic disorders (Dietz, 1998). Metabolic disorders include insulin resistance conditions such as dyslipidaemia (abnormal levels of fat in the blood), and type 2 diabetes mellitus (Daniels, 2006). Type 2 diabetes has now been found to appear in children as young as 8 years old, persisting into adulthood. Steinberger, Moran, Hong, Jacobs and Sinaiko (2001) report that obesity in children is related to decreased sensitivity to insulin and increased culating insulin (this may lead to raised blood pressure and cholesterol levels). Both cardiovascular and metabolic impairments in childhood and adolescence are major risk factors for developing cardiovascular disease in adulthood and as a result childhood obesity leads to higher rates of adult morbidity and mortality (Neef et al., 2013).

Sleep problems are also prevalent in overweight/obese children, adding to low mood and poor concentration. Studies have indicated that childhood obesity may be specifically related to shorter sleep duration (Bayer, Rosario, Wabitsch, & von Kries, 2009; Nixon et al., 2008). One study found that overweight children slept on average 22 minutes less than non-overweight children, having both lower sleep efficiency and lower rapid eye movement density (Lui et al., 2008). Obesity and obstructive sleep apnea have also been related in both adults and children. This results in snoring, irregular breathing, and disrupted sleep patterns. Sleep disruption may lead to excessive day time sleepiness affecting performance at school and other day time activities (Daniels, 2006). Obstructive sleep apnea can have long term effects on the cardiovascular system, such as elevated blood pressure, increased left ventricular mass and diastolic dysfunction of the left ventricle (Amin et al., 2005).

**Psychological effects**

As well as the physical effects of childhood obesity, considerable psychological effects have also been reported (Daniels, 2009). The health related quality of life of a sample of obese children and adolescents was measured, using the Pediatric Quality of Life Inventory. Findings suggest that obesity has a significant impact upon the physical, emotional, social and school functioning of obese children and adolescents, with pre-pubescent obese children showing the poorest emotional functioning (Riazi, Shakoor, Dundas, Eiser, & McKenzie, 2010). Interestingly, it has also been suggested that adolescents with higher depression scores than their peers are more likely to become overweight/obese and therefore, psychological factors may be important in the aetiology of childhood obesity as well as a consequence of it amongst teenagers (Goodman & Whitaker, 2002). Several other studies have found an increased risk of depression among obese children presenting for treatment (Sheslow, Hassink, Wallace, & DeLancey, 1993). A more recent study found that overweight girls reported higher depressive symptoms (in the third grade of high school), with concerns about being overweight explained by the positive association between body mass index and depression, suggesting that obesity leads to concerns about weight which may then lead to depression (Erickson, Robinson, Haydel, & Killen, 2000).

**Self-esteem**

Self-esteem also appears to be affected in obese children (Allon, 1979; Sallade, 1973; Strauss, Smith, Frame, & Forehand, 1985; Straus, 2000); with obese girls reported to be more likely to have attempted suicide than non-obese girls (Fabricatore & Wadden, 2004). The way in which self-esteem is affected in obese children has been suggested to be related to the dominant view of ‘individualism’ in the Western world. That is the view that an individual’s accomplishments and failures are the direct result of their personal motivations to be successful (Simmons & Rosenburg, 1971; Turner, 1960). Therefore, being overweight is seen as a product of personal efforts and a failure to achieve (Klaczynski, Goold, & Mudry, 2004). Peers may thus view those who are overweight as being weak-willed, lacking in skills and motivation to take control of their bodies and generally possessing undesirable characteristics (Quinn & Crocker, 1997). If an individual who is overweight begins to internalise the belief that their weight is within their direct control (according to the stance of individualism) then their self-esteem may become affected through the belief that their overweight is their fault and that they have failed to remain in control of their body (Klaczynski, Goold, & Mudry, 2004). Low self-esteem has been further linked to children holding the belief that their parents view their weight status negatively, with parents reporting higher levels of dissatisfaction with their child’s weight (Pierce & Wardle, 1993).

**Obesity is ‘controllable’**

The concept of individualism is in line with research around the ‘controllability’ of obesity, finding that most children in a study believed obesity to be under personal control; a belief that was also positively correlated with negative stereotyping (Quinn & Crocker, 1997). In another study which examined how knowledge about the aetiology of obesity impacted upon children’s views, it was found that less blame was attributed to obese children that had a medical explanation for their weight, but that this had little positive effect on participants overall attitudes (Bell & Morgan, 2000). In addition to blame from peers, it was reported that obese and overweight children who also hold themselves accountable for their size tend to show lower levels of self-esteem and believe that their weight is accountable for their exclusion from social activities (Pierce & Wardle, 1997).

**Stigma and obesity**

The stigma and stereotyping attached to obese children can often lead to them becoming victim to bullying from peers, contributing to a further loss of self-esteem, hopelessness and eventually depression (Sullivan, Joshi, Ketende, & Obolenskaya, 2010). Peers may express prejudice attitudes leading to the individuals’ eventual rejection from social groups (Schwartz & Rhul, 2003). A study conducted in the early 1960s asked school children to rank six pictures of children varying in physical characteristics and disabilities in order of who they would most like to be friends with (Richardson, Goodman, Hastorf, & Dornbusch, 1961). The picture of the obese child was ranked as being the person children would least like to be friends with, in comparison to pictures of children with crutches, in a wheel chair, facial disfigurements and an amputated hand. Findings from this very early study have more recently been replicated, showing an increase in prejudice against obese children since the original findings from over 40 years ago (Latner & Stunkard, 2003). It seems that negative attitudes towards obese children develop early, with one study of 3-5 years olds judging an overweight target as being a mean and less desirable playmate compared to an average weight target (Cramer & Steinwert, 1998). In similar studies, children aged 4-11 years old described obese targets as ugly, selfish, lazy, dishonest, socially isolated, stupid and subject to teasing; while average weight targets were considered to be a desirable playmate, happy, healthy, clever, attractive, kind and socially popular (Wardle, Volz, & Goldin, 1995).

Issues relating to stigma and stereotyping amongst peers is particularly relevant during childhood and adolescence due to the formation of adaptive social relationships being especially important for healthy social and emotional development during these periods (Pearce, Boergers, & Prinstein, 2002). Through peer interactions children learn valuable social skills (e.g. cooperation, sharing and competition) and how to form and maintain close relationships (Rubin, Bukowski, & Parker, 1998). Youth who find themselves stigmatised for their weight may therefore fail to achieve normal social developmental competences and have difficulties with peer relationships which may be predictive of poorer future psychological outcomes (Parker & Asher, 1987); including the development of internalising symptoms, low self-concept and peer rejection (Hymel, Rubin, Rowden, & LeMare, 1990; Rubin, Chen, McDougall, Bowker, & McKinnon, 1995). In addition, factors in adulthood may also be affected including job performance and the formation of intimate relationships (Bagwell, Newcomb, & Bukowski, 1998; Roisman, Masten, Coatsworth, & Tellegen, 2004).

**Behavioural difficulties**

The extent of behavioural difficulties amongst overweight children can be quite severe, with more than 81% of female children in a study (conducted in the US) showing greater odds of having substantial teacher reported externalising behavioural difficulties compared with non-overweight girls (Datar & Sturm, 2004). However, it is difficult to determine the temporal causality of this relationship as some studies suggest misbehavior may be the result of overweight children acting out in defense to bullying or due to the child having developed poor social skills (Sullivan, Joshi, Ketende, & Obolenskaya, 2010). However, it has also been reported that behavioural difficulties may precede overweight status in some cases; with clinically meaningful behavioural problems in as sample of 8-11 year old children being independently associated with an increased risk of concurrent overweight as well as an increased risk of becoming overweight (two years later) in previously normal weight children (Lumeng, Gannon, Cabral, Frank, & Zuckerman, 2003). A greater extent of externalising behaviour can eventually result in an overall poorer performance at school and a higher number of missed school days has also been correlated with poorer school performance in obese children (Fogelholm et al., 2009).

**The causes of childhood obesity: Nature vs. nurture**

In light of the potential physical and psychological negative effects childhood obesity can have, it has been necessary for researchers to develop an understanding of the mechanisms involved in its development and maintenance. It is now well recognised that childhood obesity is a multifactorial condition, with both biological and environmental factors considered to be important (Krebs et al., 2007).

**Biological factors**

**The role of genes**

According to genetic research, it is estimated that around 55% of the variance in BMI scores can be attributed to genetic factors (Maffeis, 2000). Studies such as that conducted by Lake, Power and Cole (1999), which used data from the 1958 British Birth Cohort to track familial weight patterns in over 6000 men and 6000 women, report that children of overweight parents are more likely to become overweight themselves. This pattern seems to also exist when children are raised apart from their biological parents, as shown by twin and adoption studies such as that conducted by Sørensen, Holst and Stunkard (1992). They reported the correlations found between adopted children’s BMI’s and their adopted and biological relatives (BMI measured between the ages of 7 and 13). They found that BMI was more strongly correlated with biological relatives than adoptive relatives, suggesting the important role genes play in the development of childhood obesity.

**Child development: The early years**

In addition to some children having a genetic predisposition to weight gain, when all children are born they have a biologically driven preference for certain food types high in sugar and salt (Schwartz & Puhl, 2003). However, today this biological drive can lead to negative outcomes due to the abundance of food now available which are high in both salt and sugar content, and research suggests that children now consume significantly more added sugar than is recommended (Munoz, Krebs-Smith, Ballard-Barbash, & Cleveland, 1997). The way in which children are fed from the moment they are born can have an influence on the child’s weight status later in life. Mothers who breast feed their infants are in effect responding to signs of hunger and research has found that for every month an infant is breastfed in the first 9 months, the risk of obesity deceases by 4% (Harder, Bergmann, Kallischnigg, & Plagemann, 2005). Parents of children who engage in responsive feeding practices are more likely to encourage their children to respond appropriately to satiety cues and regulate food intake (Fiese, Bost, McBride, & Donovan, 2013).

**Feeding and attachment**

The way in which parents choose to feed their child has been suggested to be related to the attachment between mother and child (Anderson & Whitaker, 2011). The optimum type of relationship between a mother and child is known as a secure attachment; with these children tending to show higher rates of healthy emotional and behavioral development (Sroufe, 2005). How this may relate to obesity was assessed in a cohort study using a national sample of children and mothers in America. Attachment security was assessed at 24 months by trained interviewers and results found that the overall prevalence of obesity at 4.5 years of age was 23.1% in children with an insecure attachment type, compared to 16.6% in children who were securely attached. The study concluded that attachment in early childhood may be a previously unrecognised risk factor for obesity. The study was however limited by the fact that attachment was determined via observation methods within the mother and child’s home, and it is possible that behaviour observed on that one occasion may not have been representative of the child’s typical behaviour (Anderson & Whitaker, 2011). However, the study does highlight the importance of the interaction between biological factors (such as hunger) and the environment (e.g. how hunger is responded to by a child’s care giver).

**Environmental factors**

The remaining amount of variance in the BMI of a population may therefore be explained by an individual’s interaction with their environment. This includes factors such as nutrition and physical activity.

**The role of modern technology**

In a cross-sectional study conducted in America, children who engaged in the least amount of physical activity or the most television viewing were found to be the most overweight (Andersen, Crespo, Bartlett, Cheskin, & Pratt, 1998). Similar results were also reported more recently by researchers Gable, Britt-Rankin and Krull (2008) who concluded that children who watched more than 2 hours of television per day were at an increased risk of developing obesity. Television viewing is thought to increase the risk of obesity by, i) decreasing the amount of attention that is paid to satiety cues, leading to an increase in mindless eating, (ii) interfering with healthy mealtime social interactions, (iii) increasing exposure to food marketing (Fiese, Bost, McBride, & Donovan, 2013) and, iv) displacing physical activity as well as increasing energy consumption (Epstein, Paluch, Consalvi, Riordan, & Scholl, 2002). The role of computer use in leisure time has been looked at in comparison to television viewing; Babey, Hastert and Wolstein (2013) report that correlates of time spent watching television and using the computer for leisure use are different depending on children’s race, age, gender and socio-economic status. However overall, participants in the study were spending more than twice the recommended time watching television or using the computer (a maximum of 2 hours per day is recommended in the USA). This was related to reduced physical activity and increased sedentary behaviour, both associated with child weight gain (Must & Tybor, 2005).

**What food is available?**

High carbohydrate and sugar consumption have both been related to increased weight gain in children. With a reduction in overall fat consumption, being replaced with higher carbohydrate consumption, especially in the form of processed and refined foods such as breads, cereals, soft-drinks, cakes and biscuits (Cavadini, Siega-Riz, & Popkin, 2000). The way in which food is available to children has also developed over the years, with greater access to fast-food and vending machines designed to target children and adolescents. It is thought that this change may interact with how children are able to self-regulate their food consumption. One study conducted with rats found that those who were given access to ‘supermarket’ foods (e.g. cookies, chocolates, cheese and peanut butter) gained on average 269% more weight than control rats (Sclafani & Springer, 1976).

**Food and society**

In addition, children are now growing up within societies that emphasise ‘immediacy and time efficiency’ (Zhong & DeVoe, 2010), with food like everything else designed to be fast and efficient. The question has been asked as to whether the rise in fast food has contributed to this way of life or exists as a consequence of it. Researchers have reported that when adult participants were exposed to symbols relating to fast food restaurants and their products, the speed at which they completed a reading task increased despite there being no time limit. This suggests that children growing up within social contexts that prioritise being ‘fast and efficient’ may begin to develop higher levels of haste and impatience. When this is applied to food that is quick and easy to access (i.e. fast food), this could lead to negative effects (Zhong & DeVoe, 2010) due to the poor nutritional content of that which is consumed.

**Food and self-regulation**

Self-regulation has been studied in terms of ‘delay gratification,’ that is the ability to forgo an immediate pleasurable reward for a postponed benefit. This has been linked to multiple health related behaviours including obesity (Epstein, Salvy, Carr, Dearing, & Bickel, 2010). Some studies have shown that overweight and obese children are more impulsive and less able to delay gratification than healthy weight children (Bonato & Boland, 1983; Sigal & Adler, 1976). A more recent study has also reported that overweight children show more impulsivity overall (not only in relation to food) and linked this to the high levels of co-morbidity between hospitalised obese children and Attention Deficit Hyperactivity Disorder (Agranat-Meged et al., 2005).

Interpersonal trust has also been related to the way in which individuals are able to delay gratification. Michaelson, Michaelson, de la Vega, Chatham and Munakata (2013), suggest that delay gratification not only depends on choosing a later reward, but also the likelihood of the future reward actually being available. In other words, people are less likely to delay immediate gratification if the person does not trust that they will be rewarded later, and this depends on who has promised to give the reward. Therefore, the relationship between parent and child may be an important factor to consider in relation to how impulsive a child can be, how able they are to delay gratification and what this means for their weight status.

**Parenting and family factors**

**Feeding strategies**

Parents have been studied in terms of the way in which food is made available to children at home, with particular feeding strategies more likely to lead to child weight gain, for example, parents who restrict food availability have been found to inadvertently, increase a child’s weight status (Clark, Goyder, Bissell, Blank, & Peters, 2007). Several studies have found a positive association between parental restriction (of foods) and dietary intake, child weight or both (Faith et al., 2004; Fisher & Birch, 1999; Fisher & Birch, 2000; Fisher & Birch, 2002; Francis & Birch, 2005; Francis, Hofer, & Birch, 2001; Lee, Mitchell, Smiciklas-Wright, & Birch, 2001); and a causal relationship between food restriction and weight gain was reported by Faith and Colleagues (2004), Fisher and Birch (2002, 2005) and Lee, Mitchell, Smiciklas-Wright and Birch (2001). Costanzo and Woody's (1985) obesity proneness model explains how excessive parental control in feeding is likely to occur if 1) parents are strongly invested in their children's eating; 2) children are perceived to be at risk of developing problems with weight, eating or both; and 3) parents have difficulties controlling their own food intake and assume that their children cannot do so either. Consistent with these points, Birch and Fisher (2000) also reported that a mother's efforts to control her own weight, in combination with her perception of her daughter's risk of becoming overweight, predicted a greater use of restrictive feeding techniques. These findings suggest that a bi-directional relationship between parent and child exists, with specific parenting practices being shaped and influenced by the child (Holden & Miller, 1999) as well as child behaviour being influenced by parenting behaviours.

**Parenting style**

Parenting style has been reported to be related to child feeding practices (Hughs, Power, Fisher, Mueller, & Nicklas, 2005). One study found that children with either authoritarian or permissive parents were twice as likely to be overweight compared to children of authoritative parents (Rhee, Lumeng, Appugliese, Kaciroti, & Bradley, 2006). It is thought that more authoritarian parents may have higher expectations for their children’s level of self-control as well as being less emotionally responsive to their children’s needs (Rhee et al., 2006). These findings are based on data from the National Institute of Child Health and Human Development Study of Early Child Care and Youth Development (2006). The four parenting styles (i.e. authoritarian, authoritative, permissive and neglectful) used in the study were constructed using scales of ‘maternal sensitivity’ and ‘maternal expectations for child self-control.’ A multivariate logistic regression analysis was then used to look at the relationship between parenting style and weight in first-graders at school; controlling for gender, race, maternal education, income/needs ratio, marital status, and child behaviour problems (Rhee et al., 2006). The study was limited by the fact that it excluded some child participants due to incomplete data and researchers noted that these participants were more likely to be of a lower socio-economic class and ethnic minority; therefore this group may have had a different parenting style to the ones that were observed in participants who took part in the study. The study also failed to use a standardised measure of parenting styles, although they combined two validated measures that reflected the construct of parenting styles as described by Baumrind (1971). Several other studies have found a relationship between parenting style, diet and activity in children and adolescents (Kremers, Brug, de Vries, & Engels, 2003). However, overall there has been mixed results from studies attempting to look only at the relationship between parenting style and child weight status. For example, Agras, Hammer, McNicholas and Kraemer (2004) did not find a significant relationship between parenting style and child weight status, however researchers reported that this may have been due to a small sample size.

Conversely, Rhee (2008) did report a significant relationship between parenting style and child weight, suggesting that parents help to mold specific behaviours of the child as well as influencing their attitudes and beliefs towards food and eating through their specific parenting style. In addition, a systematic review conducted by Sleddens, Gerards, Thijs, Vries and Kremers (2011) concluded that children raised in more authoritative homes tended to have a healthier diet, were more physically active and had lower overall BMI levels. This was in comparison to children who were raised by parents with other styles such as, authoritarian, permissive/indulgent, uninvolved/neglectful. This review also concluded that the general effect of parenting may have a differential impact on a child’s weight status, depending on individual child and parental characteristics. Further research has found that parents showing more positive parenting constructs such as nurturance and structure are associated with lower use of instrumental and emotional feeding practices (Sleddens et al., 2014). Parental warmth and sensitivity have also been related to higher fruit and vegetable consumption and more physical activity (Kremers et al., 2003); and overweight adolescents identified maternal support as being an integral factor in reducing the psychological risks associated with obesity (Valtolina & Marta, 1998). More firmly controlling parents have been found to be more likely to give their child food as a reward or to help sooth their child, as well as being more likely to pressurise their child to eat. These types of parenting styles have also been associated with other child outcomes such as lower academic grades, lower levels of self-control and poorer emotional development (Dornbusch, Ritter, Leiderman, Roberts, & Fraleigh, 1987; Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Radziszewska, Richardson, Dent, & Flay, 1996).

Specific types of parenting style affect the emotional context within which parenting strategies/practices are delivered and thus influence the way in which a child's behaviour is shaped. It has been suggested that a more authoritative parenting style tends to lead to more positive child behavior (Darling & Steinburg, 1993). Parenting styles may depend on the individual characteristics of the parent, rather than characteristics of the relationship held between the parent and child (Darling & Steinburg, 1993). However, child characteristics have also been found to influence the way in which parents respond to their child. The most commonly referred to child characteristic being ‘temperament’ (Belsky, 1984). Campbell (1979) investigated this and reported that mothers who rated their children as having more difficult temperaments at 3 months old, interacted with them less and became less responsive to their cries 3 and 8 months later. Therefore, the individual characteristics of both parent and child appear to have a bi-directional influence upon their relationship. In addition, individual parent and children characteristics have been found to influence the family as a whole. For example, research conducted by Lewis, Beavers, Gossett and Phillips (1976) found an association between adolescent psychological wellbeing and overall family competence; and Billings and Moos (1982) reported that better personal adjustment in adults and children was associated with more positive perceptions of the family environment. Thus it seems that it may be important to consider childhood obesity in terms of overall family functioning as well as individual parent and/or child factors.

**Overall family functioning**

Rhee (2008) further investigated the effect of parenting behaviour and style on child weight status, including the influence of family functioning as a whole. The study reported that parents may influence a child's weight through specific feeding and activity practices as well as, more broadly, through parenting style and management of family functioning. Family functioning can be understood as being the interactions between various family members (e.g. parent and child) and the influence that these have on the relationships and functioning of the family as a whole (Kitzman-Ulrich, Wilson, George, Lawman, Segal, & Fairchild, 2010). Family functioning is a concept related to the theoretical background of Family Systems Theory (Bowen, 1994), which suggests that families should be understood as being systems made up of interconnected and interdependent individuals. In order to understand any individual, we must first try to understand their family system (Bowen, 1994). Well-functioning families are characterised by open communication, well regulated affect and clearly defined roles. This means that these families are more likely to achieve family tasks whilst encouraging wellbeing and individual growth for its members. Poorly functioning families are thought to show poorly defined or rigid roles, disorganisation and poor communication patterns (Kitzman-Ulrich et al., 2010).

Family Systems Theory provides a useful way of exploring how the family system may influence health related behaviours in children (Kitzman-Ulrich et al., 2010). More positive child health related behaviours have been related to an authoritative parenting style as well as features of positive family functioning such as conflict resolution, cohesion and overall adaptive family functioning (McFarlane, Bellissimo, & Norman, 1995). Berge, Wall, Larson, Loth and Neumark-Sztainer (2013), have investigated specifically, the role of family functioning in relation to childhood obesity, highlighting the importance of the interpersonal relations occurring within families of obese children. Their study suggested that poorer family functioning (e.g. less structure/rules, warmth/communication, problem-solving skills) is associated with higher BMI in adolescents and an increase in negative weight related behaviour. However, the study was limited by its cross-sectional design, making it difficult to determine causality or temporality of the association between family functioning, adolescent BMI and health related behaviour. In addition, the family functioning measure used in the study (The General Family Functioning Scale from The Family Assessment Device) was not the full measure and did not include all of the familial factors that may contribute to measuring family functioning (e.g. stress and resilience). It also did not assess for change in family functioning before and after a child’s obesity and therefore again, it is difficult to determine causality. However, a recent systematic review of 21 peer reviewed papers, concluded that poorer family functioning was associated with an increased risk of childhood obesity and overweight in children and adolescents, and overweight or obese children were more likely to come from families with poorer family functioning (Halliday, Palma, Mellor, Green, & Renzaho, 2013). The review suggests that the relationship between family functioning and childhood obesity maybe bi-directional. That is poorer family functioning leads to obesity (Chen & Kennedy, 2004; De Sousa, 2009; Hanson, Klesges, Eck, Cigrang, & Carle, 1990; Hasenboehler, Munsch, Meyer, Kappler, & Vögele, 2009; Wilkins, Kendrick, Stitt, Stinett, & Hammarlund, 1998) as well as obesity having a possible impact upon family functioning (Herzer et al., 2010).

Earlier research by Kinston, Loader and Miller (1987) found that mothers of obese children rated their family as being more ‘dysfunctional’ than mothers of non-obese children. They also reported that it was not the emotional health of individual family members that was significantly different rather it was differences in the familial patterning of emotional health that was significant (Kinston et al., 1987). They explained this by suggesting that obesity within certain families may play a role in maintaining the mental health of other family members (e.g. child weight may be connected to the parent’s view of the families overall level of happiness). As obesity decreases, certain family members may become more mentally fragile and such emotional changes could be a powerful influence on the child, leading to further weight change. Crisp and Stonehill (1970) also supported this hypothesis, concluding that obesity within a family may be useful in helping to reduce ‘neurotic difficulties.’ A view in line with newer perspectives based on the Family Systems Theory and family functioning.

**Factors influencing family functioning**

The way in which families function appears to be influenced by several factors, including family stress and parental mental health. Stress is defined as a negative physiological response to external stressors (Aneshensel, 1992). Family stress can arise from individuals, households, and contextual factors external to the family (Robert, 1999).The presence of a chronic pediatric health condition within a family has been widely associated with increased family stress. This can lead to a disruption in family structure, family cohesion and intra-familial relationships (Cohen, La Greca, Blount, Kazak, Holmbeck, & Lemanek, 2008). In addition, the presence of a physical or mental health difficulty in a child may lead to an increase in stress and worry for parents (Brannan, Heflinger, & Foster, 2003). This in turn, may affect the health and well-being of the child, including increasing the child’s risk of obesity. Family stress has indeed been linked to obesity, with stress from factors such as lack of emotional support in the household, mental and physical problems and financial strain leading to an increased risk of obesity (Garasky, Stewart, Gundersen, Lohman, & Eisenmann, 2009). In light of this, it is interesting to consider how the presence of childhood obesity may itself influence levels of family stress, as well as being a possible result of family stress.

In relation to maternal mental health and childhood obesity there appears to be conflicting evidence. Gibson, Byrne, Davis, Blair, Jacoby and Zubrick (2007), found no association between poor maternal mental health and childhood obesity, instead finding an association between overweight mothers and single-parent families (single-mothers) and childhood obesity. Similar conclusions were drawn by Wen, Simpson, Baur, Rissel and Flood (2011) who suggested that family functioning is associated with a number of maternal obesity risk behaviors, an important predictor of childhood obesity. A more recent study looking at serious maternal psychological distress and childhood obesity (Ramasubramanian, Lane, & Rahman, 2013) did find a significant association, even when the results were adjusted for potential confounding variables (for example, socio-economic status).

The above research highlights that a connection exists between family systems and a child’s weight status, with some studies suggesting that childhood obesity may be connected to parenting including the specific parenting style, feeding practices and overall family functioning; and others suggesting that child obesity may play a functional role within families, helping to support the mental health of certain members (Kinston et al, 1987); or that familial stress from both internal and external sources may lead to changes in a child’s weight status through impacting upon family functioning (Garasky et al., 2009). However as yet, little research has looked into how the experience of having an obese child may impact upon these family systems. One qualitative study conducted in Australia has investigated the maternal experience of having an obese child, interviewing 11 women. The study found that overall mothers felt judged by others; responsible for their child’s weight; blamed by their partners; worried about how best to help their child; pressure to be a positive role model for their child and worried about their child’s weight in the future (Jackson, Wilkes & McDonald, 2007). This study was useful in providing an alternative view of mothers of obese children, one that contrasts the often negative discourses implied by the media (De Brún, McCarthy, McKenzie, & McGloin, 2013; Maher, Fraser, & Wright, 2010; Mitchell, 2002) and childhood obesity research (Birch and Fisher, 2000; Gibson et al., 2007; Whitaker, 2004). Currently, the way in which fathers (or the partners of mothers) also experience having an obese child, considering how this may impact upon the family system is unknown. This is despite literature identifying that the interactions between family members is an important factor to consider from the position of the Family Systems Theory (Bowen, 1994). As well as through the understanding of how family structure and parental alliance may impact upon individuals and the family as a whole.

**Family structure and parental alliance**

The impact of family structure and transitions on child BMI (ages 3-5 years old) was assessed by Schmeer (2012), who found that two-parent families were important for promoting the positive physical development of children when compared to single mother families. In addition, one study has looked at parental alliance in terms of the perceived cooperation, communication, and mutual respect demonstrated by parents when caring for their children. It found that high levels of co-parenting were predictive of lower youth weight status, indicating that the way in which parents’ perceive the level of positive alliance between them is an important factor to consider in relation to child weight status (Mazzeschi, Pazzagli, Laghezza, De Giorgi, Reboldi, & De Feo, 2013). The outcomes of this study were helpful in highlighting the role of the father in childhood obesity as well as understanding the relationship between parents and how this may also interact with a child’s weight.

The way in which parents interact with each other and with their child appears to have an effect on child weight status. Currently however, it is unknown how the experience of parenting an obese child may impact upon these relationships and thus the overall functioning of a family. In addition, it is also unknown whether poorer family functioning leads to an increased risk of childhood obesity (De Sousa, 2009) or if the presence of childhood obesity contributes to poorer family functioning (Nowicka, Pietrobelli, & Flodmark, 2007). Gaining an understanding of how parents (mothers, fathers and/or step-parents) experience having an obese child and the interactional processes within their families, could help tease apart the relationship between the family system and childhood obesity, leading to better informed family based treatment options.

**Current treatments of childhood obesity**

Current family based treatments of childhood obesity tend to be based on either behavioural approaches or Family Systems Theory (Sung‐Chan, Sung, Zhao, & Brownson, 2013).

**Behavioural approaches**

Behavioural approaches primarily focus on reducing the risk of childhood obesity through the direct adaptation of a child’s lifestyle, specifically targeting diet and exercise. Parents become involved in the intervention as a way of increasing the child’s adherence to the behavioural intervention, through providing the necessary instruction to their child as well as resources (Epstein, Valoski, Wing, & McCurley, 1994). Parental involvement has been shown to be important in promoting the effectiveness of these methods, with the provision of education to parents around the behavioural approach seeming to be of particular importance (Epstein et al., 1994).

**Family based interventions**

Interventions based upon the Family Systems Theory began to emerge much later than behavioural interventions, first seen in the early 1990’s (Flodmark, Ohlsson, Rydén, & Sveger, 1993). Instead of focusing on solely the parent-child interaction there was a shift to focus on the family as a whole. This meant considering the way in which individual family interaction patterns may relate to particular interventions and moderate their effectiveness. This unique perspective viewed childhood obesity as the result of dysfunctional family dynamics, maintained through an adopted unhealthy life style (Kinston, Loader, Miller, & Rein, 1988). The way in which families responded to proposed change was also considered. It was proposed that ‘healthier families’ may find it easier to respond to the demands of making internal and external changes to their lifestyles, whilst more ‘dysfunctional families’ may find it harder due to having more rigidly held ways of functioning. Family interventions based on this theoretical model have been praised by Kitman-Ulrich and colleagues (2010) with variables such as an authoritative parenting style and parental warmth being associated with improved study outcomes, such as a reduction in the BMI of overweight children (Golan, Kaufman, & Shahar, 2006) and family satisfaction mediating weight loss (White et al., 2004). However, in a recent review of randomised control trials (RCT’s) of family based interventions of both types reported that behaviourally based interventions show consistently better outcomes compared to those based upon Family Systems Theory or those that included an additional educational component. Researchers have suggested that this may be due to a lack of RCT’s for the relatively new intervention approaches based on the Family Systems Theory. In addition, authors also noted that attention should now be paid to factors that may influence the effectiveness of family based interventions overall for example, family dynamics and overall family functioning and resilience factors (Sung‐Chan et al., 2013).

**Rationale for the current research**

In light of the current understanding around childhood obesity, it is important to assess how having an obese child is experienced by parents as it may in turn influence specific factors with in a family system (such as stress and inter-familial relationships) and possibly the child weight status. The current qualitative study involving the parents (including mothers, fathers and/or step-parents) of obese children aimed to gain an in-depth understanding of their experience, as well as an insight into the families’ interaction patterns, looking at how these may have influenced the child’s weight status and/or vice versa. Interviews were therefore focused on how the experience of parenting an obese child has been for parents individually as well as exploring aspects of family functioning.

In an attempt to meet these research aims the qualitative methodology of grounded theory was employed. This method was particularly relevant to this topic due to its social-constructionist nature (Charmaz, 2006). Social constructionism highlights the importance of the interaction between the researcher and participants as well as, acknowledging the researcher’s perspective as being an important part of the research process and analysis. Using this approach, data was analysed using principles similar to the original Glaser and Strauss (1967) theory but with the underlying assumption that the interaction between the researcher and participants produces the data (Charmaz, 2006). In addition, social constructionism is concerned with the study of individual experiences within particular social and cultural contexts; suggesting that meanings are not developed separately within the individual but in coordination with other human beings.

The researcher aimed to interview 10 parents (mothers, fathers and/or step-parents) who were parenting an obese child at the time of recruitment and interviewing. The child’s weight status was determined using parent report of the child’s height, weight, age and gender which were then used to calculate in which Body Mass Index (BMI) centile they fell, according to national averages provided by UK growth charts from The Royal College of Pediatrics and Child Health (RCPCH, 2013). Participants were recruited through a non-government, non-NHS organisation, namely MEND (Mind, Exercise, Nutrition…Do it!). Interviews were conducted, recorded and then analysed simultaneously leading to the eventual emergence of codes and categories and the development of a model heavily grounded within the data (Glaser & Strauss, 1967).

**Research aims and question**

The study aimed to contribute to the current knowledge and understanding around childhood obesity by firstly assessing how having an obese child is experienced by parents (including mothers, fathers and/or step-parents), as well as investigating the social processes within these families, looking specifically at how childhood obesity may, or may not, interact with them.

The main research question for this study is therefore: *How is parenting an obese child experienced by parents?*

**Practical and clinical implications**

The findings from this study have the potential for both practical and clinical implications. Firstly, these findings will fill a gap in existing knowledge about the experiences of parents (mothers, fathers and/or step-parents) that have an obese child, as well as providing some insight on the patterns of interaction within these families. The theoretical model produced will enhance understanding around the processes that occur within the families of obese children, helping to increase understanding around factors that may contribute to the aetiology and maintenance of childhood obesity as well as helping to identifying potential treatment needs that are currently not met by existing methods. This model will therefore be useful for clinicians working with such families, for example psychologists and the families themselves.

**Chapter 2: Method**

The following chapter describes the methodology that was chosen and used in order to collect and analyse data in accordance with the studies’ aims.

**Research design**

A cross sectional qualitative design was adopted for this study. The principles of grounded theory (Charmaz, 2006) were used to guide the study in terms of its design, the recruitment of participants, analysis of data (from 10 semi-structured interviews with parents of obese children) and the subsequent reporting of findings.

**Choice of methodology: Grounded Theory**

Grounded theory (Glaser & Strauss, 1967) is a method of qualitative analysis developed to explore individuals’ experiences as closely as possible with an emphasis on the importance of individual perceptions and accounts of lived experiences (Pidgeon & Henwood, 1996). The method leads to the development of a theoretical model to explain phenomenon emerging from the data (Glaser & Strauss, 1967). It was first developed by Glaser and Strauss (1967) who developed very specific and systematic methods for analysing data in opposition to the dominant hypothesis-testing research of that time (Burck, 2005).

One of the main methodological features developed by Glaser and Strauss (1967) was that of simultaneous data collection and analysis; data analysis should be carried out after each piece of data is collected. This analysis should be developed into initial codes (names given to describe each segment of data). Writing memos at each stage of analysis helps to develop these codes and categories, allowing the researcher to also identify gaps in the data and further questions to address these (Bryant & Charmaz, 2010). The findings from each stage of data analysis guides the direction of further data collection. The constant comparison of data and categories within and between subjects is thought to develop categories and emergent theory further. It also allows the data to determine when theoretical saturation has been achieved; this is the point at which no further theoretical insights or properties of categories emerge and data collection can therefore end (Charmaz, 2006). The dynamic relationship between data collection and analysis helps to ensure that the emergent theory is strongly grounded within the data (Glaser & Strauss, 1967).

In contrast to using a deductive approach to data collection and analysis (e.g. testing out a specific theory) grounded theory is inductive, that is it uses the data to guide the research and the emergent theory (Charmaz, 2006; Forrester, 2010). Glaser and Strauss (1967) proposed that grounded theory allows for the emergence of concepts and hypothesise from the data forming the basis of a new theory. The emergent theory can then be compared to existing theories to consider how well previous literature explains the phenomenon and in what ways the new theory may add to this knowledge and understanding (Glaser & Strauss, 1967). This method is thought to be more faithful to the data and attempts to avoid forcing it to fit into a specific theory, hoping to achieve a greater level of objectivity and less theoretical bias (Glaser & Strauss, 1967).

**Divergent methods of Grounded Theory**

Grounded theory was originally developed from the philosophical view point of symbolic interactionism that is, meanings are derived from social interactions and are based on the interpretation made by individuals (Forrester, 2010). However, since 1967 Glaser and Strauss have taken the theory in different directions, creating debate around the methods epistemological position. This has resulted in the development of two slightly different versions of grounded theory (Heath & Cowley, 2004).

Whilst Glaser continued to define grounded theory as a method of discovery, close to the original version of the methodology (Charmaz, 2006). Strauss and Corbin developed a slightly modified version which makes use of very specific methods to analyse and organise categories, known as ‘axil coding’ (Strauss & Corbin, 1998). This involved defining the specific properties of initial codes which has been considered by some, as being too rigid a method to fully allow a theory to emerge, although it can help to define the theory in detail (Heath & Crowley, 2004).

Despite Glaser and Strauss developing slightly divergent versions of the method, they have both maintained common underlying assumptions that the emergent theory must be true to the data and that the researcher maintains a neutral stance throughout analysis. However, it has been suggested more recently, that researchers may not be able to remain entirely neutral during the research process (e.g. Bryant, 2002; Charmaz, 2006; Clark, 2005). Charmaz (2006) suggests that researchers bring their own beliefs, assumptions and experiences to research and that these will have an influence on the results derived from the data. For example, without intention, the researcher will influence the way in which data is collected (e.g. during the interviews). This may be based on the way in which the participant views the researcher, including factors such as their gender, age, profession, and ethnicity; which may then have an impact on the way in which participants respond to questions, modifying their narrative to suit the audience. These factors will also influence how the researcher makes sense of the data.

A constructionist version of the original grounded theory was developed by Charmaz (2006). This version places emphasis on the role of the researcher, suggesting that “we construct our grounded theories through our past and present involvements and interactions with people” (Charmaz, 2006, p.10). Charmaz (2006) argues that rather than purely discovering a theory, researchers become part of the world they study and collect data from. Although the coding process of this version still names concepts in the data using the language of participants, they are still constructed through the researcher’s interpretation and views of the participants’ words and language (Charmaz, 2006). The process of interpretation is thought to be influenced by the researcher’s life experiences, regardless of the degree of neutrality they hold.

**Rationale for using Charmaz’s constructionist Grounded Theory**

After considering a number of qualitative research methods, Charmaz’s grounded theory was selected as being the most appropriate method to meet the research aims of the current study for a number of reasons. When choosing a methodology, Henwood and Pidgeon (1992) suggest considering firstly, the epistemological position of the research, and, secondly the technicality of which method is most suited to the research question.

Firstly, social constructionist grounded theory is consistent with the epistemological position of the study, as the approach situates social and psychological processes in their material and cultural context (Charmaz, 2006). Historically, grounded theory as determined by Glaser and Strauss (1967) has been criticised for its objectivist and positivist foundations. More recent developments of the approach by Charmaz (2006) use a philosophical background of social constructionism. Social constructionism highlights the importance of the interaction between the researcher and participants, as well as acknowledging the researcher’s perspective as being an important part of the process and analysis. Using this approach, data is analysed using similar principles to the original Glaser and Strauss (1967) theory but with the underlying assumption that the interaction between the researcher and participants produces the data (Charmaz, 2006). In addition, social constructionism is concerned with the study of individual experiences within particular social and cultural contexts, suggesting that meanings are not developed separately within the individual but in coordination with other human beings. The current study aimed to investigate the social processes within families and how parents have experienced childhood obesity, within their individual social and cultural circumstances.

Secondly, grounded theory allows researchers to explicate what is *‘happening* (or has happened)’ in studied phenomena (Morse, 2009, p.13) and is therefore suited to research questions about the current and historical interactional processes within families as well as the current and past experience(s) of parents. Grounded theory avoids imposing pre-existing theories on the data, and therefore the method lends itself well to the gathering and analysing of data in relation to the experience of parents and family processes aside from pre-existing theories, assumptions, beliefs and/or prejudices about childhood obesity. In addition, it acknowledges the influence of the researchers current and previous professional and personal experiences on the construction of the theory (e.g. as a female trainee clinical psychologist, with an interest in family functioning and childhood obesity). Charmaz (2006) also highlights the importance of using grounded theory techniques flexibly which was thought to be useful given the constraints of conducting research within a DClinPsy programme of study (e.g. time limitations influencing aspects of data collection).

Finally, this method of qualitative analysis suited the specific research questions well, with the theoretical model that was developed being based closely on the reality of individual experiences. Data collected from participants helped to identify what was significant to them and this helped to guide the theory (Henwood & Pidgeon, 1992). The emergent theoretical model can be used to inform and expand on the current knowledge and understanding around childhood obesity, as well as being compared to existing theories, offering the opportunity to determine how well these theories may explain the studied phenomenon.

**Sensitivity to the data**

According to the principles of a traditional grounded theory approach, researchers should review the literature around the studied phenomena after conducting the research in order to prevent the researcher from forcing previously known concepts or theories on to the data (Glaser & Strauss, 1967). However, Charmaz (2006) and Corbin and Strauss (1990) make reference to the practical difficulties around this, acknowledging that it is not always possible due to the researchers professional and/or personal background, as well as the procedures involved in research requiring a submission of background to the study for example, when obtaining ethical approval (Charmaz, 2006).

With regard to the current study, the researcher was required to submit a literature review and a research proposal prior to the commencement of the study (as part of the DClinPsy). Therefore, the researcher did not begin the study without prior knowledge. However, it was felt that this knowledge would be used purely to help the researcher to remain sensitive to the data. Corbin and Strauss (2008) suggest that previous knowledge can help to enhance the degree of sensitivity and assist the researcher in responding well to the data for example, enabling the researcher to understand the meaning and significance of what participants report with their language and narrative. The actual content of the data remained the primary focus for the researcher, above and beyond any pre-existing knowledge about the subject. A research diary was kept throughout the research process, in order to help the researcher reflect upon any issues related to data sensitivity (Appendix 1).

**Exploring other qualitative methods**

Before the commencement of the current study, Interpretive Phenomenological Analysis (IPA) was also considered as a potential methodological approach. This involves interpretation of the data to hypothesise the meaning that participants ascribe to their experiences (Forrester, 2010). This method involves a great deal of interpretation of the data, going far beyond what is actually said by participants. This can prove insightful however the researcher must adopt a much more interpretive role which perhaps would not lend itself so well to the development of a theory closely grounded in the actual experience of participants.

Discourse Analysis (DA) was also considered. This focuses on the way in which language is used to create the reality of participants’ worlds (Forrester, 2010). It assumes that there are multiple realities shaped by prior knowledge and assumptions known as ‘*discourses*.’ Of interest in this type of analysis, is the way in which these discourses shape the creation of narratives through interactions. Although the current study wished to take a constructionist position to explore the role of language and construction of events (Charmaz, 2006) it was felt that the outward focus of DA on the broader societal narratives would perhaps narrow the extent to which the individual experience is understood and explored (as was aimed by the current study). It was felt that focusing on individual meanings may provide a better starting point from which to compare with pre-existing research of families in relation to childhood obesity.

**Data collection procedure**

The following section summarises the methods employed for data collection including the inclusion (and exclusion) criteria for participants, strategies of recruitment, gaining informed consent and interviewing participants.

**Participants**

Participants were defined as being the parent (mother, father and/or step-parent) of a child (or children) who is either overweight or obese. The child’s weight status was determined using parent reports of the child’s height (cms), weight (Kgs), age and gender, so that gender specific UK growth charts for children aged 2-18 years old (RCPCH, 2013) could be used to determine in which Body Mass Index (BMI) centile the child’s weight fell. Their charts combine data from the World Health Organisation’s growth standards up to age 4 years, and the UK 1990 growth reference for ages 4-18 years. These charts offer a more reliable way of determining overweight and obesity in children as they were designed in response to research investigating the reliability of older versions such as the ‘UK90’ (Wright et al., 2002). According to the RCPCH growth charts (2013) for both boys and girls, aged between 2-18 years, a BMI score within the 91st centile suggests ‘overweight,’ within the 98th centile suggests ‘very overweight’ (obese) and within the 99.9th centile suggests ‘severely obese.’ Parents of children who were identified as being either overweight or obese were included in the study in order to increase the likelihood of reaching the recruitment target.

**Inclusion criteria**

Three key inclusion criteria were used in order to optimise the quality of the data gathered. First, participants were required to be fluent in English language (in terms of both their spoken and comprehension abilities) so that they could fully understand the interview questions and were able to provide a detailed verbal response without the use of an interpreter. Second, participants were required to be the mother, father or step-parent of a child who was overweight or obese at the time of recruitment and interview. Participants were included if they identified their marital status as married, separated, divorced or single in order to maximise the opportunity for recruitment given that previous research has indicated that children within ‘non-traditional’ family households (i.e. single parent, step-parent or no parent) are at a greater risk of becoming overweight/obese (Chen & Escarce, 2010; Gibson et al., 2007; Stewart & Menning, 2009). Third, participants were required to have a child between 2-18 years of age who was overweight or obese at the time of recruitment and interview.

**Exclusion criteria**

Participants were not included in the study if:

1. The parent’s child had any genetic syndromes associated with being overweight or obese, including cerebral palsy, spina bifida, and hypothyroidism.
2. The parents and/or child were receiving any treatment for mental health difficulties at the time of recruitment.

**Ethical approval**

The study was granted ethical approval by the Royal Holloway University of London Ethics Committee prior to proceeding with recruitment (Appendix 2). Following the initial approval, one amendment to the original application was made. This was based on the stipulations made in the initial approval that “if the interview schedule is amended following feedback from MEND, the schedule should be reviewed again by the ethics committee.” Changes to the interview schedule were indeed made based on service user feedback (discussed later in the chapter) and thus the interview schedule was re-submitted and later approved by the Royal Holloway University of London Ethics Committee in July, 2014 (Appendix 3).

As this project involved interviewing parents around a potentially sensitive topic, due consideration and care was given to possible ethical implications of the study for participants. Several ethical considerations were addressed via the Participant Information Sheet (Appendix 4), these included:

* **The voluntary basis of participation**: Participation in the study was entirely voluntary. Frequent reassurance that the decision around the participant’s involvement having no impact on their right to access services for treatment or support (either NHS or voluntary) was provided. In addition to the reminder that they were free to withdraw at any point and provided with contact details so that they could do this if they wished.
* **Confidentiality**: The identity of participant’s remained anonymous at all times, as stipulated in the Participant Information Sheet (Appendix 4). Prior to the commencement of interviews participants were informed of the limits of confidentiality if any risk were to be disclosed.
* **Informed consent:** Information was provided to all parents who expressed an interest in taking part in the study. This was in the form of the Participant Information Sheet (Appendix 4) as well as verbally by the researcher. All participants were provided with the opportunity to ask any questions and were given contact details of the researcher so that this could be done at any time.
* **Emotional distress:** If there was any concern around the emotional distress of a participant during the interview the interview was stopped and the participant asked if they would like a break, to stop completely or continue on another day. Information regarding emotional support that participants could access was also provided as and when required. This included sign posting to relevant agencies and contacting their GP.

**Recruitment procedure**

A total of 10 participants were recruited through a ‘convenience’ sampling method (Morse, 2009) which was employed within one London borough.

**Identifying non-government organisations**

Internet searches were conducted in order to identify non-government organisations running with a focus on providing support to families who have an overweight or obese child (or children). From these searches, MEND (‘Mind, Exercise, Nutrition…Do it!’) was identified as an appropriate organisation. MEND is a social-enterprise set up in the year 2000 which aims to provide individual and family intervention to overweight and obese children. It runs several groups in London which are based on engaging children and families in exercise as well as providing education around nutrition.

**Initial contact**

Once MEND had been identified, initial contact was made with the organisation. Information around the studies’ background, aims, method and ethical approval were provided as and when requested and in compliance with MEND’s own research protocol.

**Participant recruitment**

A total of 10 parents were interviewed for the study, these were recruited from a specific MEND weight management group. The researcher was able to attend the group on three occasions in order to introduce and discuss the project with parents, providing them with both written and verbal information. Prior to the researcher attending the groups a brief information leaflet was circulated to provide advance notice of the researchers’ presence (Appendix 5). Following the researchers’ first attendance to the group 6 parents provided consent to taking part in the study and to being contacted by the researcher (giving their contact details and their preferred method of communication, either by telephone, email or post; see Participant Information Sheet, Appendix 4). All 6 parents were followed up by telephone which enabled the researcher to discuss the project in more detail and to answer any questions the parents had about the study. Inclusion criteria were also assessed at this point, and subsequently 4 interviews were booked with parents, 2 opted out due to feeling as though they did not have enough time to dedicate to being interviewed. On the second attendance to the group, 3 further participants were recruited, all of which were followed up and booked for interview, Following the third attendance to the group a final 3 participant’s provided consent, all of which were followed up and booked for interview. The process of recruitment can be seen in the diagram below (see Figure 1).

All interviews were conducted within the participant’s homes as it offered the most convenient location for the participants as well as providing a quiet and confidential environment in which to conduct the interviews. Lone working protocols were followed at all times and alternative locations were always offered although always declined. Participants were reminded of their right to withdraw prior to the commencement of all interviews.

***Figure 1: Recruitment diagram***

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**Participant characteristics**

Table 1 provides information regarding the characteristics of the participants who took part. Participants were notably diverse in terms of their age, ethnic origin, employment and marital statuses. Of note is the difference in the number of mothers, fathers and step-parents that took part in the study; 6 mothers, 3 fathers and 1 step-mother took part[[1]](#footnote-1). Table 2 provides information about the child/children they identified as being overweight/obese and were therefore discussed during the interview. The table shows that all children discussed in the interviews had BMI’s that placed them within the ‘obese’ centiles, with 9 out of the 10 children discussed falling in the ‘severely obese’ centile. The children discussed were also notably diverse in terms of their age, ethnic origin and gender. Information presented in tables 1 and 2 was taken from the study consent form as well as material provided by parents during the interviews.

**Obtaining consent**

Prior to commencing the interviews, participants signed a form giving their consent to participating in the study, the interview being audio-recorded, and to providing some information about their child (specifically their height, weight, age, gender and ethnicity; see Appendix 6). The researcher reiterated that participation was voluntary and if they agreed to take part they could decline to answer any specific questions, take breaks and withdraw from the study at any time without giving a reason. Participants were informed the interview would focus on their experience as a parent and on different interactions and processes within their family.

***Table 1: Participant characteristics***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Participant number** | **Relationship to child** | **Age (years)** | **Ethnic origin** | **Marital status** | **Employment status** | **Total number of children** | **Total number of children**  **overweight/obese** |
| 1 | Mother | 48 | Black British | Divorced | Unemployed | 4 | 1 |
| 2 | Mother | 47 | White British | Married | Employed FT | 3 | 1 |
| 3 | Father | 47 | Black British | Married | Employed FT | 3 | 1 |
| 4 | Mother | 47 | Black African | Separated | Unemployed | 6 | 1 |
| 5 | Mother | 35 | Black French | Married | Unemployed | 2 | 1 |
| 6 | Mother | 45 | White Algerian | Divorced | Unemployed | 2 | 1 |
| 7 | Step-mother | 35 | White British | Married | Employed FT | 2 | 2 |
| 8 | Father | 37 | White Albanian | Married | Employed FT | 2 | 1 |
| 9 | Mother | 35 | White British | Married | Self Employed | 2 | 1 |
| 10 | Father | 43 | Somalian | Single | Employed PT | 3 | 1 |
| *Note:*  FT = Full time | |  |  |  |  |  |  |
| PT = Part time | |  |  |  |  |  |  |

***Table 2: Child characteristics***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Parents' participant number** | **Child number** | **Ethnic origin** | **Age (years)** | **Gender** | **Height (cms)** | **Weight (kgs)** | **BMI** | **Weight centile** | **Obese/overweight** |
| 1 | 1 | Black British | 6 | F | 121 | 38 | 26 | 99.6th | Severely obese |
| 2 | 2 | Mixed British | 11 | M | 146 | 58 | 27 | 99.6th | Severely obese |
| 3 | 2 | Mixed British | 11 | M | 146 | 58 | 27 | 99.6th | Severely obese |
| 4 | 3 | Black British | 15 | F | 163 | 86 | 32 | 99.6th | Severely obese |
| 5 | 4 | Black French | 7 | F | 120 | 37 | 26 | 99.6th | Severely obese |
| 6 | 5 | White Algerian | 11 | F | 147 | 54 | 25 | 98th | Very overweight (obese) |
| 7 | 6 | White British | 10 | M | 147 | 55 | 25 | 99.6th | Severely obese |
| 7 | 7 | White British | 6 | F | 117 | 35 | 26 | 99.6th | Severely obese |
| 8 | 8 | White Albanian | 9 | M | 138 | 52 | 27 | 99.6th | Severely obese |
| 9 | 9 | White British | 11 | F | 160 | 79 | 31 | 99.6th | Severely obese |
| 10 | 10 | Somalian | 7 | F | 126 | 42 | 26 | 99.6th | Severely obese |

*Note:*

F = Female

M = Male

**Interview schedule**

A first draft of the interview schedule was developed during the initial stages of the research project (Appendix 7). Questions were designed to be open-ended in order to allow the participants’ own experience to emerge, as well as being in line with grounded theory methodology. Interview questions began by focusing more broadly on the participants’ family and then focused down to the parents’ experience of having an obese/overweight child. Questions were designed to tap into the experience of parents as well as offering an insight into the relationships and processes within their families.

**Adapting the interview schedule**

Questions included in the interview schedule needed to be worded sensitively in order to encourage participants to reflect openly on their experiences. A service user at MEND was therefore contacted by the Research Manager and subsequently consented to providing feedback on Draft 1 of the interview schedule. This feedback was sent to the researcher via email and based on this several changes were made including (see Appendix 8 for Draft 2 of the interview schedule):

1. Using only the word ‘overweight’ when referring to the children of parents, as ‘obese’ was considered to be ‘too harsh.’
2. Including a thorough debrief at the end of the interview and sign-posting to relevant support agencies if required.
3. The inclusion of questions that prompted parents to talk about positive aspects of their family and/or child.

A second editing process for the interview schedule followed the completion of the first 4 interviews for this study. One of the defining features of grounded theory is the simultaneous data collection and analysis (Glaser and Strauss, 1967). In line with this approach, the first four interviews were transcribed and open coded before any further interviews were conducted. Emerging gaps, areas of interest and ambiguities were identified and questions added to the interview schedule to explore these points further in subsequent interviews (see Appendix 9 for the updated version of the interview schedule). This process also highlighted directions to follow for further recruitment in line with theoretical sampling requirements.

**Interview procedure**

One-to-one interviewing was selected as the method of data collection in order to facilitate in-depth discussions of the studied phenomena. Interviews were conducted using a semi-structured interview schedule which offered a flexible approach, allowing departure from the preconceived interview schedule to gather rich and detailed descriptions as well as responding to the direction in which the participants took the interview (Bryman, 2008). All interviews were carried out by the same researcher at the homes of the participants’ and varied in duration from 50-120 minutes[[2]](#footnote-2). Interviews were guided by the interview schedule with specific questions being asked based the responses of participants. The researcher also asked prompt questions throughout to encourage participants to expand on their answers and facilitate further discussion of areas of interest. Summaries of responses provided by the participants were made by the researcher in order to confirm that they had been fully understood and properly interpreted (Forrester, 2010). Following several of the interviews participants commented on how it had been really interesting to talk about their experience and had offered them a level of insight into their families that they had not previously had. None of the participants were visibly distressed at the end of the interviews, although several appeared to become more emotional during the interviews when discussing their own childhoods’ and/or some of the negative experiences they have had associated with their child’s weight.

**Data analysis procedure**

The following section details methods employed to analyse the data as suggested by Charmaz (2006) including transcription, initial coding, focused coding and theoretical coding and diagramming; these stages were linked together and supported by on-going memo writing. Figure 2 shows an example of the coding process. Step 1 shows examples of initial codes generated from the data and their relevant quotations. Step 2 shows an example of focused coding. Step 3 gives an example of a category comprised of focused codes and step 4 shows the outcome of the process, a theory grounded in the data.

**Transcription**

Interviews were transcribed verbatim by the researcher, a useful process aimed at immersing the researcher in the data, familiarising them with it and offering an opportunity to develop a greater understanding (Charmaz, 2006). This approach to transcription incorporated verbatim elements of the participants’ speech including pauses, emphasis and utterances (Davidson, 2009). This was useful in helping to explore perceptions and constructed meanings in relation to the language used by participants’ in addition to their reported experiences

**Initial coding**

Initial line-by-line coding was conducted in each of the transcripts, this involved assigning each line a label that “categorises, summarises and accounts for” that piece of data (Charmaz, 2006, p.43). Actual words or phrases used by the participants were used as codes as much as possible (known as in vivo coding) in order to preserve the precise meaning assigned to them by participants, especially when they were felt to be important or significant concepts. Charmaz (2006) also identifies that making use of in vivo codes is an important way of ensuring that the researcher sticks closely to the data and includes actual words and/or actions used by participants, preventing the researcher from coding the data in accordance with pre-conceived categories or theories, as well as ensuring the codes are grounded in the data. As data collection and analysis occur simultaneously, initial codes from each interview were used to guide areas of exploration to peruse in subsequent interviews.

***Figure 2: Example of the coding process***

**Step 1: Initial coding**

**Devoting self to children**

*‘We have a busy life but I devote my life to the kids. My husband, he’s a typical man he goes to work and comes home you know, he does do stuff in the house and with the kids but you have to sort of nudge him to do it. I am solely devoted to the kids that’s why I do the job that I do, so I can pick them up and drop them off to school and then I work in the evening*.’

**Wanting children to be happy**

*‘I mean I’m not strict at all, I mean it’s about…I went through primary school and I was bullied and it was terrible! It was awful, you feel like your life is awful and all I’ve ever said is…I don’t care if my children can read or write cos that will come, as long as they’re happy it doesn’t matter!’*

**Step 2: Focused coding**

**Being a dedicated parent**

**Wanting to ensure children’s happiness**

The focused codes refer to the way in which parents viewed their duties as a parent. The two initial codes above show examples of parallel attitudes regarding the way in which parenting was described.

**Step 3: Category development**

**Trying to be a ‘good’ parent**

This category refers to parents drive to provide for, protect and ensure the happiness of their children.

It encompasses 4 focused codes and 12 initial codes.

**Step 4: Theoretical coding/diagramming**

The emerging categories were considered and connected through a diagram to produce a theory grounded in the data.

**Focused coding**

The second stage of coding involved constant comparison of the data (within and between subjects) to group together frequently occurring and significant initial codes considered to share similar properties. The constant comparison method ensured that the codes generated adequately conceptualised the data into categories, whilst also ensuring that they still remained close to the data. Charmaz’s (2006) methods of challenging perceptions was used to ensure that the researcher avoided over-interpreting the data and remained mindful of the tendency to force the data into preconceived categories.

**Theoretical coding and diagramming**

The final stage of coding was to describe how the initial categories may relate to each other and be integrated into a theory (Charmaz, 2006). To establish theoretical links between the codes memos were written, these were used to describe and elaborate the codes with regard to processes, actions, and assumptions contained in the data. Memos were collected and compared as part of the analysis; these were eventually developed into the grounded theory. A diagram was used to assist the development of a grounded theory and to help explain the categories, their properties and how they related to each other (Charmaz, 2006). Once a theory had been generated it was compared to existing research and literature in this area.

**Memo-writing**

Throughout the coding process memos were written in order to summarise and explore thoughts, ideas and concepts arising from the data (Appendix 10). They also offered a way of capturing the researcher’s tentative ideas about the emerging concepts and processes, allowing them to be further explored (Birks & Mills, 2011). This process helped to identify gaps and inconsistencies in the data, and thus directed the researcher to additional areas of data collection (Charmaz, 2006). Memo-writing also encouraged the researcher to be reflexive about the data as well as the process, reflecting on assumptions and insights made during the study. This stance of reflexivity has been referred to as ‘bracketing,’ a term used to describe the process by which the researcher attempts to maintain an objective stance (Dowling, 2006).

**Reflexivity**

Social constructionist approaches view researchers as being “part of what they study, not separate from it” and emphasise taking a reflexive stance (Charmaz, 2006, p.178). Researchers are encouraged to reflect upon their interactions, positions and assumptions, considering how these might influence the research process. The following section outlines reflections on the researcher’s beliefs, interests and position.

With regard to my position as a researcher I am a White-British, female, third year trainee clinical psychologist. As well as studying therapeutic work, I am also developing my skills as a therapist. My personal interests and beliefs influenced my decision to study the subject of childhood obesity in relation to family processes and parental experience. My interests pertinent to the research are as follows: I am interested in the way in which individuals within families interact and communicate with each other; I am interested in the way in which families function as a whole; I am interested in the way in which food and nutrition are valued and considered within families; I am interested in how systemic psychology may relate to health matters; and as a result I am curious about how childhood obesity interacts with family systems, how each person views and experiences it and how interactions and relationships within families may or may not be related to its aetiology and/or maintenance.

**Research quality**

Throughout the study, criteria for assessing the quality and rigour of the qualitative research were consulted in order to increase the validity of the emerging data (Elliott, Fischer & Rennie, 1999; Yardley, 2008). Regular reflections in supervision were vital in ensuring that the researcher identified and considered their own position in relation to the research process, as well as using a research diary to consider the process of conducting interviews and the subjective experience of data analysis and generation of constructs and theory (Kazdin, 2003).

To enhance the credibility of the study, validation and triangulation methods were used to allow for independent verification of the categories and emerging theory. This was done by checking the coding of interview transcripts and themes with other researchers (also trainee clinical psychologists) familiar with grounded theory techniques (Madill, Jordan, & Shirley, 2000). The resulting themes were also checked with a clinical member of staff from MEND, providing a credibility check of the analysis and supporting data (Elliott et al., 1999). This ensured that the data was considered from multiple perspectives, the researcher did not miss important themes and that the labels and interpretations fitted the data well (Mays & Pope, 2000); as well as ensuring that the presentation of the findings from the data made coherent sense to others.

Examples of themes and categories generated during the analysis are included in this report so that readers may observe the analytic process and assess the credibility of the themes generated. Quotations from the data are also included to illustrate the developing codes, memos, themes and categories, allowing the reader to again assess the ‘fit’ between the data and the researcher’s interpretations (Elliott et al., 1999). A section of a transcript can be seen in Appendix 11 to allow for transparency by illustrating the interview process, raw data and the initial and focused coding stages.

**Chapter 3: Results**

Presented below is an account of the analysis with extracts from the interview transcripts included to illustrate each theoretical category and its focused codes. In order to maintain participant confidentiality, all identifying details have been removed from the quoted extracts and participants are referred to using participant numbers 1-10 (see Table 1).

In the final stages of the analysis seven theoretical categories were produced, these are presented in Table 3 below. The seven theoretical categories are made up of 25 focused codes, with each focused code containing a number of specific properties (i.e. initial codes) developed during the early stages of analysis. A summary table in Appendix 12 shows the presence of the theoretical categories and focused codes occurring across each participant.

The chapter concludes with a diagrammatic model depicting the relationship between the seven theoretical categories.

During the analysis, transcripts of interviews with mothers, fathers and the step-mother where constantly compared and contrasted; as the coding summary table (Appendix 12) suggests, there was a high level of similarity between the codes found across participants.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Theoretical categories**  ***Table 3: Theoretical categories, focused and initial codes.*** | | **Focused codes** | | **Initial codes** | |
| **1** | **TRYING TO BE A ‘GOOD’ PARENT** | **1.1** | **Being a dedicated parent** | The children come first | |
|  |  |  |  | Devoting self to children | |
|  |  |  |  | Protecting children  Ensuring the child’s happiness | |
|  |  | **1.2** | **Satiating the child’s needs** | Always giving in | |
|  |  |  |  | Not wanting to deprive | |
|  |  |  |  | Spoiling child | |
|  |  | **1.3** | **Negotiating parental boundaries** | Being relaxed | |
|  |  |  |  | Putting the ‘foot down’ | |
|  |  | **1.4** | **Past experiences influencing parenting** | Parent experiencing hardship as a child | |
|  |  |  |  | Trying to provide a better life | |
|  |  |  |  | Trying to be different to own parents | |
| **2** | **CHILD CHARACTERISTICS** | **2.1** | **A powerful child** | Strong minded | |
|  |  |  |  | Controlling  Determined / always getting what they want  Angry when pushed | |
|  |  | **2.2** | **Physically and socially mature** | Looking older  ‘Like a mini adult’ | |
|  |  |  |  | Enjoys adult company | |
|  |  |  |  | Very helpful & caring | |
|  |  | **2.3** | **Preoccupied by food** | Obsessed with food  Always thinking about food | |
|  |  | **2.4** | **Emotionally sensitive** | Sensitive to criticism | |
|  |  |  |  | Sensitive to the emotions of others | |
| **3** | **IDENTIFYING MOMENTS: WEIGHT EXPOSED AS A PROBLEM** | **3.1** | **Difficulty finding clothes that fit** | Having to wear older clothes | |
|  |  |  |  | ‘Buying clothes is the worst!’ | |
|  |  | **3.2** | **External sources highlighting weight as an issue** | GP pointing out the problem | |
|  |  |  |  | School acknowledging weight as an issue | |
|  |  |  |  | What the bullies say | |
|  |  |  |  | Noticing change through looking at old photographs  Child weighs self | |
|  |  | **3.3** | **Family teasing** | Family name calling  Jokes about weight | |
| **4** | **PARENT’S EXPERIENCE OF CHILD’S OBESITY** | **4.1** | **Feeling responsible for child’s weight** | Reflecting on contribution to weight gain | |
|  |  |  |  | Feeling guilty about weight | |
|  |  | **4.2** | **Worry about the health and social implications for child** | Worry about impact of weight on child’s friendships | |
|  |  |  |  | Noticing that the Child misses out on things | |
|  |  |  |  | Worry about the effect on child’s physical health | |
|  |  | **4.3** | **Worry about the future** | Worry that weight will increase as child gets older | |
|  |  |  |  | | Worry that bullying will increase as child becomes a teenager |
|  |  | **4.4** | **Worry about the views of others** | | People are quick to judge  Society is shallow  People make assumptions about the cause of weight gain  Friends try to reassure or keep opinion to themselves |
|  |  | **4.4** | **Feeling frustrated** | Feeling lost and frustrated  Weight gain seems unfair | |
|  |  |  |  | Weight gain doesn’t add up | |
|  |  | **4.5** | **Trying to make sense of the weight** | Noticing family weight patterns  Considering what the child eats | |
|  |  |  |  | It must be in the genes | |
|  |  |  |  | The use of modern technology | |
|  |  |  |  | Identifying reasons behind eating | |
| **5** | **ATTEMPTING CHANGE** | **6.1** | **Talking and planning for change** | Conversations around what not to eat  Conversations about losing weight  Using others as examples of weight loss or further weight gain | |
|  |  | **6.2** | **Trying to adopt healthier habits** | Changing what food is bought  Restricting food  Trying to be more active | |
|  |  | **6.3** | **Paying more attention to weight** | Keeping an eye on the weight  Taking more of an interest | |
| **6** | **BARRIERS TO CHANGE** | **7.1** | **Lack of motivation or willingness** | Lacking motivation to be active  Not wanting to go out when weather is cold/wet  Dislike of walking | |
|  |  | **7.2** | **Delaying action** | Hoping child will grow out of weight  Child is too young to worry about weight | |
|  |  | **7.3** | **True feelings about weight are hidden** | Child hides feelings about their weight  Parent dismisses upset about weight  The child’s true feelings are unknown | |
|  |  | **7.4** | **Conversations about weight are difficult** | Not wanting to make weight the focus  Weight is a sensitive topic  Not wanting to cause upset | |
| **7** | **THE EMOTIONAL CONTEXT OF THE FAMILY** | **8.1** | **Being a happy and close family** | Being a ‘happy’ family  Having a laugh  A close family unit  Always together | |
|  |  | **8.2** | **Communication viewed as ‘open’** | Talking as a family  Valuing being ‘open’ about things | |

**1. Trying to be a ‘good’ parent**

**Being a dedicated parent**

A prominent characteristic described by the majority of participant’s with regard to their parenting was their propensity to want to put their child first, often parents would describe devoting themselves to their children. This seemed to manifest in parents being very protective of their children as well as some parents subjugating their own needs in order to ensure that their children were adequately attended to.

*But you know once you…when you don’t have them [children][[3]](#footnote-3) you can’t see why you wouldn’t have them, and then you have one and then you find you have another one and then your whole world changes, your whole thinking pattern changes, now we’re more focused on like providing stuff from them, rather than your own self, getting what you need really, you really wona protect them umm yeah. (P2)*

*So I never had enough time to study really, my main focus has always been to look after the children well you know, to make sure they have everything they need... (P4)*

*I think that, especially with X, I was over mothering her, especially when she was a baby....so I was over protective….if someone did something to her I would get mad ‘don’t touch her, don’t do this’ even with my family, I was overprotective of her from everybody. (P5)*

*We have a busy life but I devote my life to the kids. My husband, he’s a typical man he goes to work and comes home you know, he does do stuff in the house and with the kids but you have to sort of nudge him to do it. I am solely devoted to the kids, that’s why I do the job that I do, so I can pick them up and drop them off to school and then I work in the evening. (P9)*

The drive behind the parent’s dedication to their children often seemed to be focused on ensuring that they remained happy and enjoyed their childhoods, this seemed to also connect to the expressed belief that having an upset child indicated the parent’s (perceived) failure to ensure their child’s happiness.

*Umm I don’t know, I don’t know well, I would go for more happiness, everyone wants more happiness, especially for the children they deserve it so they enjoy their childhood. (P6)*

*I like my children to have everything they need so that they are happy… [but if they didn’t] it might mean that I was a bad Mum and my children would say ‘you’re a bad Mum’ or I would say that to myself inside. I don’t know, I just like my children to be happy every day… (P4)*

In addition, it appeared that for some parents, having an unhappy child was very difficult for them to tolerate due to the experience of negative emotion(s) as a result. Parents described feeling ‘upset’ or ‘bad’ in response to their child being unhappy.

*Umm I’d feel upset [if my child was unhappy]…cos like I said, I live for my kids to make them happy and if they were unhappy…I dunno we’d get to the bottom of things. Seeing them upset is heart-breaking, it’s really difficult. (P9)*

*A long time ago, about three or four years ago he’d cry so much he’d kind of get short of breath...well that’s why we’d kind of change, that’s why we give up...I mean it makes us feel bad [seeing child upset], it does, it makes us feel guilty, because we’re doing it and that’s why we give up… (P8)*

This final quote illustrates how the parent’s dedication to ensuring their child’s happiness can result in them ‘giving up’ (or ‘giving in’ to their child), see below for further discussion.

**Satiating the child’s needs**

Many participants described finding it hard to say ‘no’ to their children, often leading to them ‘giving in’ so that the child eventually received what they wanted.

*She always got what she wanted…..I could never say ‘no’ to her. (P4)*

*I just gave her what she wants and I don’t think that’s always the right thing. (P1)*

*She keeps on asking and I say ‘no, no’…she doesn’t give up! If it’s a food I would say ‘no,’ but if I know, deep down that she hasn’t had that kind of food for a long time I say ‘well you know it’s a treat.’ (P6)*

As well as not wanting to upset their children, parents expressed the concern that they did not want to ‘deny’ or ‘deprive’ them of things they wanted. This suggests that to say ‘no’ means that the child would not receive something they needed or wanted and that this would mean that they were in fact being deprived of something. Deprivation and/or denial are both emotionally laden concepts connected to ideas of ‘suffering’ and/or ‘unmet needs,’ both of which parents are likely to want to protect their children from experiencing; particularly in light of some of the features within the code ‘being a dedicated parent’ discussed earlier.

*But it’s sometimes really hard to keep just denying her you know, but umm you know friends have said ‘don’t just deny just give her smaller portions of what her brother has’… (P1)*

*But you know…sometimes he just finishes the plate and you think ‘ok that’s a bit too much’ and he’ll say…’but I really enjoy that’ and you think ‘ok’ you know, you don’t want to stop something they enjoy. (P8)*

*My husband is quite good, I mean if they’ve had a treat during the day he won’t let them have another one and if they say they’re hungry he’ll say ‘well have a piece of fruit instead’ but even then, I think ‘do they actually need that? It’s just extra calories.’ I just think they eat way too many calories but I think my husband finds it hard to say ‘no.’ He’s getting better but it’s that feeling of not wanting to deprive them rather than actually doing something helpful. (P7)*

The result of parents ‘giving in’ and not wanting to ‘deny’ or ‘deprive’ their child is that they often begin to feel that they are ‘spoiling’ their child and/or it becomes noticed by others (i.e. another family member or friend).

*I think I’m too caring maybe, I don’t know, I think I spoil X [the focus child] a bit, giving her what she wants all the time, if we went out and wanted this she’d get it, same with food really if she wanted a McDonalds I’d say ‘Ok’ and treat her. (P1)*

*I think I did spoil her quite a lot cos as a Mum, as my daughter, my only daughter, I think I did spoil her a bit really… (P1)*

*Umm the boys are quite good together, although X [the eldest child] thinks we spoil X [the focus child] quite a lot which he may be right because he’s the last and I think that you know considering X [the middle child] has left and may or may not come back, and X [the eldest child] being 21, may or may not come back, so we may just be left with X [the focus child. (P2)*

The spoiling of children may result in the parent beginning to experience a range of complex emotions for example, they may feel satisfied that they have achieved their goal of wanting to ensure their children's happiness and that their needs are being adequately met. However alongside this, they may also begin to face criticism from others (i.e. family members and/or friends) about their propensity to spoil, possibly leading them to feel anxious about their ability to parent and to becoming defensive towards others about their tendency to spoil.

*My Mum used to say ‘oh you spoil her you really do spoil her’ umm and I said ‘I don’t spoil her cos her brother’s got everything she’s got, they’ve both got everything.’ I don’t just spoil her I spoil both of them so I don’t just see myself as spoiling just her… (P1)*

**Negotiating parental boundaries**

A feature that may underpin the participant’s difficulty in saying ‘no’ to their children appeared to be the way in which they negotiated parental boundaries. Most parents described themselves as being either ‘soft’ or ‘laid back’ parents.

*Err I don’t know, I find it really hard sometimes, I’m quite soft really, I do get hard when they really push it but I’m quite soft and quite often I just say ‘alright then, just one’ but one sometimes leads to ‘oh can I have another one!?’ And instead of going for the healthy option, a bit of fruit, it was ‘ok.’ (P1)*

*We’re a lot more laid-back. (P3)*

However, it was also common for parents to note that they were not always ‘soft’ or laid-back,’ referring to occasions when they had had to ‘put their foot down’ or they had ‘suddenly exploded with stress.’

*It’s only when, you know, things get really, they go over the top they don’t listen and I have to put my foot down. (P1)*

*But I blow up like a fire work and then fizzle down and start to think things through... (P2)*

*It’s unfortunate that I ruined their [the children’s] aspect of Christmas because one day I came home and I’d been shopping, I left them with a few tasks to do and came back and the place was chaos and nothing had been done, and the boys came down and I said ‘I asked you to do something, why didn’t you do it?’ and that’s when I burst and said ‘you know I’m Father Christmas don’t you!!’ (P2)*

*They’re good kids, they don’t argue. All I can say I tell them off for is if I’ve asked them to do something and they haven’t done it and I ask them again and again…then I say ‘right enough!! Fuck sake!’ I do start swearing then they know and start doing it. (P9)*

Parents appeared to find it difficult to maintain boundaries that lie somewhere in the middle of ‘being relaxed’ and ‘suddenly exploding.’ This may relate to the earlier focused code of ‘being a dedicated parent,’ as well as some parents expressing a fear of not wanting their child to view or experience them as being ‘strict.’

*Sometimes I shout at them and can get very angry! I don’t like doing this though because the children get upset and I don’t like to see them like that. I like them to be happy, laughing and joking like they do! (P4)*

*Sometimes I am angry, like if they don’t do their homework, or don’t go to school, something like that. Every day I tell them to do their homework and go to school, and to come back at the normal time. I think when I talk to them like this my children think I am a strict Mum, but I try not be like that all the time, I try to be more relaxed sometimes too. (P4)*

The root of this apparent difficulty in negotiating boundaries also seemed to connect with factors that had informed the participant’s ways of parenting, including the parents experiences of growing up and being parented themselves.

**Past experiences influencing parenting**

Most participants described how their parenting had been influenced by past experiences, often reporting a strong desire to ensure that their own children had a different experience of childhood than their own. Many parents described experiencing situations of hardship as children, for example:

*I try hard to work for them and provide everything for them you know…I was brought up in a hard way, we didn’t have anything you know we didn’t have the money. I was brought up and never had a toy when I was little, I never had a push bike, it just wasn’t there, forget about it!! You couldn’t even mention it, it was out of the picture it was like ‘a bike, what is that!?’ We just didn’t have it, we couldn’t mention it you know…I think yeah we’re a bit more lenient cos we didn’t have it, we never had the chance to have it you know, so we provide these gadgets and things for them. (P8)*

*I never had all of this you see, when I was growing up there was nine of us and only my dad worked so we didn’t have, it was like one doll, we had one doll for Christmas and that was it really for the girls. There was six girls and thee boys. The boys had a car. There wasn’t, I never had anything really because we were quite poor really. My Mum made sure we had a proper meal in us and proper shoes and clothes and stuff but things were really hard. We didn’t have you know, buggies, some people have prams with their dolls, we didn’t have…or maybe like two, three, four dolls, I didn’t, I had one doll and then every year I’d maybe get another one. But you know it wasn’t like how it is now, things were a lot harder so I think I go out of my way a bit now with my children. (P1)*

The experience of hardship as a child for some parents appeared to motivate them to try and provide a ‘better life’ for their children. This may be connected to codes above, specifically ‘being a dedicated parent,’ with participants wanting to protect their children from wanting things they do not/cannot have, a situation in which both the parent and child are at risk to experiencing negative emotions (e.g. feeling ‘upset’ or ‘bad’). One parent also seemed to want to protect her children from experiencing negative situations she had once had to endure as an overweight child.

*Yeah I do, cos I mean, as I said, I was bullied at primary school, so it wasn’t very happy... but I had a happy childhood growing up in general cos it was just me and my Mum really but yeah no I suppose I do want to protect them from feeling that. (P9)*

*My Mum said she took me to ‘Fats and Wets’ for all of the kids that used to wet the bed and were overweight, you couldn’t call it that now! So un-pc!! So I went to ‘Fats and Wets’ apparently and I remember going to the dieticians and just feeling really really naughty when I was a kid and I don’t think I ever want to put X [focus child] in that situation. (P9)*

Several participants appeared to be making a conscious effort to parent differently to their own parents, particularly in cases where the participant reported that one or both of their parents had been either ‘strict’ or ‘cut off.’

*I need to be firm with her all the time otherwise…this is difficult because my Mum was like that and it is something I don’t like...[I feel] that I am bad, what can I say I am bad. Because for me a parent shouldn’t have to shout at their children, because it’s like we are arguing all the time and that’s something that I don’t want in my house. (P5)*

*My childhood no it was different my father was very strict; yeah he passed away now so he was very strict we weren’t open with him… (P6)*

*With my Mum and Dad they cut a lot of things off, my Mum and Dad didn’t talk to us about things, you know you grow up not understanding why life was like that cos they hid so much…but then you grow up and you think ‘oh this is why it’s like this, but they never said’ you know, so I try and be quite open with X [focus child]… (P1)*

As well as the participants own experiences having an influence on their parenting, it was also reported that in some cases the experiences of grandparents had influenced how the participant’s subsequently parented their children.

*My Mum is really good you know, she had three kids by the age of 21 and then had me 12 years later, so I’m the baby, so I kind of grew up with my Mum. I know that she kind of had it tough…but then she was sort of quite lenient with me because she didn’t want me to feel how she’d felt it being tough, if that make sense…and so that kind of rubs off on me. (P9)*

*Well its interesting cos my husband’s Mums’ parents both died when she was very little, she was about ten, both of them died quite quickly, so she was raised by her older brother. So they’ve got this thing about storing food, and have this big pantry with food stocked up and now we’re doing it too and that’s what his mum does. (P7)*

The features described above are important to consider in relation to childhood obesity as parenting is directly related to the development of children, influencing many aspects of their behaviour, their ways of thinking and their feelings. Parents who devote themselves to their children, find it hard to say ‘no’ and struggle to maintain boundaries may also struggle in similar ways when it comes to food and feeding. For example, parents may give the child the food they want so as not to deprive or upset them, they may also rarely say ‘no’ to certain food choices the child makes and they may feel a level of satisfaction (or positive reinforcement) to see that their child is happy on receiving something that they longed for.

**2. Child Characteristics**

**A powerful child**

Related to the parenting characteristics described above are the child characteristics described by parents. The characteristics of both parent and child are in a constant pattern of interaction with one and other. That is a bi-directional relationship. A bi-directional relationship is not a linear one in which A leads directly to B. Rather it is a circular relationship where A leads to B, which leads back to A and then to B, and so forth. Therefore child characteristics may influence parenting, and parenting may influence child characteristics. There is no beginning or end point and therefore causality cannot be determined (Dallos & Draper, 2000, p.33). However, it is possible that some children may also be more or less genetically predisposed to the development of certain personality traits, and the development of these traits over the course of their childhood may be mediated by their interaction with others including their parents, as well as the innate personality traits of the child influencing parenting.

Nine out of ten participants described their children as possessing seemingly ‘powerful’ characteristics such as being ‘strong minded,’ ‘controlling,’ ‘determined,’ ‘always getting what they want’ and/or the ability to become ‘angry when pushed.’

*I have to be firm with her otherwise she wants to do what she wants to do…she is strong minded….I need to be firm with her all the time otherwise…..this is difficult because I feel like I ‘m fighting with her all the time, not fighting but I am shouting at her all the time. (P5)*

Strong minded children may be more likely to receive the things that they want or desire (including food). It may be harder for parents to remain firm and to say ‘no’ due to them wanting to avoid conflict as this brings about negative emotions for both parent and child. Many parents also described their children as having the propensity to be ‘bossy’ or ‘controlling.’

*Well it’s interesting because sometimes she’ll want to play this game where she’s the teacher and she’s bossy and she’ll sort of boss you about and he won’t have that he’ll say ‘no this game is not fun thank you.’ He sees her as being bossy in a way, he sees her as bossy…and he’ll tell her to stop being bossy you know because she can be like ‘me and you are gona do this…’ and you do end up feeling a bit sort of controlled. (P7)*

*Yeah it’s her trying to take charge all the time. I can deal with her when she’s a little girl but when she tries to control me I find it quite hard. (P7)*

*She will put him in his place if he’s done something wrong or he’s not doing something, she will say ‘you know you’re not supposed to climb up there X [brother], you know you’re not supposed to do that X [brother]…’ she will tell him and then you know, she’s sort of a bit bossy in that way. (P1)*

*Yeah she does she’s the biggest in her class and she can be quite bossy too. But she’s a very soft little girl she doesn’t get in to trouble really. (P10)*

This feature may again relate to the child’s ability to get what they want, especially when parents are relaxed in their approach to boundaries (see ‘negotiating parental boundaries’ above). In addition several situations were described in which the child had been very determined; resulting in them obtaining something they had wanted or being able to prove themselves (suggesting ‘competitiveness’).

*And sometimes he tries to prove that he’s right and he’s like just so determined to…that’s what he’s like! I mean until he gets it, he won’t give up! I mean probably we’re too soft in a way. I suppose…until he gets it he’s so desperate he just won’t give up, he won’t give up. He won’t take no for an answer. I mean that is probably one of the things that we do need to look at really because if we don’t change it now then it will get worse. (P8)*

*...and I think sometimes having older brothers who are very critical, because they’ve all done well, X [eldest child] did very well with his A-levels and chef stuff, and X [middle child] got his A-levels you know although not as good, and X [focus child] is clever but more persistent, and he will constantly just try and carry on to work it through but umm X [focus child] has tried to compete with them because he won’t let them have one up on him and if there is…he will attack through a different way…’well you know I’m gona try and get to Oxford’ and he throws things in like that, it’s really strange. (P2)*

As children become older, it may be that these types of interactions increase within families and the child then begins to get what they want more frequently. When this is applied to food, it may thus become much harder for the parent to be able to have an influence on what their child consumes; particularly when the child begins to show some more challenging emotions such as anger.

*She can get angry quickly at the moment, so now I’m trying to be more strict because if one of her friends says something wrong she’s gona cry and last time she squashed her friends face...If you’re laughing at her or if you say something about her that she doesn’t like….she gets angry….she can get physical. (P5)*

*If you try to push him it does affect him in a negative way. He can get quite angry sometimes, he throws things around. (P8)*

Or, they begin to develop an understanding of how to use emotion to get what they want, as one parent explained.

*And I think with her Mum she does a lot more emotional manipulation as well, like she does things there that wouldn’t wash with us, maybe she knows she won’t get away with it with us...Like the crying thing ‘Mummmmy I don’t wonna do that!’ Like when their Dad has gone to pick her up once she started crying saying ‘Mummy I don’t want to gooooo’ and it’s really rare that she does it but the moment she gets out of the house she starts laughing and joking with him and he is like ‘what’s that about?’...But I think with X [focus child] if she doesn’t want to do something she’ll put on that crying…you know she’s learnt these sort of techniques. (P7)*

Indeed three parents reported that they found it difficult to control what their child consumed. This was because they would either help themselves to food or they bought food for themselves when they were alone.

*Well yeah they do say ‘check the food, check what he eats…’ but until he gets what he wants to eat in the fridge he won’t stop, if he was here now and I went to the toilet he would go there and get what he wanted, I cannot lock the fridge it’s a simple as that! I’m not trying to give excuses I do tell him. (P8)*

*Umm but you can’t stop them from buying stuff as they come home from school or whatever its just….I’m trying to cut down the portion size to make it a smaller amount of food that he eats as well but you know he just seems to be a little snacker he finds things from god knows where!! (P2)*

**Physically and socially mature**

Many children were described as looking older than their age, often as a consequence of their weight.

*She looks older than she is too, even with clothes I have to buy ten/eleven year old clothes just so they can get round her really. (P1)*

*I think sometimes people might forget that she’s only 11. She’s just so tall, taller than my mother in law now and she does…its only when you catch sight of her just having a doll and you think oh gosh she is only 11. She is very young still a child. (P9)*

*One person asked how old she is….I said 15 and he said ‘wow…she looks so much older, like 18-20!’ Her face isn’t old but her size makes her look older. I think because she looks older people forget that she is 15 and treat her more like an adult. She has always been like that. (P4)*

The appearance of children who are overweight or obese may have an effect on the way in which people view them (i.e. as being older than they are). This could mean that more is expected of them and/or that they are also given more responsibility for themselves, for example they may be more able to determine what food they do or do not eat. Several parents also describe their children as seeming very grown up for their age (i.e. ‘like a mini adult’). This related mainly to the personality of the child and the way in which they interacted with others.

*She is very much this little adult, it’s really strange and I was talking to someone about it and she was saying that some children sometimes literally feel as though they are an adult and as big as an adult, they see themselves as being able to do things that adults do like lifting things, she literally always needs to get involved in things, she’ll literally feel as though she can lift really heavy things and not realise she can’t and you almost feel that you’re criticising her if you say that she can’t help you, you know, ‘you can’t do that,’ it’s like saying ‘you’re not a good enough adult. It’s quite hard to be with her sometimes you know, cos she can be so….she acts in this way and I really do forget that she’s so young, I think of her as being much older really. (P7)*

*Yes…in the way of personality wise and stuff she’s quite clued up, she’s quite responsible and she will say ‘no don’t that you can’t do that…’ (P1)*

*I don’t think he’s ever been a child, I think he’s always been sort of an old sole in a little boy’s body. (P2)*

Children that seemed to act in a more grown up way also seemed to be perceived as being older, with many parents sharing that the child’s age was easily forgotten. As a result of their maturity many parents found that their children very much enjoyed adult company, and even on occasion preferred it to the company of children their own age.

*At school she loves the teachers and the teaching assistants more than the children. She’d much rather hang around with them...Yeah she’s always had an old head on her shoulders, she gets on so well with the teachers and teaching assistants, it’s weird! (P9)*

Another feature that was often reported as being a positive facet of the child was that they were known to be very helpful and caring towards others.

*So the teachers love her they say ‘oh X [focus child], she’s just like a little teacher really.’ (P1)*

*I think what she does with them is to take that sort of parental, maternal role, you know in her report it always says ‘X [focus child] is always there if someone is upset, she’s always caring and always helpful’ and they sort of see this as such a positive thing and I sort of think yeah…but it’s a bit worrying as well you know, they think she’s kind which she is but it’s also about her own unmet needs that sort of….not being able to be a child, not being age appropriate. (P7)*

*Well yeah, a few friends because of the way he speaks and the way he answers to you is so grown up, he gives you the picture or the like….I mean to his friends if they’re three or four kids from the same class he’ll try to tell them ‘no you can’t, that’s stupid’ they think ‘oh ok!’ And he gives you the clue like that’s definitely right…or even they say that like he’s more caring as a person. I mean even teachers they say it. I mean if his friends argue sometimes he goes to them and tells them not to argue. (P8)*

This may reflect a high level of maturity as the children appear able to empathise well with others and to notice when others may need additional emotional support. However, it may also suggest a need to be liked by others with being overly caring acting as a way of interacting with children their own age in light of their heightened sense of maturity. This may be a consequence of their overweight status meaning that they find it hard to ‘fit in’ with peers their own age. It may also feed in to others viewing the child as older and therefore more responsible for them self, making it again more likely that they are trusted with making more decisions for them self (e.g. food consumption). It is unknown whether the children were actually emotionally mature or that is just how they were viewed/perceived by their parents.

**Preoccupied by food**

In eight out of ten cases children were described by parents as being somewhat preoccupied with food, including being ‘obsessed with food’ and ‘always thinking about food.’ It could be that this preoccupation relates to codes discussed earlier in the chapter including ‘trying to be a ‘good’ parent’ and other specific child characteristics (i.e. being ‘powerful’ and ‘mature’) in the way that children may have developed more control around what food they do and do not eat, when and how much, and therefore may have become accustomed to thinking about and/or planning what they will consume next. As well as gaining pleasure from eating and receiving something they wanted which is positively reinforcing for both the parent and child.

*But it’ll be like, sometimes when they come round he’ll do them a breakfast like eggs and soldiers and it won’t be long after before X [focus child] is thinking about lunch ‘what are we having for lunch? What are we having for tea?’ Umm….you just think what is that about? Is it about them meeting an emotional need? Or…..I don’t know…..they’re sort of obsessed with food….is it the sorts of foods or is it a lack of boundaries? (P7)*

*She thinks about food all of the time, even if she has something to eat at ten o’clock, at eleven o’clock she will ask me for something, but I think it’s not because she’s hungry, it’s because she saw something in the kitchen so she wants to have it. Or even if she eats at eleven o’clock at twelve o’clock she will need to eat her lunch even if she’s not hungry. She wants to eat all of the time. (P5)*

**Emotionally sensitive**

Many children were described as being sensitive to the views of others particularly when the views were critical in nature.

*She has been like this since she was two years old. She…umm…I mean what people think of her it does make her…..worry…..what they think of her. (P5)*

*… maybe from five or six, she’s better now but if somebody is laughing about her she will get upset. (P5)*

*I just think that he is very sensitive; it may be different when he grows up but at the moment he looks a bit too sensitive to be a toughty! (P2)*

This may be a result of the child’s obesity; with children becoming more sensitive to criticism following the experiences of being bullied or others making judgements and/or assumptions about their weight. In general, parents did not appear to connect the child’s emotional sensitivity to their weight status. However, there was one example when this connection may have been made.

*Dad bought this big popcorn and he said they were sharing it and of course Dad will take a handful and will gradually go through and X [focus child] is taking mouthfuls and Dad goes ‘you’re eatin too much!’ and X goes ‘no I’m not’ and Dad goes ‘look I’m gona take it away!’ And of course it goes everywhere, and X is furious because he is convinced that Dad did it on purpose to stop him from getting the popcorn. And so it’s very confrontational with X. (P2)*

Negative case analysis also highlighted that not all parents reported their children to be sensitive to criticism, rather some children were described as being hyper-sensitive to emotions in general. This included their own emotions and those of others. This may relate to the child’s perceived ‘maturity’ (specifically being 'helpful and caring') as well as serving as a protective function in that, if they are better able to read the emotions of others they may be better able to foresee criticism and/or bullying and thus prepare a response or avoid the situation.

*Yeah very, very!! Wherever you go, at school, outside, he is very sensitive to how other people feel, their emotions, I mean like, I’m a bit like… it shouldn’t be like that he should be a little bit more like ‘well I don’t care.’ (P8)*

*And the thing with the phone, he’ll be on the phone to her and say ‘I love you millions and trillions….100%....love you…love you’ all this really gushy stuff that feels a bit like yuuuuk and he was even talking for ages, I mean god knows what he was saying to her. (P7)*

**3. Identifying moments: The child’s weight becomes exposed as a problem**

All parents spoke about occasions when their child’s weight had been exposed as being an issue. These occasions appeared to be infrequent yet poignant when they did occur, causing a level of emotional upset and distress to both the parents and the child. However in some cases, these experiences also appeared to prompt the parent and/or child to begin to view the child’s weight as something that may need to be addressed, thus prompting communication between parent and child around possible change.

**Difficulty finding clothes that fit**

Most parents explained that it was difficult to find clothes to fit their children due to their being overweight. This often led to them having to wear clothes for older children and in some cases clothes for adults.

*And actually my husband’s Mum bought X [focus child] an adult night shirt, I mean it fits her, its long in the arms but fits her round the middle, I mean I could probably wear it! (P7)*

*I can’t find clothes to fit her in children’s clothes. I have to buy her adult size clothes sometimes those leggings are a size 8 adult clothes. (P10)*

This difficulty often meant that the child was somewhat limited in the clothes that they could wear, being restricted to leggings and/or tracksuits in order to accommodate their size (no parents mentioned how this may impact upon their child’s developing identity).

*She’s erm she loves trainers, she loves track suits and that’s all she wants is numerous…I just let her be who she wants to be. I hate it I think she looks like a tramp every day….Yeah, men’s, adult, Adidas track suits. I mean I shop around and she has got ladies track suits too like pink ones or Matalan or whatever, but I do the majority of shopping she might come with me and do the odd thing but…oh yeah we did go out on boxing day last Christmas and she chose like 10 Adidas and Nike t-shirts and when we were in America in October that’s what she wanted, she’s got a big collection and she likes caps those snap back caps, so she’s got that whole...She doesn’t wear school uniform so she just wears a different tracksuit every day, a different snap back, different trainers…(P9)*

Many parents also reported that shopping for clothes with their children was a very negative experience. It seemed that it was an occasion when the child’s weight status became exposed due to a difficulty finding clothes that fitted, highlighting how the child differed to other children their age, as clothes sizes are based on averages. Both parents and children seemed to find this a stressful event as a result.

*Buying clothes is the worst!! Um that is one of the most difficult things to be honest…we have such difficulty. We do argue about it sometimes cos she says ‘I’ll buy size 11’ but different shops have different size styles American, European, it’s so annoying… Um he knows sometimes, cos his Mum will say ‘get a size 10 or 11’ and he’ll say ‘no’ cos he knows they won’t fit. I mean the other day I bought a size 12 and brought it home and it didn’t fit. So we were thinking…is it what we’re doing? I mean he said ‘they won’t fit’ and I said ‘try them’ and he said ‘no they don’t fit.’ Yeah it is a struggle. (P8)*

This difficulty meant that some parents had to resort to buying clothes online, possibly to avoid the distress and/or exposure associated with shopping.

*Phhhh it’s difficult…the shop only sells slim things and she can’t have them, they are so tight it doesn’t matter the age they are, they are too tight….so I can’t get it....Well now I by tracksuits or shorts, dresses or skirts but jeans are difficult. Or I buy things online. (P5)*

**External sources highlighting weight as an issue**

In many cases the child’s weight was identified as being an issue by external sources such as the General Practitioner (GP) or the child’s school/school nurse.

*My 15 year old daughter. Before going to X we went to the hospital and she was weighed and it was 100 and something, and also the GP said that she weighed 100 and something kilos too. That’s when I thought she is too big now and we have to try and so something about it. (P4)*

*It’s only like recently because I think the school has highlighted the fact, because at one point he looked normal and then I thought what might happen is that he’d grow bigger [indicates height] and then he would lose it all… (P2)*

Parent’s also seemed to acknowledge their child’s weight as being a problem when the child reported being teased or bullied at school about their weight.

*She’s had one or two cases where someone’s called her ‘chubby’ or ‘fat’ and I say to her ‘well you know it’s true, you know that you’re over weight.’ And she says ‘yes I know I am.’ And I say ‘do you want to do something about it?’ (P9)*

Looking back at old photographs of the child was also reported to be a way of noticing the child’s change in weight as it appeared to be difficult to notice change on a day-to-day basis.

*You look at the pictures and you see the difference…. Day to day no, you can’t notice it. (P6)*

Three parents also described times when their child had weighed themselves independently. These occasions seemed to suggest that the child was aware of their overweight status and that they were possibly attempting to communicate with their parents about it. However, as one parent reported, it

was difficult for them to know how to respond to their child, possibly because they did not want to upset them.

*He does weigh himself sometimes, like we’d had dinner at my husband’s parents and he sort of went away and weighed himself and came back and said ‘oh I’m eight and a half stone’ and his Nan said ‘oh yes you’ve been that for a while now…that’s how you are.’ I’m not sure what he thought about it. I wasn’t really sure what to say to be honest, I was shocked!! You know I just thought well I could be eight and a half stone and it would be alright. (P7)*

**Family teasing**

Within the majority of family’s most communication about the child’s weight appeared to take on the form of ‘teasing.’ It was common for the child to be teased by another child within the family or on occasion by their parents and/or grandparents. When participants recounted these occasions, they often did so in a seemingly light hearted way. It appeared that teasing (or the use of humour) may act as a way of communicating about the child’s weight.

*Umm sometimes I say ‘ooooh look at that gizzard!!’ and I say ‘look at that all poking out!’ and she says ‘you can talk!’ We are very open about things, we don’t sit there and say ‘oh no we mustn’t say she’s overweight.’ (P9)*

**4. Parent’s experience of child’s obesity**

**Feeling responsible for child’s weight**

As parents began to reflect on their child’s weight during the interview, they often identified feeling responsible for their weight gain. Parents reflected on how they may have contributed to the child’s weight, often expressing feelings of guilt and/or upset.

*...and so yeah, I do feel a little guilty umm but I’m hoping that because I’m doing something with him that it’s gona have a positive impact. (P2)*

*It makes me feel quite upset really, cos I’m thinking ‘no you shouldn’t have to worry about that darling.’ (P1)*

It was common for participants to reflect on how their parenting may have influenced their child’s weight gain, connecting with codes discussed earlier such as ‘satiating the child’s needs’ and ‘negotiating parental boundaries.’

*I just gave her what she wants and I don’t think that’s always the right thing. (P1)*

*It’s not nice! I feel so guilty sometimes like it’s all my fault, I worry that I let her have too much bad food, I should have been more strict. (P4)*

**Worry about the health and social implications for the child**

It may be that part of the parent’s feelings of guilt about their child’s weight was related to their worry about some of the outcomes of it. Worry about the impact it may have on the child’s health was often discussed as well as the way in which it may impact upon their friendships.

*It’s really hard you know because their Dad does really worry about it, he worries about their health and doesn’t want them to get picked on at school. (P7)*

*I worry because if someone is too big they might have a heart attack or something… (P4)*

*I’m sure she would have more friends if she lost a bit of weight cos she can’t run around as much as the other children, I’m sure children probably look at her as if to say ‘god you’re a bit fat’ which I think upsets her a little bit. (P1)*

**Worry about the future**

Worry about the impact of obesity on their children seemed to also extend into the future, with parents sharing concerns about how the weight may affect their child in years to come. A major concern with children in primary school was how their transition to secondary school would be, as parents felt that bullying would often increase as the child became older. In addition, many parents were concerned that their child’s weight would keep increasing, causing worry about the unknown consequences of this (i.e. what it would mean for the child socially and physically).

*I’m nervous obviously, because we’ve had such a good run at primary school, am I just beating myself up thinking it’s gona be all change and she’s gona be all bullied, why am I thinking that you know!? (P9)*

*I am worried. We tried in the summer to try and lose quite a bit of it for secondary school cos I thought he might get bullied and I was very concerned that you know he’s got enough on his plate not to be a fat little bloke gettin bullied. (P2)*

*No she never does. And if she carries on like this, her weight will go up and up and it won’t be a nice life for her. She doesn’t seem to think that though, I don’t really know if she thinks about her weight at all. (P4)*

**Worry about the views of others**

The majority of parents expressed concern around what other’s may think of their child’s weight, concerned that people can be judgmental about weight and also make assumptions as to the cause of it. They often felt that people do not openly express their views about the weight of others, and worried that people were often thinking negatively about their child’s weight but would not say. They seemed to attribute this to the belief that others did not wish to upset or offend them by being open about their views on the child’s weight. It was also common for parents to describe their friends as being reassuring when worries were discussed, however this seemed to result in the child’s weight and the need for change being somewhat minimised.

*To think that in society people can be so shallow about people’s weight, thinking that if you’re overweight you must eat McDonald’s every day. (P9)*

*I didn’t ask them [friends], and nobody told me exactly what they thought. (P5)*

*Well you know it’s like that 'oh it’s just puppy fat, it’ll come off her when she’s a teenager,’ well it didn’t for me so why is it gona for her!?...I dunno…if I was to talk to anyone about it that’s the first thing people will say…they try to reassure me cos I’ll say 'I’m a little bit worried about X [focus child].’ (P9)*

**Feeling frustrated**

The parents’ negative feelings about their child’s weight (e.g. guilt, upset, worry) appeared to also contribute to them feeling quite frustrated about it. This was often expressed as feeling as though the child’s weight was ‘unfair.’ Many parents also reported feeling as though nothing helped their child to lose weight and that they were unsure about what to try next.

*I have friends and they’ve got children and when I see what they feed their children every day and their children are slim so I don’t get it, I don’t get it….Yeah! Frustrating! They give them fizzy, orange juice, every day, I don’t buy those, I don’t but fizzy, I don’t buy orange juice I say to them ‘go and have water.’ So I don’t feed her that kind of food. So it’s frustrating! Because you know I help her! You know I even go to X and I do exercise with her yes, and errr other parents they don’t do this, yeah well their children will go for football and exercise by they don’t go with them…Yes it is, I see them buying coco-pops I don’t by coco-pops I buy Bran and errr Wheat-a-bix and errr brown toast…and I find it really frustrating you know, I am trying my best to feed them healthy here and she’s fat! I don’t get it sometimes as you say it’s unfair! (P6)*

*They do so much and it doesn’t make a difference, what’s next you know? I’m trying to think of a solution but over the time you’re thinking time is going by, the clock is ticking! He’s growing up things are changing. I’m annoyed though cos a few times he lost a few kilos for a week…then it goes back on and you can see he has swollen up. So I wonder what it is you know. (P8)*

Frustration was also apparent when some participant’s seemed to feel that their child’s weight gain was difficult to understand, with children often described as being very active.

*You know the kids have a lot of activities….so they both do football, her brother does football, he’s not really into it he just has to go, he does Beavers. X [focus child] did Brownies for a number of years but when she turned ten and a half last year she was due to go into Guides, that put her off so she stopped doing it, which is a shame cos that was an hour and a half of exercise, socialising you know. Umm we did dancing religiously for three hours a week for five years and I used to make them do it! That was tap, ballet, modern and acrobatics so it was like 45 minute lessons, so we stuck at that for years. (P9)*

**Trying to make sense of the child’s weight**

As a possible result of the parent’s frustration about their child’s weight as well as some of the experiences mentioned above, all participants appeared to consider different factors that may have led to their child gaining weight. They often considered what food the child preferred to eat (e.g. sugary snacks such as sweets and/or chocolate), the role that genes and biology may play and the child’s use of modern technology. They also identified possible reasons that may lead to their child to eat for example, food being given as a treat, the child having certain routines around food, the child copying their parent’s ways of eating or food fulfilling an emotional need for the child. Parents also compared their child’s size to other members in the family, considering who the child might ‘take after,’ often feeling as though the child is ‘the odd one out.’

*Well when she was born she was little but now she has put on weight because she’s not eating normal food. She eats a lot of sweets, like chocolates, she loves it! (P4)*

*But I can understand where she’s come from cos I don’t eat healthy myself, I have a lot of snacks and a lot of cakes and tea and biscuits umm sometimes I don’t have a meal I’ll have a biscuit and cake for my meal. And that’s where she’s got it from as well, and now I’ve decided you know what I need to try, if I do snack its usually when they’re in bed. I don’t smoke I don’t drink and it think I should be able to eat what I want and I don’t care what people think, but I’m a 47 year old woman and I can do what I want so umm I do watch what I eat around her as well. (P1)*

*I think my husband has changed since he’s been with me about the relationship he has with food, he used to be a bit like ‘food is love’ type thing cos he will want to give them things and he still does it now, and he does it to me too. Like he cooked dinner and he always gives too much, huge portions, way more than I needed, and even before I had taken a mouthful he said ‘there’s more if you want it…’ it feels like he’s saying ‘don’t worry…there’s enough.’ And he’ll say that to the children like even before X [focus child] is finished he’ll ask him if he wants more, you know but he’s slowly trying to change it cos I think that’s to do with wanting to give stuff cos he’s not there all the time, like compensating with food. (P7)*

**5. Attempting change**

**Talking and planning for change**

Following the child’s weight being identified as a problem, the parent’s experience of it and trying to make sense of it, some parents had begun to consider how they might start to reduce it. Change was often discussed with the child by considering what they should not eat, how the child should try to change their habits as well as using the weight of others as examples of what happens if one’s weight continues to increase or alternatively how others had managed to lose weight.

*Umm well we talk about food, he says umm ‘I want to stop eating this and that so I don’t put on weight…[A: What do you say to that?]...’that’s good, that’s good’ try to encourage him really, and say ‘we can do it together…’ cos sometimes he tells me I’m putting on weight. But you know sometimes he just finishes the plate and you think ’ok that’s a bit too much’ and he’ll say ‘but I really enjoy that’ and you think ‘ok’ you know, you don’t want to stop something they enjoy. (P8)*

*I’ve got a niece who’s really overweight, she’s obese, she’s really big, she’s 22 and she’s massive, she’s like a size 24 and I said ‘look at her, do you wona look like her in the next ten years?’ and she says ‘no Mummy,’ and I say ‘well that’s what you’re gona look like if you carry on eating.’ And I keep pointing people out to say ‘look at that girl, did you see that big girl on the bus?’ and she said ‘yes,’ and she was just eating and she was massive like a size 16 but she was only about 14 years old. I said ‘do you wonna look like her when you’re in secondary school?’ and she says ‘no Mummy,’ and I say ‘well there you go!’ And this is what’s gona happen and so I’m trying to get it into her head that you know it’s what you eat, it’s what you’re gona be, you’ve got to watch what you eat. (P1)*

**Trying to adopt healthier habits**

The main methods for change were to try and alter the child’s food consumption by stopping buying certain foods as well as restricting the child’s access to them, trying to support the child in adopting healthier habits in general and trying to be *more* active.

*I’m not gona say no to buying certain foods. I think I need to change some of what I buy like in cereals, looking for things that are less sweet and less sugary. (P1)*

*I try to say to them when they’re eating, sometimes they ask for more before they’ve even finished, it’s like an anxiety around food like a need to get food, and I’ll say ‘are you actually full, are you actually hungry?’ and I’ve noticed recently X [focus child] is getting better at saying ‘no, no I’m not actually hungry’... (P7)*

*Yeah we try to be more active; we do swimming and things like that. At school they are very active too. We’re always on the go! We go to something at school as well to help, no other parents go, it’s just me and my kids!! (P10)*

**Paying more attention to the weight**

Three parents also commented on how they had recently started to pay more attention to their child’s weight, feeling as though it had perhaps not received enough attention previously. This seemed to connect with the parents feelings of guilt and/or responsibility for their child’s weight gain (see above).

*I think I am much more conscious of what is going on with him, and therefore I’m sort of trying to push him toward more exercise, push him to eat less, pushing less sugar but sometimes you see we all do it, all of the family are starting to do it. (P2)*

**6. Barriers to change**

**A lack of motivation or willingness**

It was common for participants to describe factors that may limit the effectiveness of efforts to reduce the child’s weight. Eight of ten participants’ felt that it was difficult to motivate their children to engage in exercise or to adopt healthier habits.

*Umm my wife will try and encourage him to do things, and sometimes he will and sometimes he won’t. He knows he’s got to lose weight and so we take the….ok we take the…’we’ve push the ball this way and the incline is that way and so we’ll try and push it that way,’ so we’re constantly trying to keep things on a straight line, but sometimes we have to let it go a certain way to bring it back. (P3)*

*Yeah, the way she eats it’s just not good, and nothing seems to make any difference she never seems to lose any weight it’s always going on. I try to say ‘stop doing this, stop doing that, try this, try that…’ you know, but she doesn’t change and her weight stays the same….she just doesn’t seem motivated, I don’t know what we can do now to be honest. (P4)*

A lack of willingness also seemed to manifest itself as the child having a dislike of walking, with one child reported to find walking ‘painful.’ Reduced activity levels during the winter months, when it was cold and/or raining outside were also described.

*No, no, she’s quite active, she does everything that we do you know, only when we do walking she says ‘oh Mum do we have too?’ she doesn’t wona do the walking, but I said ‘everybody else is doing it, you understand you have to do it put your trainers on, let’s go!’ (P1)*

**Delaying action**

Despite parents becoming aware of their child’s weight via ‘identifying experiences’ and often acknowledging the need for change, many parents appeared to also hold the belief that their child would ‘grow out’ of their weight. This seemed to suggest that parents hoped their child’s weight would disappear on its own accord; a factor that may contribute to parents and/or children putting off making change (or avoiding change) leading to maintenance of the child’s weight status.

*So I think sometimes he feels a bit depressed about his size, but we keep on saying ‘hopefully you will grow out of it.’ (P2)*

*I say ‘I don’t know, she is growing, she will lose the weight when she gets older.’ (P5)*

**True feelings about weight are hidden**

When participants were asked what they thought their child might think about their weight, it became clear that no parents knew exactly what their child thought about it. They often guessed what they thought their child would be thinking or feeling about it. Suspected feelings ranged from ‘depressed,’ ‘sad’ or ‘bothered by it’ (the weight) to ‘she doesn’t care,’ ‘I don’t think she’s bothered.’

*Myself I……if X [focus child] is happy with his weight as it is I’d be happy, but X isn’t as happy with his weight even though he’d say ‘I’m ok’ he sees his friends doing other things that he can’t really compete with, so he’ll…it affects him. He won’t outwardly show it but you know that umm he would like to be that person on the football pitch charging around with the ball and ultimately scoring goals, whereas he plays*

*positions where he isn’t running as much so he’ll play defender or be in goal, and we…I think he definitely would like… (P3)*

*She knows that she’s overweight but she don’t care! We talk about it when she tells me the kids at school call her fat, and I just say ‘don’t worry about it.’ So she doesn’t really get upset. (P10)*

Parents who suspected that their child was not ‘bothered by their weight,’ had all also recounted occasions when they had known that their child had been bullied by others (about their size) and had become upset as a result. This seemed to suggest that actually the child had experienced some difficult emotions as a result of their weight, however these were not reported to have been explored or validated by parents, despite parents acknowledging that their child may be 'emotionally sensitive.'

**Conversations about weight are difficult**

One reason behind the child’s emotions seeming to lack exploration or validation from parents may be that conversations about weight appeared to be difficult to have. The majority of participants reported finding conversations with the child difficult as they wanted to avoid upset or making their size too much of a focus, they also mentioned finding it difficult to know what to say or how to respond to their child as and when the topic did come up. This may be related to earlier categories such as ‘being a dedicated parent’ as participants may aim for their child to be happy most/all of the time, finding it distressing when they did show upset.

*Well X [focus child] said, when they were with us at Christmas, we were watching TV and I said something about resolutions and asked her if she had any resolutions…and she said ‘well I’m going to keep my room tidy here and at Mummy’s and I’m going to start a diet’ and actually it made me feel sad and so then I responded ‘why, why do you need to do that?’ you know in this way to try and make her feel better, when actually she does need to go on a diet, and I said “’well maybe it’s about just sort of you know eating well and making healthy choices, like you do, you eat all the nice vegetable’ and I did it too, tried to make it better when actually maybe I didn’t need to....It was so difficult, I wouldn’t have thought I would have said that like if I had known she was going to say that I probably would have responded differently, but the instant thing was to try and make it better cos I felt really sorry for her and sad that she felt that she should go on one, you know maybe she had started to think that she needed to do something….she is a lot bigger than other children in her class, you know she’s taller as well. (P7)*

In addition, one participant reflected on how conversations were also difficult to have with other adults in the family, wondering whether this was due to people not wanting to offend or be seen as being critical.

*It’s something that people just are not talking about...umm I think it’s that thing of not wanting to be, I don’t know mean. I think my husband doesn’t want to raise it with either of their Mum’s because he thinks it’ll just cause an argument and it probably won’t get anywhere which is probably true. I can imagine they’d just be…I think they should all try and work on it together, be adults about it and be like ‘look this is what we’re doing’ and when they come to you at weekends, ‘this is what needs to happen.’ (P7)*

The difficulties in being able to have conversations around weight may also be a factor contributing to the maintenance of the child’s obesity.

**7. The emotional context of the family**

**Being a happy and close family**

One theme that was apparent across all participants was their account of their families’ being ‘happy and close.’ This was a factor within families that appeared to be positive and may act as a protective factor (e.g. by helping families to feel more positive about any attempts at change and ensuring positive regard towards the child, important as they may be at risk of negative experiences/relationships with peers). However, holding the belief that one’s family is ‘happy’ may also relate to the participants propensity to want to ensure the overall happiness of their child. As a result negative emotions may be associated with distress as well as a possible sense of failure for the parent. These may therefore need to be avoided. Thus, in order to protect the families ‘happiness’ conversations about weight may be avoided adding to the maintenance of the child’s weight status.

*We’re a happy family truly speaking, we work, they are happy, we’re comfortable, there is no massive pressure. (P8)*

*Oh we’re fine, we’re absolutely, we’re quite happy, we’re quite happy and close, so I don’t think people just looking in thing oh my god you lot are weird!! Cos we get on and we laugh a lot and mess about, I mean I mess about, even when I go to the park I get on the swings with the kids, or get on the slide with the kids cos I can you know, they just think oh my gosh, some of the parents are sitting down there all frumpy and I think no no I run about with them on the grass and do things with them. (P1)*

**Communication viewed as ‘open’**

In addition many participants reported the belief that communication within their family was ‘open,’ meaning that their child was able to talk openly about anything they needed to. However, this seemed to contrast with codes above, in which conversations about weight were reported to be difficult and had rarely taken place in such a way that the parents were able to give a reliable account of how their child felt about it.

*Good! I think she is comfortable, she is telling me everything errrr I don’t think there’s any problem. (P5)*

*Yeah I like to be [open] just in case there is anything that she needs to talk about, that she will come to me yeah. (P1)*

**8. A model of family processes and parental experience in relation to childhood obesity**

Figure 3 below depicts the multiple factors that may influence the aetiology and maintenance of obesity in childhood according to the findings of the current study and previous research reported in the literature. The two boxes labelled ‘genes’ and ‘society’ outside of the model, represent the important influence both of these factors appear to have on a child’s weight as identified by the literature (Maffeis, 2000; Zong & DeVoe, 2010).

The outer ring in the model contains the category ‘the emotional context of the family,’ representing the overall influence this appears to have on both parenting style and the child’s characteristics. The second ring contains two categories ‘trying to be a ‘good’ parent’ and ‘child characteristics,’ highlighting the way in which the bi-directional relationship between parent and child may contribute to a child’s weight gain (within a specific emotional context, and influence by a specific set of genetic and social factors).

The inner circle shows how four categories may inter-relate and contribute to a child’s weight gain and its possible maintenance. ‘Identifying moments’ may contribute to the ‘parent’s experience of their child’s weight,’ as well as influencing ‘attempting change’ (as the child’s weight has been highlighted as an issue). Parental experience may also influence ‘attempting change,’ however ‘barriers to change’ ensure that the child’s weight either stays the same or increases. These factors all occur within the context of the parent and child interaction (a bi-directional relationship), the emotional context of the family as well as a specific set of genetic and social factors. As the combination of factors influencing a specific child and their family will be unique, the causal and maintaining factors of a child’s obesity may be difficult to identify and difficult to influence (through intervention or treatment).Treatment should therefore be individualised based on a complex and thorough assessment.

Bi-directional arrows connect layers within the model, showing how each factor may influence another and vice versa:

* ‘The emotional context of the family’ (i.e. being ‘happy and close’ and ‘communication being viewed as open’) may influence the parent’s beliefs around trying to be a ‘good’ parent. This may be related to the parent’s understanding/values around what being a ‘good’ parent means (i.e. being a ‘good’ parent may mean ensuring a positive emotional context is maintained within the family).
* The parents aim to be ‘good’ parents may also in turn influence ‘the emotional context of the family.’ Again this may be through the beliefs and values around being a ‘good’ parent, possibly meaning that parents feel they should provide a positive emotional context for their family.
* The emotional context of the family also influences ‘child characteristics,’ which in turn feedback to ‘the emotional context of the family.’
* ‘Child characteristics’ and ‘parenting’ factors together influence a child’s propensity to gain weight. Once the child becomes overweight the experience feeds back to both the parent and child individually, influencing the interactions between them, as well as the overall emotional context of the family, contributing to the weight being maintained.

**TRYING TO BE A ‘GOOD’ PARENT**

*BEING A DEDICATED PARENT*

*SATIATING THE CHILDS NEEDS*

*NEGOTIATING PARENTAL BOUNDARIES*

*PAST EXPERIENCES INFLUENCING PARENTING*

**CHILD CHARACTERISTICS**

*A POWERFUL CHILD*

*PHYSICALLY AND SOCIALLY MATURE*

*PREOCCUPIED BY FOOD*

*EMOTIONALLY SENSITIVE*

**GENES**

**THE EMOTIONAL CONTEXT OF THE FAMILY**

*BEING A HAPPY & CLOSE FAMILY*

*COMMUNICATION VIEWED AS ‘OPEN’*

**SOCIETY**

***Figure 3: A model of family processes and parental experience in relation to childhood obesity***

**Chapter 4: Discussion**

This study explored family process and the experience of parents in relation to childhood obesity. Ten parents with an obese child were interviewed about their experiences and data was collected and analysed in accordance with the principles of grounded theory (Charmaz, 2006). The study aimed to answer the following question: *How is parenting an obese child experienced by parents?*

Seven overarching themes emerged from the analysis, which were mapped onto a model outlining how some of the categories may contribute to the development and maintenance of childhood obesity. These themes related to:

1. Trying to be a ‘good’ parent
2. Child characteristics
3. Identifying moments
4. Parental experience of child’s obesity
5. Attempting change
6. Barriers to change
7. The emotional context of the family

**Overview of findings**

The findings from the study indicate that there are a number of ways in which family processes and parental experience of a child’s obesity may interact, highlighting the importance of systemic and relational aspects in the aetiology and maintenance of childhood obesity. Participants described several characteristics relating to the way in which they parented their child; characteristics of their children and how they appeared to interact with others (including themselves); as well as an account of how they have experienced their child’s weight status as a parent.

Participants described their parenting as being dedicated to their child, ensuring that their child’s needs are adequately met (satiating) and finding it hard to maintain firm parental boundaries that were neither too strict nor too relaxed. These features were often accounted for by the parent’s reflections on their own childhoods and how they had been parented themselves. Historical aspects of the parents past, relating to themselves as well as grandparents thus appeared to influence how parents interacted with their own children. For example, most often parents described childhoods that were a struggle in some way (e.g. financial difficulties were present), and this had led them to ensure that their own children were not exposed to the same or similar experiences.

Alongside the parenting described, participants often described their children in quite ‘powerful’ terms. This meant that within the family, the child appeared to hold a position of control, and that they often received the things they desired. The child characteristics and parenting style described, appeared to interact so that they each influenced the other (a bi-directional relationship). This interaction may be a possible factor contributing to the child’s initial weight gain and its subsequent maintenance.

In addition, within the family context, the child’s weight appeared to be underplayed except for moments in which it was exposed as a problem. These moments appeared to serve two functions. One, to have a possible impact upon the child and their emotional status (due to the experience of negative emotions as a result of exposure) and two, to contribute to the parents experience of their child’s weight, often leading them to consider change in order to reduce their child’s weight. Possible reasons behind the child’s weight being underplayed appeared to relate to the families propensity to avoid seeing the weight as a problem. This was usually driven by a fear of upsetting the child by bringing up the topic.

The child’s weight appeared to feedback to the child themselves in terms of their development of certain characteristics (i.e. being emotionally sensitive), it also seemed to feedback to the parent through the way in which it was experienced by them. Some of the experiences associated with their child’s weight appeared to be quite challenging (e.g. feeling responsible, feeling worried) and may thus have provided additional motivation for parents to provide a positive experience of childhood for their children (meaning that their happiness is ensured and that they are protected). This may have meant that parents were in fact more likely to continue with their already established ways of parenting (i.e. being dedicated, satiating the child’s needs and finding it hard to say ‘no’), leading to the child’s weight status being maintained and/or increasing.

When change was considered by parents, it mostly seemed to take the form of conversations around what not to eat, trying to adopt healthier habits (e.g. being *more* active) as well as paying more attention to the child’s weight. However, as parents explained, they often felt frustrated by their child’s weight as nothing seemed to help reduce it (i.e. the majority of attempts to change were unsuccessful). Possible reasons behind this as described by parents were the child showing a lack of motivation or willingness (this may be related to their high level of apparent control within the family, meaning they have the opportunity to choose whether they engage with change or not); and the true feelings about the child’s weight being hidden, as parents often described what they *thought* their child would be feeling about their weight however never recounted occasions when thoughts and/or feelings had been discussed openly and/or explored with the child. This related to a final barrier in which conversations about the child’s weight appeared to be difficult and so occurred infrequently. This was contradictory to the parent’s overall view of the family being ‘happy and close,’ with communication seen as ‘open.’ On considering this contradiction, it may be that parent’s strong belief and desire to ensure the happiness of their children (i.e. trying to be a ‘good’ parent) may actually have meant that they were less likely explore a potentially upsetting topic. In addition, the parent’s view of communication being ‘open’ may have also meant that they lacked motivation to alter the communication style within their family (in order to explore their child’s weight) as it was seen as adequate.

Thus, in the current study family processes and the parent’s experience of childhood obesity appeared to have combined in a way that may have contributed to the child gaining weight and its subsequent maintenance.

**Key findings**

**Trying to be a ‘good’ parent and child characteristics**

When thinking about family processes it is important to consider what individuals may make up a ‘family.’ Within this study all families were made up of a mother, father or step-parent, as well as a child (and/or children). Understanding the way in which these individuals interacted with each other was part of the studies’ original aim. Therefore the way in which parents reported to interact with their children and vice versa, was of key interest. Through participants providing an account of their parenting it was clear that there were certain themes common to all. Overall these themes related to participants’ desire to be ‘good’ parents, by providing the best possible experience of childhood for their child. This meant ‘being a dedicated parent,’ ‘satiating the child’s needs,’ ‘negotiating parental boundaries’ and parenting being informed by their past experiences. Within the literature, these features of parenting relate most readily to research around ‘parenting style.’ This is specifically known as a typology of behaviours and attitudes characterising how a parent will interact with their child, providing a context for their development which may either help to facilitate or undermine certain parenting strategies (or practices) used (Darling & Steinberg, 1993). The particular set of parenting characteristics described by participants map on to a more ‘permissive’ parenting style. This is characterised by parents having few rules or standards of behaviour, rules being inconsistent, parents usually being very nurturing and loving towards their children, and parents sometimes seeming more like a friend than a parent (Baumrind, 1967). Outcomes of such parenting are thought to be that the child may lack self-discipline, show poorer social skills, be self-involved and demanding and can feel insecure due to the lack of boundaries and guidance (Baumrind, 1967). In relation to this participants often described their children in very ‘powerful’ terms, that is they were viewed as being ‘strong minded,’ ‘determined,’ ‘controlling’ and ‘quick to anger,’ features in line with some of the expected outcomes of permissive parenting as described above. The possible outcomes of parenting style on child weight status was investigated in a longitudinal study conducted by Rhee and colleagues (2006) who found that children with either authoritarian or permissive parents were twice as likely to be overweight compared to children of authoritative parents two years later, after controlling for several covariates such as BMI at the beginning of the study, race, socio-economic status and parental marital status. The current study is the first to demonstrate the connection between parenting style, child characteristics and child weight status, using a qualitative approach (within this specific sample of parents). However, the direction or causality cannot be determined.

The way in which parenting style may influence a child’s weight status is thought to be through the use of particular parenting strategies (or practices). It is reported that families with overweight children are more likely to use permissive (or indulgent) feeding styles as well as maladaptive behavioural control strategies (i.e. a poorer ability to express and maintain standards for the behaviour of its members) when compared to families with non-overweight children, after controlling for parent BMI and socio-economic status (Moens, Braet, & Soetens, 2007). In line with this, the current study found that the majority of participants reported ‘spoiling’ their children, ‘always giving in’ and ‘not wanting to deprive’ them. They also appeared to have some difficulty in negotiating parental boundaries, often describing themselves as being ‘relaxed’ parents, reflective of a permissive parenting style mentioned above.

However, despite a relationship between parenting style and childhood obesity appearing to exist, it remains difficult to assess whether parenting style leads to childhood obesity or occurs as a consequence of it. Research investigating how parenting may influence child development in general takes a position similar to this, in that the relationship between parenting style and child development is thought to be a dynamic one. This way of thinking is the result of Baumrind (1971) who shifted the view from parenting influencing children, to the acknowledgment that children may too influence their own development through their influence on their parents. Furthermore, Baumrind hypothesised that parenting style may actually alter how open children are to their parents parenting strategies, positing that authoritative parenting enhances the value to parental reinforcement as well as their clear articulation of desired behaviours enhancing the child’s ability to discern the correct response (Baumrind, 1967). Thus parenting style either increases or decreases the effectiveness of parenting by altering characteristics of the child that in turn strengthen or weaken the parent’s ability to use certain strategies. A permissive parenting style may therefore reduce the value of parental reinforcements, with parents showing lower levels of clear articulation of desired behaviours and children repeatedly failing to provide the ‘correct’ response. A ‘correct’ response when thinking about childhood obesity may be the child’s ability to acknowledge and adhere to parental advice and/or instruction around food and/or lifestyle and then to consider carefully what they may then consume and/or do. Parents reported in the current study that this rarely happened, with eating often seeming to be ‘out of control’ and children lacking willingness or motivation to engage with attempts to reduce their weight or to be more active. However, it is also important to consider the fact that some children may also influence parenting style through their genetically inherited personality traits (McCrae et al., 2000), food consumption preferences and a genetic predisposition to weight gain (Hebebrand & Hinney, 2009; Sørensen et al., 1992). These factors may influence parenting style from the moment the child is born, which in turn may influence the continuing development of child characteristics and then again feedback to parenting, and so on (Dallos & Draper, 2000, p.33). It is therefore difficult to determine causality.

A more recent study finding that permissive and coercive parenting practices are more common in families with obese children suggests that the reason behind this may be related to traits of ineffective parenting (including a lack of parental confidence), with repeated failed attempts to manage children’s behaviour likely to erode parents self-efficacy, exacerbating ineffective parenting (Morawska & West, 2012). This is not something that was reported by parents in the current study however may relate to the parent’s experience of their child’s obesity, often meaning that they felt frustrated due to a lack of change in their child’s weight despite efforts made to manage it.

The antecedents to certain parenting styles are largely unknown, however Belsky (1984) suggests that the values parents hold and the goals toward which they try to socialise their children, the parents' emotional and material resources, and both the parents' and child's personalities may be of importance. Within the current study, analysis revealed that in general, parenting was largely influenced by the participants past experiences, including their own childhoods and experience of being parented. This is not something that has previously been reported in literature related to childhood obesity. Research related to this found that mothers who had had significant negative experiences as children showed higher levels of maladaptive parenting strategies and were more likely to increase or reinforce demanding and defiant behaviour in their children (Harmer, Sanderson, & Mertin, 1999). In addition research investigating the intergenerational transmission of parenting, suggests that the most valid explanation may be through understanding the attachment between parent and child across generations (Van Ijzendoorn, 1992). Within literature relating to childhood obesity there are no studies which investigate how the past experience of parents may influence their parenting style and what this may mean for the child’s subsequent weight status, it is therefore difficult to draw comparisons. However, within the realm of psychological therapies childhood experience and the way it may impact upon a person’s later development (including their ability to parent) is a factor held to be of central importance (Freud, 1924/1962). It would thus seem reasonable to consider the past experiences of parents to be important in relation to the parenting of obese children. However, it is also important to consider that it may not be a simple case of parents reacting to their own experiences in childhood. There may be additional factors involved in the reasons why parents in the current study find it hard to say ‘no’ to their children, appearing to be less aware of the long term consequences of doing so.

Alongside common features of parenting being described by participants, certain characteristics of their children were also described. Firstly, these related to children seeming to be somewhat ‘powerful.’ As mentioned previously the relationship between parent and child is thought to be bi-directional (Baumrind, 1971). This is a view in line with the Family Systems Theory which stresses the interdependence of action in families, with each person seen as influencing the other(s) and their responses in turn influencing them, which influences the first person’s responses and so on (Dallos & Draper, 2000, p.33). Therefore it is possible that parents and child in the current study had a bi-directional relationship; with children often being described as ‘strong minded,’ ‘determined,’ ‘controlling’ and ‘quick to anger,’ all of which are in line with the expected outcomes of a permissive parenting style (Baumrind, 1967). These child characteristics may then feedback to parenting, influencing their use of certain practices, for example the parent’s ability to say ‘no’ (something that was reported to be difficult for participants in the current study). Thus, this bi-directional relationship may result in the child having more control or influence over the food that they eat, leading to possible weight gain.

Secondly, children were described as being both ‘emotionally and physically mature,’ subsuming codes such as ‘looking older,’ ‘acting like a mini-adult,’ ‘enjoying adult company’ and ‘being helpful and caring.’ It is possible that some of these features may have developed in the child as a result of their weight status. Research has previously found that obese children are often highly stigmatised and therefore excluded from social groups (Schwartz & Rhul, 2003). Thus as a result of their obesity children may develop certain pro-social behaviours such as being helpful and caring, in an attempt to secure friendships despite their weight, especially as most victims of bullying blame themselves for its occurrence (Smith, Talamelli, Cowie, Naylor, & Chauhan, 2004). Being helpful may also act as a coping mechanism, helping the child to avoid the stress of bullying or being socially excluded (Newman, Holden, & Delville, 2010). They may also prefer the company of adults as they may be more accepting of them compared to peers, and a child’s relationship with a teacher at school is thought to help buffer the impact of bullying and also to make it less likely to occur in the future (Flaspohler, Elfstrom, Vanderzee, Sink, & Birchmeier, 2009). Obese children have been reported to lack the social skills required to maintain peer relationships for example, the ability to share and cooperate (Rubin, Bukowski, & Parker, 1998). These may also be particularly difficult skills for children to develop in light of the ‘powerful’ characteristics mentioned above. When considering themes of children ‘being emotionally and physically mature’ in terms of the family system, it may be that they too feedback to parenting, influencing the way in which certain parenting practices are delivered. As it is natural for children to become more responsible with age (Peterson, 1983) parents may be more likely to allow children to make decisions for themselves (including what they eat) if they are viewed as being older, more mature, helpful and caring; feeding into and maintaining their already permissive parenting style and again increasing the risk of weight gain.

Lastly, parents described their children as being ‘emotionally sensitive’ both in terms of their own emotions and those of others (i.e. they appeared to be highly attuned to the emotional needs of others). This may again be a consequence of the child’s weight, due to the impact upon their self-esteem meaning that they become more sensitive to criticism from others (French,

Story, & Perry, 1995). Depression and anxiety amongst obese children is reported to be common and may also contribute to children seeming hyper-vigilant to the emotions of others (French, 1995); particularly as both separation anxiety and social phobia have been found to be the most prevalent of the anxiety disorders amongst obese children (Vila et al., 2004). Children who are rejected (or actively disliked) or neglected (i.e. socially excluded) have been reported to show substantially more social anxiety than accepted children (La Greca & Stone, 1993). Amongst obese children, due to stigmatisation, they are often prone to social exclusion and are therefore vulnerable to experiencing negative emotions as a consequence (Schwartz & Phul, 2003). Hypervigilance may also serve as a protective function to obese children as being able to read the emotions of others may be helpful in reducing the possibilities of being victim to stigmatisation (or bullying). Emotion-focused coping skills such as distancing self from stress inducing stimuli, reappraisal of self and escape or avoidance of the situation are all ways children might cope with bullying (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Being able to read the emotions of others may enhance the effectiveness of these by helping the child to assess and predict possible ‘dangers’ (i.e. criticism/bullying) in situations with peers, making them easier to avoid.

**Parental experience**

On describing their experiences of parenting an obese child, it was common for parents to report feeling responsible, worried about the health and social implication of their child’s weight, worried about the future (including further weight gain and bullying), worry about the views of others (feeling judged), frustrated by the weight and trying to make sense of it. These findings are similar to those reported by Jackson and colleague’s (2007) who found that overall mothers felt responsible for their child’s weight; worried about their child’s weight in the future and felt judged by others. However, they also reported that mothers felt blamed by their partners, worried about how best to help their child and pressure to be a positive role model for their child. These were not replicated by the current study. However, findings from the current study also support the idea that the experience reported by the mothers of obese children is often contrary to the somewhat simplistic representation commonly portrayed by the media, that is mothers are either uncaring or lazy (Mitchell, 2002; Teutch, 2002). In light of this Jackson and colleague’s (2007) suggest that the inclusion of fathers is particularly important in research around childhood obesity as the experience and portrayal of fathers is less well known, due to mothers being the primary focus of research into parenting and childhood obesity. The current study found little difference between the experience of mothers, fathers and a step-parent, suggesting that it may be important for all parents to be included in intervention and research related to childhood obesity. As well as for professionals to ensure that parents are aware of their having a non-blaming, non-judgmental stance. This may have important implications on the way which help is sought and adhered to by parents.

Haugstvedt, Graff-Iversen, Bechensteen and Hallberg’s (2011) qualitative study also reported that parents worried about the stigmatisation of their child (which they wanted to protect them from); they felt insecure about setting ‘limits’ for their child, and felt that questions were raised around their parenting in light of their child’s weight (feeling judged); in general parents accepted their children whilst hoping for change however they also felt ambivalent to acknowledging their child’s weight as being a problem. This last theme connects with the ‘barriers to change’ category in the current study. It was common for parents to delay taking action on their child’s weight due to the belief that their child would grow out of their weight or that the child was too young to start worrying about it. It is important that parents become aware of the potential difficulties associated with their child’s weight as this helps to motivate them to start making changes (Ginger, 2006).

What this study helps to highlight is that parents are often very concerned and worried about their child’s weight but may not know exactly what needs to be done in order to change things; this may contribute to them ‘delaying change.’ Participants described trying to be ‘good’ parents (i.e. doing their best for their children) however they also appeared to find it difficult to tackle their child’s weight and to have conversations with their children about how they really feel about it. One reason behind this may be that facing the child’s weight directly, either through engaging in a committed way with intervention or by having open conversations with their child, may impact upon what their perceptions of being a ‘good’ parent are. For example, the risk that addressing the child’s weight could lead to upset and discomfort for the child and the parents (Keating, Russell, Cornacchione, & Smith, 2013), this may be an uncomfortable prospect for parents who have tried to do their best for their children (driven by their own past experiences).

In relation to family processes, it appeared that some of the parent’s experiences of their child’s weight may have also influenced other factors including their consideration of change as well as their overall parenting. Feelings of responsibility, guilt, worry and upset were all commonly reported. These feelings may have interacted with certain features of their parenting including ‘wanting to protect’ and ‘wanting to ensure their happiness’ meaning they found it difficult to witness the negative emotions related to their child’s weight; especially in light of the understanding that being overweight may lead to low self-esteem in children (Nowicka et al., 2009) possibly motivating parents to want to protect their children by avoiding the problem and thus disturbing the child as little as possible (Haugstvedt et al., 2011). Parents may have also been more motivated to further satiate, give-in to their child and find it even harder to say ‘no’ (again contributing to their already permissive parenting style) in an attempt to ensure their child’s happiness. Parental experience also seemed to interact with the families overall emotional context (that of ‘being happy and close’). Parents may have tried to ensure this was maintained, leading them to protect their children from any negative weight related experiences through their permissive parenting style. However, it was apparent that despite their best efforts, it was not always possible for parents to protect themselves and their children from acknowledging the child’s weight, with ‘identifying moments’ meaning that on occasion it was highlighted as a problem (Laurent, 2014).

**Identifying moments, attempting change and the barriers**

Research has suggested that it is often difficult for parents to recognise their child as being overweight, commonly underestimating the value of the child’s weight or showing a lack of concern about the associated risks (Towns & D’Auria, 2009). In the current study, there were certain experiences that seemed to expose the child’s weight as being a problem. These included going shopping and finding it difficult to find clothes that fit, external sources highlighting the child’s weight as an issue (including the GP, the child’s school and the child’s peers when they bullied) and also family teasing about the child’s weight. The role of the health care provider (HCP) in supporting parents to recognise their child’s weight was also reported by Laurent (2014). Parents who reported negative interactions with HCP’s that had left them feeling blamed, shamed and isolated were more likely to terminate care with that HCP or to seek advice from elsewhere, having a potentially negative effect on the families engagement with a weight management programme.

Although some ‘identifying moments’ often seemed to be associated with negative emotions for both the parent and child in the current study, they also seemed to be useful as they limited the families’ propensity to want to avoid the problem. Avoidance was most apparent though parents believing that their child would ‘grow out of their weight’ or that the child was too young for the parents to be worried about their weight, contributing to their delaying of change. Avoidance is a commonly used cognitive strategy which helps individuals to supress unwanted or distressing thoughts from being in current awareness (Borkovec et al., 2004). In terms of family functioning avoidance does not contribute to an ‘open’ communication style which is one of the facets of positive family functioning (Halliday et al., 2014). Parents may wish to avoid identifying or labelling their child as overweight due to fears of stigmatisation (Latner & Stunkard, 2003). In addition some parents may lack understanding around the meaning of ‘overweight’ and its relationship with other diseases (Jain, Sherman, Chamberlin, Carter, Powers, & Whitaker, 2001; Rich, DiMarco, Huettig, Essery, Andersson, & Sanborn 2005).

The use of humour in families as a way of identifying the child’s weight (i.e. ‘family teasing’) was also an interesting theme. It seemed that families adopted this strategy as a way of ‘making light’ of the situation and therefore avoided seeing the weight as being problematic. Research looking into the way in which obese adults may cope with stigmatisation around their weight found that 79% of women and 91% of men used humour, witty come backs or jokes (Puhl & Brownell, 2006). Thus it may be that family teasing is also a way of coping with some of the negative effects of the child’s weight. The use of humour may also be a positive feature within these families as it is thought that when faced with a stressful situation individuals using humour to a greater extent can show enhanced performance and tend to appraise the situation in a more positive way rather than focusing on the negatives (Dixon, 1980). Family teasing was also reported in Shrewsbury and colleague’s (2010) qualitative study which suggested that it was more consistent with a ‘direct’ style of communication. Therefore family teasing may be valuable in that it is a rare moment when the child’s weight is communicated about in a ‘direct’ way. Parents who are able to recognise their child as being overweight are more likely to encourage them to diet (Neumark-Sztainer, Wall, Story, & van den Berg, 2008). However, it has also been reported that humour can act as a coping mechanism, helping individuals to distance themselves from negative stimuli (Kuiper, Martin, & Olinger, 1993). It may thus contribute to the families’ avoidance of the child’s weight and their delay in taking action.

In a related vain, most parents reported finding it difficult to have conversations about their child’s weight. This seemed to relate to them not wanting to make the child’s weight into ‘too much of a problem’ or having difficulty knowing what to say. Interestingly this difficulty appeared to contradict with features of the families overall emotional context; specifically that communication was viewed as ‘open’ by most parents. Most parents believed that their child would feel comfortable talking to them about anything. However it was clear that none had discussed the child’s weight with them in an in-depth way, including the associated emotions and experiences. It may thus be important to consider how the emotional context of these families could influence their ability to communicate about a potentially negative or emotional topic (i.e. childhood obesity).

Research investigating family communication around childhood weight has further commented on the difficulties it can bring. Studies such as that conducted by Shrewsbury and colleague’s (2010) have reported that in general, adolescents and parents prefer to use ‘indirect’ methods of communication (e.g. focusing on the eating or activity levels of the child). The current study found similar results in that change was often talked about in terms of what the child should not eat, as well as how they could become more active than they already were. Other than ‘family teasing,’ ‘direct’ or ‘open’ conversations around the child’s weight were not reported by participants. Shrewsbury and colleague’s (2010) study makes some useful recommendations based on the general preference for ‘indirect’ communication (i.e. to encourage parents to provide an environment that supports more healthy eating behaviours and physical activity). However, it is also important to consider the fact that parents of obese or overweight children often fail to recognise their child’s weight (Doolen, Alpert, & Miller, 2009) and thus the avoidance of direct discussion in some families may actually be counterproductive. Furthermore, providing an environment encouraging healthy eating may lead the parent to restrict access to certain foods. Most parents in the current study reported doing this in attempt to manage their child’s weight. However, it is well documented that restricting certain foods may inadvertently lead to weight gain in children (Faith et al., 2004; Fisher & Birch, 2002, 2005; Lee, Mitchell, Smiciklas-Wright, & Birch, 2001).

It is interesting to consider how ‘identifying moments' may relate to pre-existing theory around health behaviour change. The Health Belief Model (Hochbaum, 1958) is one of the best known and most widely used theories in health behaviour research (Carpenter, 2010). The model suggests that change is influenced by people's beliefs about health problems, the perceived benefits of action, the barriers to action and [self-efficacy](http://en.wikipedia.org/wiki/Self-efficacy) (Janz & Becker, 1984). It also suggests that a stimulus, or ‘cue to action,’ must be present in order to trigger the health promoting behaviour. In the current study the parents ‘cues to action’ may be their experience of ‘identifying moments’ in which the child’s weight was exposed as being a problem, along with their ongoing experience of parenting an obese child. However, due to their desire to ensure the happiness of their child, the influence of these ‘cues to action’ (or ‘identifying moments’) on the child may have been somewhat diluted. This may have impacted the child’s apparent level of willingness and/or motivation to change, factors that were raised within the current study as being ‘barriers to change.’ Therefore in relation to Prochaska’s (1979) Trans-theoretical model of behaviour change (used to help assess an individual's readiness to act on a new healthier behaviour), it seems that parents and children may possess different levels of ‘motivational readiness’ along the continuum of behaviour change (Heimlich & Ardoin, 2008). That is, parents in the current study appeared to shift between the stages of ‘contemplation’ (where an individual begins to recognise a behaviour as being problematic, and starts to look at the pros and cons of their continued action), ‘preparation’ (meaning a person is ready for change and starts to take small, initial steps towards change) and ‘action’ (specific and overt modifications to behaviour are being made); whilst children appeared to lag behind, remaining at the ‘pre-contemplation’ stage of change (i.e. no intention to start behaviour change and may not be aware of problematic behaviour). Neither the parent nor child appeared to achieve the ‘maintenance’ stage of change (where behaviour change is sustained for more than six months). It is interesting to consider whether this may be due to the mismatch between the parent’s and child’s stages of change, and whether this may be related to the interactions between them (e.g. parent’s propensity to protect their children from experiencing negative outcomes of their obesity).

In relation to the participants overall family context (described as ‘happy and close’) literature around the families of adolescents with an eating disorder, reports that it is also common for these families to present themselves as being ‘happy’ and ‘exclusive’ with few external pressures (Heron & Leheup, 1984). Authors of this research proposed that within these types of families, ways of individuating are limited and so gradually the child becomes unable to identify what their own needs might be (leading to changes in weight). Although obesity is not an ‘eating disorder,’ it is interesting to note how the overall emotional context of a family may influence a child’s eating behaviour during their development.

Finally, it is interesting to consider the relationship between parenting style and the emotional context of the family, thinking about the wider influences on their development. Family ethnicity has been considered to be an important factor which may influence parenting style and family functioning, due to differences in family systems variables such as family structure and intergenerational value (McGoldrick, Giordano, & Garcia-Preto, 2005).There is however, little research investigating ethnic minority families and their use of family based health behaviour programs or parenting styles and family functioning (Wilson, 2009; Wilson & Kitzman-Ulrich, 2008). The current study also highlights the importance of the past experiences of parents and how this may influence their parenting style and the emotional context of the family, a factor that has not previously been reported within literature around childhood obesity.

**Conclusion**

The current research highlights the importance of systemic and relational aspects in the aetiology and maintenance of childhood obesity. Indicating that the interactions between parent and child may contribute to a child’s weight gain, and that the consequences of the child’s weight as experienced by both parent and child, may also lead to its maintenance (via feedback to the individual characteristics of both parent and child, which in turn may influence the interactions between them). The past experiences of parents and how these may influence parenting style was also found to be an important factor, influencing the overall emotional context of the family, the interactions between parent and child and ultimately the child’s weight status.

Childhood obesity is a complex condition involving interaction between multiple factors such as genes, the environment as well as the family system. Each overweight child should be considered individually with the aim of mapping out all of the possible contributing factors for *that* child and their family (including past and present factors) so that treatment may be adapted to suit their individual needs (please see clinical implications below).

**Strengths and limitations**

**Strengths**

Due to the stigmatisation of obese children and their parents, it may have proved difficult to recruit parents of obese children for research (Phul & Latner, 2007). However, one of the key strengths of this study was that a wide range of participants were recruited, including mothers, fathers and a step-parent. The literature also indicates that single parent families are at a greater risk of having an obese child, it was therefore important to include single parents in the current study (Gibson et al., 2007). Of ten participant’s, six were married, two were divorced, one was separated and one was single (see table 1). Participants also had a wide range of ethnic origins and ages ranged from 35 to 48 years old. The sample therefore appears to be representative of a diverse range of parents of obese children.

A second strength was the use of various credibility checks and triangulation methods in order to ensure quality was maintained, as well as allowing for the validation of the categories and the emerging theory (Madill, Jordan, & Shirley, 2000). Both supervision and peer-support from the Royal Holloway Grounded Theory Trainee Support Group provided opportunities for the validation of the initial coding table, ensuring that ‘sense and clarity’ was maintained (Charmaz, 2006). This helped the researcher to identify all themes that may have been present in the data and not to miss anything that may have been important; as well as ensuring that the labels and interpretations were a good fit for the data.

To ensure that codes did not overlap and that higher order themes captured lower order themes, internal supervision was used. Following the initial analysis of data in order to validate key themes and draft a model, a face-to-face consultation was carried out with a clinical member of staff from MEND who had supported most of the participating parents in the weight management program. This helped to increase the quality and clarity of the findings. These features of the research helped to ensure results were coherent, a factor held to be important in the design of good qualitative research (Patton, 2001).

Feedback from a service user on the interview schedule before data collection was also helpful in ensuring clarity and sensitivity around the questions asked. Whilst email feedback may have been less informative than face-to-face feedback, it was a way of ensuring that service user feedback was obtained within the time constrains of the project. Furthermore at the end of each interview all participants were asked what the experience had been like for them. This was in line with Kvale and Brinkmann’s (2009) suggestion that asking participants about their experiences of being interviewed can help to strengthen the validity of a qualitative study. Feedback from participants suggested that the interviews had been positive for most, they had enjoyed talking to someone about the experiences associated with their child’s weight, an opportunity they felt they rarely had. Many also commented on how they felt that it may now be a good idea to start doing something about their child’s weight (the researcher suggested contacting the GP for additional support when it was appropriate), a possible indication of the usefulness of talking openly about childhood obesity and family functioning with parents.

Lastly, the use of a reflective diary (Appendix 1) and the writing of memos (Appendix 10) throughout the research was helpful in shaping the research questions. As well as capturing the researcher’s thoughts about their potential influence on the study findings.

**Limitations**

As a part of the DClinPsy course and ethics committee requirements a literature review was carried out prior to data being collected and analysed. This goes against the principles of Charmaz (2006). However to counter the effects of this, during analysis the researcher focused on what was emerging, using the actual words of participants and making continual comparisons within and between data to ensure that the emerging theory was heavily grounded in the data (Charmaz, 2006). In addition the researcher attempted to ‘bracket’ any prior assumptions before data collection was commenced. Care and attention was also taken during interviews to watch for when questions might be leading. Validation of the study’s findings with a participant would have further enhanced quality checks of the study however due to time constraints this was not carried out (Elliott et al., 1999).

Participants in this study were all recruited from a weight management program that runs in one London Borough. This may therefore limit the external validity and generalisability of the findings to other areas in London and the UK; as well as to parents who are not accessing a weight management program. In addition, it may be that parents who agreed to take part in the present study were those with a more positive outlook on their child’s weight status and family processes and therefore, parents and families facing additional challenges may not have been captured. This may have had a limiting effect on the generalisation of the findings. Although the emergent model from grounded theory is aimed to be relevant to the population sampled (Corbin & Strauss, 1990), it would have been clinically advantageous for the model to be applicable to families not currently accessing a weight management group.

As with any retrospective study there may have been a risk of bias in the participant’s recollection of prior experiences (Kazdin, 1998). This may have compromised the reliability of the study. The predominant media and research portrayal of childhood obesity being related to parents (particularly mothers) may have led to desirability effects (Jackson et al., 2007). In addition previous research has found that mothers who participate in research are more likely to be influenced by cultural and societal expectations of being a parent, again leading to potential desirability effects (Paulson, Dauber, & Leiferman, 2006). The researcher attempted to reduce these biases by including fathers in the research, ensuring the anonymity of the participants, emphasising confidentiality and clearly outlining the purpose of the research as trying to understand family processes and parental experience in relation to childhood obesity.

In light of genetic factors being associated with childhood obesity (Sørensen et al., 1992) it may have been useful to collect data relating to the weight status of the parents, in order to assess for familial patterns of overweight and how their own experiences may have influenced the family system as a whole. In addition, Fisher, Terry and Ransom (1990) suggest using a multi-dimensional family assessment which includes observation of family interaction, interview, taking a history and self-report. Arguing that such a comprehensive assessment with multiple measures is likeliest to give a reasonable picture of the system as a whole. Due to time and resource limitation, multiple measures were not used, however may have been helpful in providing more detailed accounts of the family interactions and process at work.

Although the interviewing of participants in the current study appears to have allowed the researcher to gain in-depth access to the parent’s individual experiences, it is difficult to assess systemic variables by hearing from only one member of the family system. This is due to the fact that family systems are made up of multiple individuals and the way that they interact with one and other is of key interest when studying ‘systemic factors.’ Using alternative methods may have allowed the researcher to gain a better understanding of the multiple perspectives within these families, providing a more accurate representation of the potential systemic variables at work. Alternative techniques that could have been used include focus groups and observations. To further increase the level of depth and accuracy of the material gathered, the triangulation of different methods would have also been useful for example, conducting interviews with parents followed by an observation of a family meal time (Borra, Kelly, Shirreffs, Neville and Geiger’s (2003) study is a good example of more than one qualitative method being used).

According to Charmaz (2006, p.189) data saturation is the point at which gathering more data about a theoretical category reveals no new properties nor yields any further theoretical insights about the emerging grounded theory.It is often felt that researchers claim to have achieved saturation but are not necessarily able to prove it (Bowen, 2008; Morse, 1995). Within the current study it is unlikely that all of the categories reached the point of saturation. This is due to there being a relatively small sample size as well as the heterogeneity of obesity in general meaning that there is no one ‘obesity.’ Despite the common presentation, it is often the result of a complex interrelationship between multiple factors. Family systems are also heterogeneous, making it a challenge to research obesity and family systems in relation to each other. Ritchie, Lewis and Elam (2003, p.84) suggest that studying a heterogeneous population is a factor that may limit a researchers ability to reach the saturation point.

**Evaluating the grounded theory**

Charmaz’s (2006) criteria were used to evaluate the present research in terms of its credibility, originality, resonance and usefulness.

**Credibility**

Credibility was achieved in the current study through reviewing the literature both before and after data analysis, allowing the researcher to develop sensitising concepts; reading and re-reading interview transcripts in order to assess for negative cases and to ensure that emerging codes and categories remained grounded in the data. Theoretical sufficiency was achieved through the interviewing of ten participants using an in-depth method of data collection. Logical links between analytic arguments and analysis were constructed via constant comparison between data sets as well as memo-writing. Finally, evidence of the researcher’s claims was provided through presenting quotes of extracts from interview transcripts to illustrate conceptual links between the data, also allowing readers to develop their own opinions of claims made by the study.

**Originality**

Ways in which the current research ‘challenges, extends and offers new insights to current ideas,’ (Charmaz, 2006) have been discussed through comparing findings with existing literature. The social and theoretical significance of the research has been addressed through the discussion of the clinical implications of the research in informing the assessment and treatment of childhood obesity.

**Resonance**

The concept of ‘resonance’ relates to portraying the fullness of the studied experience. Including mothers, fathers and a step-parent in the current study ensured that the experience of parenting an obese child was investigated from multiple perspectives, including multiple family contexts and different ages of children (and therefore a varied number of years parenting experience) helping to reveal the complexity associated with the studied phenomenon. The researcher has also sought to reveal taken-for-granted meanings in the data, as well as to contextualise the data within the social context of the UK.

**Usefulness**

According to Charmaz (2006) the ‘usefulness’ of research is defined by the way in which interpretations can be made by people in their everyday lives, speaking to generic processes, and contributing knowledge to make a better society. Through grounding the construction of the analysis in the participants’ accounts, the analysis and findings in comparison to the existing literature can be applied to people’s everyday worlds, and used by others working in the area. These findings may have implications for professionals such as nutritionists, GP’s and teachers, working in the realm of childhood obesity, as well as relating to direct work with overweight/obese children and their families.

**Reflections on the epistemological position**

The epistemological position of social constructionist grounded theory suggests that the researchers themselves construct and influence the social world, rather than representing it as an independent reality (Hammersley & Atkinson, 2007). Charmaz’s (2006) social constructionist grounded theory adopts a relativist position. The usefulness of the findings generated from such studies has been questioned. This is due to the multiplicity of accounts produced each being able to claim legitimacy (Hammersley, 1992). The concern is that if a piece of research is not contributing to knowledge in a meaningful way, then its usefulness may be questioned, particularly in relation to health care research (Murphy, Dingwall, Greatbatch, & Parker, 1998). However, Charmaz (2003, p.250) suggests that social constructionist grounded theory “assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and viewed, and aims toward an interpretive understanding of subjects’ meanings.” This process is supported by the researcher’s constant reflexivity about the research process and their own assumptions. However, it is not yet clear whether more is required than just the recognition of the role and contribution of the ‘active researcher.’ It has been suggested that a social constructionist perspective may be enhanced by taking into account the role of language in the construction of categories, this would mean engaging in a type of ‘discourse analysis’ which would in turn transform the current version of social constructionist grounded theory into something entirely different (Willig, 2008).

Grounded theory fitted well with the aims of the current research which were to explore how family process and childhood obesity may interact, as well as understanding the experience of parenting an obese child. Due to the complexity of the studied topic as well as the fact that it is an under researched area meant that grounded theory was best placed to guide an explanatory piece of research (Willig, 2008). In addition the unbiased nature of grounded theory (i.e. being aware of the assumptions of the researcher; aiming for minimal influence of pre-existing theories and perspectives on research outcomes) was useful in being able to examine relationships and behaviour of the studied phenomenon from an unbiased and in depth perspective. This was particularly important with the current sample who have previously been found to be subject to stigmatisation within society (Jackson et al., 2007).

**Personal reflections**

With regard to Chamaz’s (2006) emphasis on the researchers’ sensitivity towards how they are perceived by participants, it was important to consider how the participant’s perceptions of myself may have influenced the accounts they provided. As a female, trainee clinical psychologist, parents may have felt pressurised to ensure they provided a positive account of themselves, their children, and their parenting, restricting the openness and richness of the data. With this in mind, I aimed to be transparent in my position as a non-judgemental researcher as well as being mindful of the way in which I reacted to participants as they spoke about their experiences.

In relation to my interests, when deciding to focus on the present study, childhood obesity struck me as such an interesting topic due to its complex and multi-faceted nature. It seemed to connect with many areas that interest me including physiology, society and the influence this has on individuals and families, viewing families as systems and understanding complex issues with the help of a systemic lens. In addition, throughout the completion of the current research project childhood obesity has received an increasing amount of attention in the media. In light of this I was aware of trying to understand and think critically about new pieces of research being reported on. It was also important to consider how the media representation of childhood obesity may have influenced the way that parents felt talking to me. I wondered if they felt more or less blamed, more or less judged and more or less stigmatised following media coverage.

With regard to my clinical experiences on the research, during data collection I was on placement with a specialist child and adolescent mental health outreach team. Work on the placement was highly systemic in its nature, and I was mindful of how my developing skills in formulating the mental health needs of children (and their families) through a systemic lens may have influenced my approach to the current research, including my interpretation of the data. In light of this, I was careful to question my interpretations and ensure that the analysis remained grounded in the data, reading and re-reading the transcripts several times help me to do this.

Furthermore, in light of the widely documented social stigma attached to obesity, I was mindful that I too was not exempt from making judgements or assumptions about the families I heard about. In response to this, I attempted to remain empathetic towards parents and the children they spoke about, taking an open minded and accepting approach to the difficulties that they face, ensuring that assumptions did not guide my data collection rather data collection was guided by the accounts provided by participants.

**Clinical implications**

In terms of the clinical implications from the study, it is useful to refer back to the model developed from the data (figure 3). As the model suggests, childhood obesity appears to be connected to a wide range of contributing factors. It is therefore a difficult and complex condition to assess and treat. In light of this, it would seem reasonable to consider the role of a skilled practitioner in being able to assess what the possible contributing factors may be for an overweight child. Considering factors related to biology, psychology (including aspects of family functioning) and society, would be beneficial (a ‘biopsychosocial’ approach; Engel, 1981); as well as considering how they may influence one and other. Gathering a clear picture of the influencing factors behind each child’s weight and their family context would help to ensure that treatment is individualised, and therefore better able to address the specific set of needs and circumstances for that individual and their family (this is in line with guidance from the National Institute for Health and Care Excellence, 2013).

A second implication of the study is around understanding the history behindparenting. When considering the role of parents and parenting in families, it appears that it may be helpful to explore the past experiences of parents in order to inform how and why certain parenting styles have been adopted. Understanding why certain parenting styles have developed may help parents to become more insightful and mindful about the strategies they currently use, particularly if offered alongside parenting skills advice.

Lastly,supporting parents and children to have more in depth and open conversations about the child’s weight including the various feelings and experiences, may help to ensure that attempts to manage weight are sought out at the earliest possible opportunity, a factor which is likely to enhance the effectiveness of intervention (Edmunds, 2005). One way of enhancing communication about weight may again be through understanding what the historical influences are on family functioning (i.e. why a parent can talk openly about something’s but not others, is this related to their own past experiences?).

In addition, it may be that giving families the opportunity to talk with a professional about their experiences would be helpful in them acknowledging the child’s weight as being an issue; allowing them to then take action in an open, committed and realistic way. Therapeutic techniques which aim to increase motivation toward health behaviour change (such as motivational interviewing; Rollnick & Miller, 1995) may be useful in supporting children and parents to become more aware of the need for change, as well as encouraging children to become more likely to engage with change. This would be helpful in narrowing the gap between the parents and child’s stages of change suggested by the current study (Prochaska, 1979). Ongoing emotional support may also help families to make better sense of the experiences associated with a child’s weight status, in order to prevent these experiences and the associated emotions from feeding back to the parent and child, factors which may contribute to the problem being maintained.

**Future research**

* The cultural differences between family functioning and the influence this may have on a child’s weight requires further investigation, especially in light of the fact that children from ethnic minority backgrounds are more vulnerable to becoming overweight (Kitzman-Ulrich et al., 2010).
* The influence of parent’s past experiences on their parenting style and the emotional context of the family should be explored in relation to the aetiology and maintenance of childhood obesity.
* The way in which family members communicate about a child’s weight status should be further explored, especially in relation to how this might influence a family’s engagement with treatment and how it may contribute to the maintenance of a child’s weight through its possible interaction with parenting style.
* It may also be helpful to include the perspective of overweight children in research around family functioning and the experience of childhood obesity, comparing their experience with those of their parents and/or siblings. This may help to highlight how effective parents are at protecting their children from some of the possible negative weight related experiences such as stigmatisation and low self-esteem.

**Final comment**

This was a qualitative study investigating the experience of ten parents of obese children. Interviews were collected and analysed using the technique of grounded theory. The study appeared to show that parents of obese children are often ambivalent towards being able to acknowledge their child’s weight status in a meaningful way (that is in an open, honest and accurate way). This means that they are often unable to commit to making changes which could lead to long term weight loss. Repeated failed attempts at weight loss means that unhealthy eating and activity behaviours go un-changed and the child’s weight status is maintained. The data gathered provides an account of parents starting to make sense of their child’s current situation. Over the course of the interviews parents began to identify factors both past and present that may have contributed their child’s weight. Of significance, it appeared difficult for parents to acknowledge their own role in their child’s weight gain and also their failed attempts at weight loss; alternative explanations were often sought for example the consideration of genetic factors, child characteristics and the role of modern technology. In the current study, parents’ abilities to take responsibility for the child’s weight status appeared to be hindered by a strong desire to maintain the status-quo in their families, this means avoiding upset at all costs. The topic of weight or weight loss was therefore avoided and parents found it hard to say ‘no’ to their children. Supporting parents to be able to talk more openly about themselves and their families may contribute to them developing a greater level of insight into their child’s weight status. This may help them to access help and support in a more realistic and committed way, leading to sustained weight loss and the development of healthier life styles.

As a final comment, it is important to remember that obesity may not reflect dysfunctional aspects of a family system. Many happy, healthy and well-functioning families may have an obese member (Harkaway, 2000).

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**Appendix 1: Excerpts from the research diary**

**Reflections following recruitment time 1, Sat 11th of October 2014:**

The group was held in a leisure centre and so it immediately felt that weight issues were related to physical aspects rather than anything else (e.g. psychological or social).

The group leaders were very warm and welcoming of the children and parents. The children seemed very engaged and appeared to find the activities fun.

Things noted were that the group was overwhelmingly attended by mothers and their children, there were no dads present at all when I arrived. The people accessing the group were from a very wide range of ethnic backgrounds, some with no English language. Some of the mothers were quite difficult to talk to and seemed reluctant to engage with me. I wondered whether this was due to them feeling a sense of shame about having to be there and that talking to someone 'external' may highlight their being there because of something negative (i.e. their child being overweight). The group was heavily focused on nutrition and exercise. I wondered again about the psychological aspects of their attendance to the groups.

Some people were happy to listen to me talk about the research, others really not wanting to engage.

**Reflections following recruitment time 2, Sat 18th of October 2014:**

Slightly different feel to the group this week as there were some fathers present (2 noticed) however the majority was again, mothers. At this point, I reflected on how the low attendance of fathers to the group may impact upon my ability to recruit them for the study. I also thought about why it seemed to be mostly the mother’s role to take their child to the group, considering their probable role in determining what the child and family eats at home as well as possibly holding more of an emotional role within the family. Do fathers find it more difficult to engage with things that have an emotional aspect, including coming to the group and possibly taking part in my research project? Most parents present this week had been recruited last week so it was more difficult to engage those that didn't want to talk to me last week.

I noted that it was much easier to have conversations with parents outside of the main activity room, and thought that this may be because it was much quieter and a bit more private. Most of the parents seemed to enjoy talking about their experience, and some had a lot to say about their experiences so far however, some did then not wish to take part in the research. The main reasons for this seemed to be around having a lack of time ('being busy Mums); having poor English language; having had very difficult experiences in the past (e.g. depression in both child and parent, concerns around the child being bullied at school) and feeling that they're in a 'better place' now so not wanting to open up the past; in some cases no reasons were given and I thought that perhaps the parents may not have been interested in giving up time for free, or be willing to talk to a stranger?

Again, I was struck by the cultural diversity at the group and thought about how the different cultural views on health may have impacted the children’s weight statuses. I had a long conversation with one mother outside the main activity room, she shared her daughters’ experiences of being bullied at school, it seemed very difficult for the Mum to see her child being unhappy and also very difficult for her to then restrict what food she consumed as it was a source of comfort and something that reduced the level of unhappiness of her child in the short-term.

However, overall the group seemed to install a sense of positivity and hope, some teenagers expressed that they liked it and felt very positive towards losing weight.

**Reflections following interview with participant 1, October 2014:**

During and after the interview, I felt privileged to have had the opportunity to have such an in-depth and interesting conversation with the participant. The participant was so open and honest in the way that she responded to my questioning and I was struck by how readily she appeared to share her experiences with myself (an unknown person to her). I reflected on how the research process involving in-depth interviews relies heavily on trust and I wondered how this level of trust had been established between the two of us in such a short amount of time. This led me to consider my dual role as both an in-training therapist and as a researcher. It felt as though my developing skills as a therapist had been drawn upon for the purposes of the interview. I noticed myself thinking of key therapeutic concepts which I hold to be important within my clinical work for example building a therapeutic relationship, being client centred, being transparent and clear about my role. I also found myself wanting to respond to the participant in ways I might do in a therapeutic setting. Responding therapeutically was ethically appropriate in terms of the emotions that arose during the interview. However, I was aware of balancing this with the information gathering purpose of the interview. The semi-structured interview schedule was useful in directing me back to the purpose of information gathering.

When I asked the participant the first question about her family, I found myself wanting to draw the family system out visually (as a genogram) so that I was sure I had a clear understanding of the family in my mind’s eye, as well as helping me to be clear about the relationships between a complex family. I think this was helpful in being able to see, visually where in the family the identified child (overweight/obese) was positioned, and what the family context was around her. Things that I noticed from this were that the overweight child was the youngest in a large family, with three older brothers (aged 9, 25 and 27). The child was also the only girl, and was already an aunt herself. I wondered how she may have felt within this large family system, being the youngest and long sought after girl. The mother herself came from a large family, being one of nine children. She described her childhood as being highly religious and without the luxuries of today; her parents had emigrated from Jamaica and were always short on money. She seemed to really value the opportunity to now provide an enriched childhood to her children; she wanted to ensure that they did not have to experience the hardships that she had once had to. The participant struck me as being such a strong and independent woman, she was determined to make life positive for her children, and seemed to have learnt a lot about parenting from bringing up her first 2 children with her first partner. I was very moved when she began talking about her unplanned pregnancy at the age of 17, although supported by her parents I got the sense that it was not something she had wanted for her life. Despite this she managed to remain strong and to look after her child independently, carving out a family life for herself, partner and her children. Now as an older parent, she seemed to reflect back on the way that she had parented her children in the past, learning from her mistakes, and carrying positive points forward. She seemed to be much more relaxed now as a mother, compared to the earlier years with her older children (when she described herself as being much more anxious). It wasn’t that she didn’t care anymore, but seemed to have adopted a much more philosophical stance to mothering which felt like a ‘what will be, will be’ kind of attitude.

I noticed that throughout the interview humour was used a lot by the participant. This seemed to be partly to do with the participant’s generally positive outlook on life, with laughter being a way of coping with hardships. It also seemed to be a large feature within her family, ‘having a laugh’ was referred to on several occasions. I wondered whether this was a result of positive interactions between family members and trying to ‘look on the bright side of life’ and/or it was a way of reducing the level of distress associated with difficult experiences, such as childhood obesity. This lead me to think more carefully about how family members may relate to each other, having developed complex and ingrained interaction processes and ways of coping individually and as a whole such that they may be more difficult to observe than I first thought as often the individual will not even be aware of them themselves.

During the interview I felt that the participant and I had developed a good rapport, this seemed to create a sense of safety and allow the participant to open up. When transcribing the interview, I noticed several points the participant had made that I wished I had followed up at the time. However, I was mindful that it is impossible to follow up on everything the participant says during the interview and that it is much easier to see these points when at a distance from the data (i.e. when transcribing).

**Reflections following interview with participant 4, October 2014:**

The interview with participant four was again conducted at her home. When I arrived she was very warm and welcoming however explained that her son who is severely disabled (physically and mentally) is due to arrive back from school in the next hour. We therefore agreed that we would make sure the interview did not last longer than an hour, it was the shortest interview conducted (50 mins). The participant was a Somalian woman who again was very open and honest in her responses to my questions. I had wondered how her cultural beliefs and values may impact upon her ability to feel able to answer my questions, however she appeared to enjoy talking to me and shared lots of information about her family as well as her own experiences growing up in Somalia. I was struck by the way that relationships between men and women are constructed differently within her culture, she described having a relationship with a man who had had multiple wives. The participant seemed to find it difficult to talk about emotions related to her experiences, I felt this was perhaps due to her matter-of-fact way of viewing things and wondered whether this was part of her culture. She expressed vast amounts of love and care about her children, she again expressed a desire to provide them with a positive experience of childhood, not wanting them to be unhappy – ever. I wondered about this common theme of parents not wanting to see their children unhappy, almost afraid of what this would mean and not being able to tolerate it at all. Thoughts about this were related to the attachment between mother and child – an evolutionary process that helps to ensure the optimal development of children. I also considered how parents themselves are able to tolerate experiencing negative emotions, which seeing their child unhappy may insight. This appears to drive parents towards providing everything they can to ensure negative emotions are not experienced. Why this happens seemed unclear to me – I thought that perhaps negative emotions may be intolerable for some parents due to their own childhood experiences (and so later interviews included this as a topic to investigate in greater detail) meaning that they never learnt how to identify and cope with negative emotions in an adaptive way. Or, I wondered whether it may be related to how the parent feels as a person, what their beliefs about themselves are? For example, do they view them self as ‘a failure,’ ‘a bad mother,’ ‘not being good enough,’ or do they have low self-esteem and gain it by being ‘the perfect parent?’ These thoughts made me consider the generational transmission of psychological factors such as self-esteem, and how this may relate to parenting, family functioning and then specific factors such as eating, activity and being overweight.

After the interview with participant four, I felt excited that I had begun to hear some common things from each of the participants so far. I looked forward to transcribing the interview and beginning the initial coding. It was interesting that despite cultural difference, certain feelings and experiences within families appeared to be common in relation to childhood obesity.

**Reflections following initial coding of first three interviews, October 2014:**

When analysing the first interviews, I was aware that I had no previous experience of coding qualitative data. Although I had found Charmaz’s (2006) recommendations on initial coding useful, I felt anxious as to whether or not I was coding the data in the ‘correct’ way. I wondered whether I had stayed too close to the data, and was using the participants’ words as in-vivo codes too much. However, I also wondered whether I had been coding in a way that really captured the participants’ true accounts. I found coding became easier the more interviews I did, and that I started to be become better able at balancing the need to be conceptual with being descriptive.

**Reflections during data analysis, February 2015:**

After transcribing and coding the final interview, I realised that I had collected a large amount of data and that conducting further analysis would be quite a difficult task. I felt overwhelmed. I began the process of focus coding and this was helpful in offering slightly more distance from the data than the initial, line-by-line coding had. I began to see patterns emerging from the data. This was interesting as it felt as though the data was somehow beginning to make sense. The structure of Grounded Theory was also helpful in offering a step-by-step approach to the analysis, making an overwhelming task seem a bit more manageable. The focused and initial codes were easiest to manage in spread sheets alongside quotes from the data. Codes were then moved around so that they could be fitted into categories. This was a challenging (and time consuming) task as each code was considered from many different angles and perspectives in order to determine where it would be best placed. Once the categories had been formed, I then had the task of trying to represent their interconnectedness through a diagram. This was challenging as most of the categories could be related to each of the others somehow and so it was difficult to determine what the most significant connections between categories were.

**Appendix 2: Email from Royal Holloway University of London ethics committee**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Ref: 2014/037 Ethics Form Approved** | | | Psychology-Webmaster@rhul.ac.uk [Psychology-Webmaster@rhul.ac.uk] | | |  | | | **Sent:** | 09 May 2014 16:29 | | **To:** | [nxjt021@rhul.ac.uk](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&a=New&to=nxjt021%40rhul.ac.uk&nm=nxjt021%40rhul.ac.uk); [Riazi, Afsane](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&id=RgAAAAD5chM49gMFQp4S%2bZXtvctIBwCiQvUH6LHyR4sCtAulY5POAAAAJf7xAABob9ijr1BMT6KlWDsS6io3AACY%2bHKQAAAJ) | | **Cc:** | [PSY-EthicsAdmin@rhul.ac.uk](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&a=New&to=PSY-EthicsAdmin%40rhul.ac.uk&nm=PSY-EthicsAdmin%40rhul.ac.uk); [Leman, Patrick](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&id=RgAAAAD5chM49gMFQp4S%2bZXtvctIBwCiQvUH6LHyR4sCtAulY5POAAAAJf7xAABob9ijr1BMT6KlWDsS6io3AACY%2bHKQAAAJ); [Lock, Annette](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&id=RgAAAAD5chM49gMFQp4S%2bZXtvctIBwCiQvUH6LHyR4sCtAulY5POAAAAJf7xAABob9ijr1BMT6KlWDsS6io3AACY%2bHKQAAAJ); [umjt001@rhul.ac.uk](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&a=New&to=umjt001%40rhul.ac.uk&nm=umjt001%40rhul.ac.uk) | |
| |  | | --- | |  | |
| |  |  | | --- | --- | | Application Details: | View the form click [here](https://outlook.office365.com/owa/redir.aspx?SURL=9EK1OGfJ9wuK1G-MFyBMyGN8PYsR5yqGqhv_UfWwzeJYNCF1DVLSCGgAdAB0AHAAOgAvAC8AdwB3AHcALgBwAGMALgByAGgAdQBsAC4AYQBjAC4AdQBrAC8AUwB0AGEAZgBmAF8AaQBuAHQAcgBhAG4AZQB0AC8ARQB0AGgAaQBjAHMAQQBwAHAAcgBvAHYAYQBsAC8ARABpAHMAcABsAGEAeQBGAG8AcgBtAFIAZQB2AGkAZQB3AGUAcgAuAGEAcwBwAD8ARgBvAHIAbQBJAEQAPQAzADMAOAA.&URL=http%3a%2f%2fwww.pc.rhul.ac.uk%2fStaff_intranet%2fEthicsApproval%2fDisplayFormReviewer.asp%3fFormID%3d338)   Revise the form click [here](https://outlook.office365.com/owa/redir.aspx?SURL=OxBJY0ryVBMJXjQ-4s2AjEKR0hEi5yAl9HmbZRL_hJxYNCF1DVLSCGgAdAB0AHAAOgAvAC8AdwB3AHcALgBwAGMALgByAGgAdQBsAC4AYQBjAC4AdQBrAC8AUwB0AGEAZgBmAF8AaQBuAHQAcgBhAG4AZQB0AC8ARQB0AGgAaQBjAHMAQQBwAHAAcgBvAHYAYQBsAC8A&URL=http%3a%2f%2fwww.pc.rhul.ac.uk%2fStaff_intranet%2fEthicsApproval%2f) | |  |  | | Applicant Name: | **Alison Ram** | |  |  | | Application title: | **Childhood obesity: Investigating parental experience and family processes.** | |  |  | | Comments: | |  | | --- | | Approved.  Reviewer comments for information.   In general, I think that the potential issues have been carefully considered and addressed  and I have no substantive concerns about the project as it is currently described.  However, it sounded as if the interview schedule might be amended following feedback  from people at MEND. If this leads to any significant changes,  the schedule should be reviewed again by the ethics committee.  One smaller point: Question 1 on the consent form should read "...read AND understood..."  rather than "...read OR understood..."! | | |

**Appendix 3: Email approval from** **Royal Holloway University of London ethics committee following submission of amendment**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Ref: 2014/037R1 Ethics Form Approved Subject to Amendment** | | | Psychology-Webmaster@rhul.ac.uk [Psychology-Webmaster@rhul.ac.uk] | | |  |  | | **Sent:** | 14 July 2014 15:16 | | **To:** | [nxjt021@rhul.ac.uk](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&a=New&to=nxjt021%40rhul.ac.uk&nm=nxjt021%40rhul.ac.uk); [Riazi, Afsane](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&id=RgAAAAD5chM49gMFQp4S%2bZXtvctIBwCiQvUH6LHyR4sCtAulY5POAAAAJf7xAABob9ijr1BMT6KlWDsS6io3AAC48rLGAAAJ) | | **Cc:** | [PSY-EthicsAdmin@rhul.ac.uk](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&a=New&to=PSY-EthicsAdmin%40rhul.ac.uk&nm=PSY-EthicsAdmin%40rhul.ac.uk); [Leman, Patrick](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&id=RgAAAAD5chM49gMFQp4S%2bZXtvctIBwCiQvUH6LHyR4sCtAulY5POAAAAJf7xAABob9ijr1BMT6KlWDsS6io3AAC48rLGAAAJ); [Lock, Annette](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&id=RgAAAAD5chM49gMFQp4S%2bZXtvctIBwCiQvUH6LHyR4sCtAulY5POAAAAJf7xAABob9ijr1BMT6KlWDsS6io3AAC48rLGAAAJ); [umjt001@rhul.ac.uk](https://outlook.office365.com/owa/?ae=Item&t=IPM.Note&a=New&to=umjt001%40rhul.ac.uk&nm=umjt001%40rhul.ac.uk) | |
| |  | | --- | |  | |
| |  |  | | --- | --- | | Application Details: | View the form click [here](https://outlook.office365.com/owa/redir.aspx?SURL=JTCtI0yp2XfO7FB9utYN4dLty9lSAGpgqWakTo5e6m6seFPaDFLSCGgAdAB0AHAAOgAvAC8AdwB3AHcALgBwAGMALgByAGgAdQBsAC4AYQBjAC4AdQBrAC8AUwB0AGEAZgBmAF8AaQBuAHQAcgBhAG4AZQB0AC8ARQB0AGgAaQBjAHMAQQBwAHAAcgBvAHYAYQBsAC8ARABpAHMAcABsAGEAeQBGAG8AcgBtAFIAZQB2AGkAZQB3AGUAcgAuAGEAcwBwAD8ARgBvAHIAbQBJAEQAPQAzADkAMwA.&URL=http%3a%2f%2fwww.pc.rhul.ac.uk%2fStaff_intranet%2fEthicsApproval%2fDisplayFormReviewer.asp%3fFormID%3d393)   Revise the form click [here](https://outlook.office365.com/owa/redir.aspx?SURL=Yl-0ySSjYLwsu_nUabI4q_np1UgMH808VyWEvO0HdAOseFPaDFLSCGgAdAB0AHAAOgAvAC8AdwB3AHcALgBwAGMALgByAGgAdQBsAC4AYQBjAC4AdQBrAC8AUwB0AGEAZgBmAF8AaQBuAHQAcgBhAG4AZQB0AC8ARQB0AGgAaQBjAHMAQQBwAHAAcgBvAHYAYQBsAC8A&URL=http%3a%2f%2fwww.pc.rhul.ac.uk%2fStaff_intranet%2fEthicsApproval%2f) | |  |  | | Applicant Name: | **Alison Ram** | |  |  | | Application title: | **Childhood obesity: Investigating parental experience and family processes.** | |  |  | | Comments: | |  | | --- | | Approved subject to amendment.  Please include the info and consent form in this version and save. No need for resubmission. | | |

**Appendix 4: Participant information sheet**



**Department of Psychology**

Royal Holloway, University of London

Egham, Surrey TW20 0EX, UK

**PARTICIPANT INFORMATION SHEET**

**‘Childhood obesity: Investigating parental experience and family processes.’**

We would like to invite you to take part in a psychology research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please read the following information sheet carefully and feel free to talk to others about the study to help you decide if you wish to take part. You may also wish to talk to the project researcher, Alison Ram.

* Part 1 provides information about the purpose of this study and what is involved should you decide to take part.
* Part 2 provides you with some more information about the conduct of the study.

**Part 1**

**What is the purpose of the study?**

The main aim of the study is to explore the parental experience of childhood obesity, investigating what their experience is and how this relates to the wider family. If we can gain a better understanding about the impact of childhood obesity on parents and families, it may help clinicians to provide the families with the best support possible.

**Who is organising and conducting the research?**

The research is being overseen by Dr Afsane Riazi, a Senior Lecturer in Health Psychology at Royal Holloway University of London. The study is being carried out by Alison Ram, a Trainee Clinical Psychologist at Royal Holloway.

**Why have I been invited to take part?**

We would like to speak to people who have had, or are currently having the experience of being a parent of a child who is obese. We hope to interview up to 10 parents in total.

**Do I have to take part?**

Taking part in this study is voluntary and entirely your choice. Your decision will not affect your access to any support or treatment you may be receiving at the present time. If you decide to take part, you will be asked to sign a consent form to show that you have agreed to take part; you will also be given a copy of this. You are able to change your mind at any time and stop participating in the study. You do not need to give a reason for this.

**What will happen to me if I take part?**

If you decide to take part, we will meet on one occasion for 60-90 minutes with the researcher (Alison Ram) at Royal Holloway, your home or a confidential place in the community, whichever is most convenient for you. The length of the interview will vary depending on how much you wish to share. This meeting will be arranged to take place at a time that is convenient for us both.

At the meeting, you will be asked for some background information about yourself and your family, including age, ethnicity and the height and weight of your child. Then an interview will take place, in which you will be asked questions about the impact that childhood obesity has had on you (as a parent) and on your family. There are no right and wrong answers, and you are free to decline to answer any questions you do not feel happy to answer. If you give consent, the interview will be audio recorded and only the researcher (Alison Ram) will be allowed to listen to recordings. The recordings will only be used for the purposes of this research and will be destroyed after this purpose has been met. Some of your comments may be directly quoted when the research is written up; however, each comment will be completely anonymous. If you disclose something that suggests you or others are at risk, the researcher is obliged to act in accordance with NHS protocol and respond to concerns raised. If the researcher felt you would benefit from medical or psychological input, this would be discussed with you and the researcher would recommend that you contact the appropriate person for example your GP.

After the study has finished, the researcher will send you a brief summary of the findings from the research.

**Expenses and payments**

Taking part in the study is voluntary and you will not be paid for your participation.

**What are the risks and benefits of taking part?**

Risks: There are no direct risks from taking part, although some people may feel uncomfortable talking about their experiences. This is an understandable reaction to discussing a personal subject. However you will not have to say anything you do not want to. If you become distressed at any time, you can take a break or decide to stop talking altogether. You will also be given time at the end of the conversation to compose yourself if you need to. If you feel you need to speak to someone after the meeting, suggestions will be made to help you with this.

Benefits: We cannot promise the study will help you but it is hoped that by taking part in this research, you will be providing valuable information regarding your experiences of childhood obesity. This would be extremely helpful, because understanding how childhood obesity impacts on parents and families will help us to support families better in the future. It may also help to develop treatment approaches for helping families to cope with and understand the experience of having an obese child.

**What if there is a problem about taking part in the study?**

Any complaint about the way you have been treated during the study will be addressed. Detailed information on this will be provided later on this Information Sheet (see Part 2).

**Will my taking part in the study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. Detailed information on this is provided later on this information sheet (see Part 2).

*If the information in Part 1 has interested you and you are considering taking part, please read additional information in Part 2 before making any decisions.*

**Part 2**

**What will happen if I later change my mind and don’t want to carry on with the study?**

Even after you have decided to take part, you can change your mind and withdraw from the study at any time and you do not have to give a reason for this. The researcher will give you her contact details so that even after the interview you can let her know if you have changed your mind or wish to have parts of the interview taken out. Again you do not need to give a reason for this. Any data you do not want to include will be destroyed. Choosing to withdraw from the study at any time will not affect your access to any treatment or support you may be accessing.

**What if there is a problem?**

If you have any concern about any aspect of this study, you should ask to speak to Alison Ram (Researcher) who will do their best to answer your questions (contact details are provided at the end of this Information Sheet). If you remain unhappy and wish to complain formally, you can do this by contacting at the Department of Clinical Psychology, Royal Holloway, University of London (telephone Susan Waud on 01784 443851).

Royal Holloway, University of London, is providing negligent indemnity cover for this research. In the unlikely event that something goes wrong, you may have grounds for legal action for compensation but you will have to pay your own legal costs.

**Will my taking part in this study be kept confidential?**

Yes, we will follow ethical and legal guidelines, and all information about you will be kept strictly confidential and known only to the researchers.

All data collected during the course of the study will be held in accordance with the Data Protection Act (1998). This means that we keep it safely and cannot reveal it to other people, without your permission. The tape recording of the interview and transcripts of the interview will be given an identification number. So only the researcher will know whose data belongs to whom. The interview will be anonymous since any identifiable information will be deleted when the researcher listens to and transcribes the interview tape. You will not be identifiable in any report or publication of the results of the research.

All anonymised paper copies of information that you provide will be kept in a securely locked filing cabinet that only Alison Ram or Afsane Riazi will have access to. Similarly, the electronic recordings of the interview and any other electronic information such as the interview transcripts will be saved on an encrypted memory stick. On completion of the research, all of the interview tapes will be wiped clean.

Disclosure of information gained from the study will be shared only in exceptional circumstances. If the researcher is concerned about any risk of harm to either yourself or anyone else, these she is legally obliged to share this information with the appropriate people (for example, your GP). The researcher will always try to discuss these concerns with you first, before doing anything.

**What will happen to the results of the research study?**

The results of the study will be written up as part of a Doctorate in Clinical Psychology. Anonymised quotes from your interview may be used in the final report to help explain the key findings. The research may also be published in a journal, or presented at a scientific conference. You will not be able to be identified from any of these. You will also be sent a summary of the research findings.

**Who has reviewed the study?**

This study has been reviewed and gained approval from the Department of Psychology, Royal Holloway, University of London, Research and Ethics committee.

**Contacts for further information:**

If you would like further information about taking part, please do not hesitate to contact Alison Ram or Afsane Riazi on the details below:

* Alison Ram: nxjt021@rhul.ac.uk **or** 0203 153 319
* Dr Afsane Riazi:[Afsane.Riazi@rhul.ac.uk](mailto:Afsane.Riazi@rhul.ac.uk) **or** 01784 443601

**If you are interested in taking part you can either email or telephone Alison Ram on the details above or complete the reply slip below and return in a pre-paid envelope. Alison Ram will then contact you to arrange a convenient time to meet.**

*Thank you for taking time to read this.*

***(Tear off slip) PARTICPANT REPLY SLIP***

**- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -**

**Research study: ‘Childhood obesity: Investigating parental experience and family processes.’**

*Please tick the box to show your response and give your contact details.*

I have read the Participant Information Sheet and I would like to take part in this study. I am happy to be contacted to arrange a time to meet with Alison Ram

☐

My name is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like to be contacted by (please circle): telephone/ email/ post

My telephone number is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My email address is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My address is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Please return this slip in the pre-paid envelope, or alternatively you can contact Alison Ram on 0203 153 319 or email her on nxjt021@live.ac.uk***

**Appendix 5: Information leaflet for parents at MEND prior to researcher’s attendance for recruitment**

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**Appendix 6: Consent form**

**Consent form**  Study ID number……………….

**“Childhood obesity: Investigating parental experience and family processes.”**

You have been asked to participate in a study about childhood obesity, investigating parental experiences and family processes. The study is being carried out by **Alison Ram.**

**Have you (please circle yes or no):**

1. Read and understood the information sheet about the study? Yes/no
2. Had an opportunity to ask questions? Yes/no
3. Got satisfactory answers to your questions? Yes/no
4. Understood that you’re free to withdraw from the study at any time, without giving a reason and without it affecting your access to treatment or support? Yes/no
5. Do you agree to take part in the study? Yes/no
6. Do you agree to have the interviews audio recorded? Yes/no
7. Do you agree to providing information about your child’s height, weight, age, gender and ethnicity? Yes/no

Name in block letters \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­­­­\_\_\_\_\_\_\_\_\_\_

NB: This consent form will be stored separately from the anonymous information you provide.

**Appendix 7: Initial draft of interview schedule**

**Introductions**

* Introduce self and the purpose of today.
* Obtain informed consent.
* Explain recording, right to withdraw and confidentiality.
* Ask participant to talk in as much detail as possible about their experience. There are no right or wrong answers.
* I will be asking open questions so it may feel like you’re talking a lot, but that’s Ok, as I would like to get as much detail as possible.
* Take your time to think about your own experience.
* Any questions?

**Questions**

1. **Can you tell me about your family?**

*Prompts: How many children do you have (birth order)? What are their names, ages? Who is your partner? Draw a family tree?*

1. **Who in the family is overweight or obese?**

*Prompts: How do you know that they are obese? When did they become obese? When did you first notice this happening? How did you feel about that? And now?*

1. **What does it mean to you that [child’s name] is obese?**

*Prompt: How has this experience been for you? How does it make you feel? How do you think your partner feels about it? How do you think [child’s name] feels about it? What do you think other people think about it?*

1. **Do you think [x’s] obesity has impacted on the family in anyway?**

*Prompts: How/In what way? How are things different now? What did things used to be like in your family?*

1. **How do you feel about your child?**

*Prompts: What is your relationship like with [child’s name]? How do you interact with them? Do you notice any patterns of behaviour between the two of you? Has it always been like that (since birth)?*

1. **Do you think anyone in your family has a particular ‘role’?**

*Prompts: ‘Role’ meaning they have particular responsibilities within the family. In what circumstances does their role become particularly apparent? What is your role within the family? You partner’s? Your children’s?*

1. **If someone was looking in from the outside, how do you think they would describe your family?**

*Prompts: How would they describe all of the different relationships within it? And, all of the different personalities?*

**Ending**

1. **Is there anything else you think it would be important for me to know? Anything you would like to add?**
2. **What has it been like discussing this today?**
3. **Explain what happens now i.e. how the data is stored and how the findings will be disseminated.**

**Appendix 8: Draft 2 of interview schedule**

**Introductions**

* Introduce self, the purpose of today and state that the purpose of the interview is not to judge, blame or criticise parents, but to gain an understanding of their experiences.
* Obtain informed consent.
* Explain recording, right to withdraw and confidentiality.
* Ask participant to talk in as much detail as possible about their experience. There are no right or wrong answers.
* I will be asking open questions so it may feel like you’re talking a lot, but that’s Ok, as I would like to get as much detail as possible.
* Take your time to think about your own experience.
* Any questions?

**Questions**

1. **Can you tell me about your family?**

*Prompts: How many children do you have (birth order)? What are their names, ages? Who is your partner, how long have you been together? Draw a family diagram (ask if would be helpful)?*

1. **Overall, how are things in your family?**

*Prompts: Can you describe a typical day? How would you describe your children? Partner? How would you describe each of your parenting styles (yours and your partners)? How are decisions made in your family (who has input in these)?*

1. **Who in the family is overweight?**

*Prompts: How do you know that they are overweight? When did they start to become overweight? When did you first notice this happening? How did you feel about that? And, how do you feel about their weight now?*

1. **What does it mean to you that [child’s name] is overweight?**

*Prompts: How has this experience been for you? How does it make you feel? How do you think your partner feels about it? How do you think [child’s name] feels about it? What do other people think about it, how have they reacted?*

1. **What effect (if any) do you think your child’s weight may have had on you as a parent?**

*Prompts: Any impact on your parenting style? What might you do differently now? Has it impacted on the way that you feel as a parent?*

1. **Do you think [x’s] weight has impacted on the family in anyway?**

*Prompts: How/In what way? How are things different now? What did things used to be like in your family?*

1. **Could you describe your relationship with your child?**

*Prompts: How do you interact with them? Do you notice any patterns of behaviour between the two of you? Has it always been like that (since birth)? How does your child relate to other members in the family? How do you and your child share and/or express emotions with each other?*

1. **As your child grows older, do you think your relationship with them is changing?**

*Prompts: If so, in what way, what is different now? Is that the same for your partner too? In your opinion, what things may impact on the way that you and your child relate to each other?*

1. **Do you think anyone in your family has a particular role?**

*Prompts: By ‘role’ I mean, someone that holds particular responsibilities in certain situations, these may be emotional roles and/or practical roles [\*if still unsure offer more detail explanation below]. What is your role within the family? You partner’s? Your children’s?*

1. **If there is a difficult time in the family (for example an argument) typically, what does each person do?**

*Prompts: How do they behave/act/feel? If there is a happy time, typically, what does each person do?*

1. **If you could change something about your family, what would it be?**

*Prompt: If someone could wave a magic wand and overnight something miraculous happened what would you like to be different? What do you like most about your family?*

1. **If someone was looking in from the outside, how do you think they would describe your family?**

*Prompts: How would they describe all of the different relationships within it? And, all of the different personalities? And positive things too?*

1. **What is your happiest memory of your family?**

*Prompts: A time that you remember vividly and feel happy about when you think of it (e.g. a family holiday, Christmas or a birthday).*

\* *The most basic types of roles are “father,” “mother,” “aunt,” “daughter,” “son,” “grandmother,” etc. But there are also roles beyond this most basic level. For example, one person may be the “joker” of the family. Another person may be the “sensible one” or the “emotional one.” There are a lot of different roles in families.*

**Ending**

1. **Is there anything else you think it would be important for me to know? Anything you would like to add?**
2. **What has it been like discussing this today?**
3. **Explain what happens now i.e. how the data is stored and how the findings will be disseminated.**
4. **Offer time for reflection and debriefing, sign post to relevant support agency if appropriate.**

**Appendix 9: Updated version of interview schedule**

**Introductions**

* Introduce self, the purpose of today and state that the purpose of the interview is not to judge, blame or criticise parents, but to gain an understanding of their experiences.
* Obtain informed consent.
* Explain recording, right to withdraw and confidentiality.
* Ask participant to talk in as much detail as possible about their experience. There are no right or wrong answers.
* I will be asking open questions so it may feel like you’re talking a lot, but that’s Ok, as I would like to get as much detail as possible.
* Take your time to think about your own experience.
* Any questions?

**Questions**

**1. Can you tell me about your family?**

*Prompts: How many children do you have (birth order)? What are their names, ages? Who is your partner, how long have you been together? Draw a family diagram (ask if would be helpful)?*

**2. Overall, how are things in your family?**

*Prompts: Can you describe a typical day? How would you describe your children? Partner? How would you describe each of your parenting styles (yours and your partners)? How are decisions made in your family (who has input)?*

**3. Who in the family is overweight?**

*Prompts: How do you know that they are overweight? When did they start to become overweight? When did you first notice this happening? How did you feel about that? And, how do you feel about their weight now?*

**4. How does food it into the family?**

*Prompts: What role does it hold?*

**5. What does it mean to you that [child’s name] is overweight?**

*Prompts: How has this experience been for you? How does it make you feel? How do you think your partner feels about it? How do you think [child’s name] feels about it? What do other people think about it, how have they reacted?*

**6. How do you feel about X’s future?**

**7. What effect (if any) do you think your child’s weight may have had on you as a parent?**

*Prompts: Any impact on your parenting style? What might you do differently now? Has it impacted on the way that you feel as a parent?*

**8. Do you think [x’s] weight has impacted on the family in anyway?**

*Prompts: How/In what way? How are things different now? What did things used to be like in your family?*

**9. Could you describe your relationship with your child?**

*Prompts: How do you interact with them? Do you notice any patterns of behaviour between the two of you? Has it always been like that (since birth)? How does your child relate to other members in the family? How do you and your child share and/or express emotions with each other?*

**10. As your child grows older, do you think your relationship with them is changing?**

*Prompts: If so, in what way, what is different now? Is that the same for your partner too? In your opinion, what things may impact on the way that you and your child relate to each other?*

**11. Do you think anyone in your family has a particular role?**

*Prompts: By ‘role’ I mean, someone that holds particular responsibilities in certain situations, these may be emotional roles and/or practical roles [\*if still unsure offer more detail explanation below]. What is your role within the family? You partner’s? Your children’s?* If there is a difficult time in the family (for example an argument) typically, what does each person do? *How do they behave/act/feel? If there is a happy time, typically, what does each person do?*

**12.****How was your childhood?**

*Prompts: What can you remember about growing up? What were your parents like?*

**13. If you could change something about your family, what would it be?**

*Prompt: If someone could wave a magic wand and overnight something miraculous happened what would you like to be different? What do you like most about your family?*

**14. If someone was looking in from the outside, how do you think they would describe your family?**

*Prompts: How would they describe all of the different relationships within it? And, all of the different personalities? And positive things too?*

**15. What is your happiest memory of your family?**

*Prompts: A time that you remember vividly and feel happy about when you think of it (e.g. a family holiday, Christmas or a birthday).*

*The most basic types of roles are “father,” “mother,” “aunt,” “daughter,” “son,” “grandmother,” etc. But there are also roles beyond this most basic level. For example, one person may be the “joker” of the family. Another person may be the “sensible one” or the “emotional one.” There are a lot of different roles in families.*

**Ending**

**16. Is there anything else you think it would be important for me to know? Anything you would like to add?**

**17. What has it been like discussing this today?**

**18. Explain what happens now i.e. how the data is stored and how the findings will be disseminated.**

**19. Offer time for reflection and debriefing, sign post to relevant support agency if appropriate.**

**Appendix 10: Example memos**

**Memo (20.02.2015): Making sense of ‘The Family’**

When meeting individuals from different families, I noticed that the meaning of ‘family’ seemed to be constructed differently in each. This is in terms of what form the family actually takes i.e. single-parent, married parents, co-habiting parents, one child vs. several children, step-children and step-parents. As well as, how the family viewed themselves (i.e. as being a ‘unit’ or ‘being close.’) And how their existence within a particular social context changed over time, for example a couple who moved to the UK from a European country 10 years ago initially felt isolated, unsupported and alone, but now they feel less like this. The breakdown of certain barriers has assisted them in feeling more settled, for example they have over-come the language barrier and the attitudes of society towards people of different ethnic origins is changing. The experience of raising children for this couple would be totally different 10 years ago compared to now, and this led me to wonder what the past context would have meant for the formation of relationships with in this family and how these relationships have changed as factors around them change and the family has evolved.

I also noticed how integral the individual experiences of the parent were in influencing the family system as a whole, for example parents who described their own childhoods as being ‘hard,’ ‘poor,’ or ‘a struggle,’ appeared to be more motivated to provide their own children with a different experience; one characterised by positivity/happiness, the child should never need or want something that cannot be had i.e. they should not be a deprived child.

I wondered how these beliefs around parenting interact with the current society – one in which ‘things’ are more available - immediately (including food and modern technology). Desirable food (high in fat and sugar content) can be bought cheaply and quickly from fast food restaurants or on special offer in supermarkets. Things can be constantly bought or bought in bulk to reduce the probability that someone will have to ‘go without.’ This may allow parents to protect their children from experiencing a level of ‘deprivation’ that could lead them to experience to negative emotion. Does having an unhappy child mean that the parent has failed to reach their goal of giving them a positive experience of childhood; based on their own beliefs and values?

When thinking around these topics, it felt necessary for me to begin to unpick what a ‘family’ consists of, what meaning it holds and therefore how it should be best understood.

**What is the ‘family’?**

The concept of the ‘family’ is changing, with over 40 per cent of new marriages in the UK ending in divorce. Many people chose not to marry, preferring to co-habit and raise children and many variations exist including single-parent families and homosexual families. The idea of ‘family life’ is influenced by the ideologies and discourses inherent in society at any one time. However, certain ideologies remain somewhat consistent for example, the role that women have in taking on the main responsibilities of child care has not changed significantly despite changing attitudes towards the role of women in other areas. Many people still view the concept of the ‘nuclear family’ as that which most ideally represents family life despite the increasing variance in how this achieved.

**Families reproduce themselves.**

The family life cycle was developed by Carter and McGoldrick (1980) in order to identify some of the major changes and transitions occurring within family life. Families need to continually evolve and adapt to the changing tasks, whilst all the time negotiating social, cultural and spiritual influences, family values and beliefs and individual /personal beliefs and values derived from experiences encountered both before and after an individual becomes a parent. **A family is thus an interpersonal system – made up of the experience of different generations.**

**Family narratives**

Families are multi-generational systems, made up of different individuals. Over time each individual encounters a number of different life experiences relating to the people they meet and the society and culture around them. These experiences contribute to an individual’s sense of self and to the development of their own unique set of beliefs and values; making each individual different from the other.

At the current time families are commonly made up of at least two or three generations, children, parents and grandparents (multiple individuals). This means that within a typical family system, experiences dating as far back as the early 1900’s may still be relevant today. How can we make sense of the influence of these historical experiences? Family narratives are sets of beliefs and values transmitted down through generations within families; they are the stories held to be important in families from the past brought into the future. Sharing family narratives can help people to understand themselves and their family (past and present), giving meaning to ways of being and interacting.

Many families that I encountered shared an **ascending type family narrative** for example: “When we came to this country, we had nothing. Our family worked. We opened a store. Your grandfather went to high school. Your father went to college. And now you....”As opposed to a **descending narrative**: “Sweetheart, we used to have it all. Then we lost everything,” or the most healthful narrative, the **oscillating family narrative**: ‘Dear, let me tell you, we’ve had ups and downs in our family. We built a family business. Your grandfather was a pillar of the community. Your mother was on the board of the hospital. But we also had setbacks. You had an uncle who was once arrested. We had a house burn down. Your father lost a job. But no matter what happened, we always stuck together as a family.’

Specific family narratives around food and feeding also existed for example: ‘food is love,’ ‘there’s plenty more,’ ‘don’t go hungry,’ ‘please…help yourself.’ I wondered where these came from and felt that they may be connected to an ascending type of family narrative (i.e. ‘let’s make a better life for the kids than we had…’) and determination from parents never to see their children at a disadvantage – ‘children must be happy all the time’

**Memo – ‘She’s like a mini-adult.’**

Something that has struck me whilst interviewing participants is the emergence of common theme around the presentation of overweight/obese children. So often have the children (both boys and girls) been described as being like ‘a mini-adult,’ ‘an old soul,’ ‘grown up’ and ‘older than their years.’ I have found this a very interesting characteristic which often goes hand-in-hand with the children being described as ‘helpful,’ ‘caring,’ ‘maternal/paternal,’ ‘responsible,’ *as well as* ‘determined,’ ‘head strong,’ ‘never giving up,’ ‘not taking no for an answer,’ *and* ‘the entertainer,’ ‘always in your face,’ ‘you know when they’re around,’ ‘bubbly,’ ‘very active.’

These descriptions conjure up the sense of a highly developed child, one who is advanced beyond their years in terms of both their social and emotional behaviours. They are highly attuned to the emotions of others. The reason for this rapid development may be an adaptive one. Perhaps it has been helpful for the child to learn to read the emotions of others so that they can ensure their own emotional needs are met (?attachment); perhaps it serves as a protective function - when a child feels vulnerable they project a more dominant façade (?defensive); perhaps they have learnt to be adult-like as they have always been treated like one or have always been around people who are older than themselves – they therefore have never developed a child-like concept of themselves (?self-identity); perhaps their physical appearance makes others see them as being older which means they try hard to live up to expectation – more beingexpected of them as they are considered to be older than their years (?stigma/ the assumptions of others).

Thinking around the circumstances which may lead to these characteristics occurring:

1. The parents are isolated (due to immigration, socio-economic status, language barrier, wider/historical family conflict) and so when the child is born they become a unit of three (? enmeshed) and the child is included in (almost) everything the adults do.
2. Parents separate and the child finds them self in a single parent family – they may then take on some of the emotional burden e.g. soothing the parent, being re-assuring – leading to enmeshment with the single parent until they meet a new partner.
3. The child grows up around older siblings or is an only child who spends time with their parents’ adult friends – learning adult ways of interacting – missing out on being child-like.
4. Other children do not interact with the overweight/obese child and so they start to interact more with adults e.g. teachers at school.

The child may begin to view themselves as an adult and adults may collude with this as it may make life easier in some ways as the child is well behaved, academically bright, and poses seemingly pro-social characteristics e.g. being kind, caring and helpful. Parents may also not want to ‘burst the child’s bubble’ as it may risk damaging their self-esteem or be seen as rejecting or criticising.

Another factor which may be connected and has been frequently shared is that of parents finding it hard to say ‘no’ to their children, children are thus often in control i.e. they always end up getting what they want as parents give in eventually. Parents may find it hard to bare seeing their child upset/unhappy – as this may lead to guilt. Children can help themselves to food but then their eating is perceived to be ‘out of control…’ - how did these children end up with such power? Why is it so hard to say ‘no?’ Should children be in charge of what they can and cannot eat?

**Parent-child interactions:**

1. Dominant/submissive
2. Strong/vulnerable
3. Distant/close

**Memo: Family roles**

**Child’s conflicting** **roles**:

* mature/needy
* Caring/vulnerable
* Determined/insecure
* Entertaining/eager-to-please
* Helpful/wanting-to-be-included
* Active/alone
* Bright/needing-to-prove-self

**Mother as:**

* The matriarch
* The organiser
* The soother
* The care giver

**Father as:**

* Emotionally distant
* The provider
* The practical one
* The doer

**Memo: Avoidance**

**Why avoidance is useful**

Avoidance is a defence mechanism which means that negative emotions do not have to be experienced and/or processed by the individual. Avoidance can function in behavioural and cognitive ways (both conscious and unconscious). For example, someone who is worried about an exam may avoid revision as it makes them feel too stressed, someone who is scared of spiders may avoid a walk in the woods. They may also try not to think about a certain thing, they may distract themselves when a negative emotion/thought starts to emerge, they may convince themselves that everything is ok – rationalise.

Parents that I have spoken to seem to maintain a level of avoidance to distance themselves from upset or distress in the child; weight is often not talked about as it is a hard topic to broche.

Avoidance works well most of the time –allowing people to keep functioning ‘normally’ however there are certain times when things cannot be avoided….

**When things cannot be avoided**

Things cannot be avoided when external factors point out the problem; they shine a light on what is being hidden. When interviewing parents there has been a common experience shared around finding it difficult to buy clothes that fit the children properly. Shopping has been described as being a ‘nightmare.’ It seems as though having to buy clothes made for much older children brings up a wave of negative emotion, stress and discomfort. Parents struggle hard to find something suitable, something age appropriate *and* desired by the child. Children are disappointed that they cannot wear what their friends are wearing or what they want to wear. A six year old girl wearing clothes made for a 12 year old points out the fact that something may be a bit out of the ordinary. Clothes sizes are based on averages – and so when clothes don’t fit - the child is not an average size. Moments like this seem to be saturated with problem solving and trying to make things better. Conversations around the emotions within the situation are not discussed. I wondered how children really feel in these moments. How do they feel about being limited to what they can wear? Could this impact upon their developing identity? Does wearing clothes for older children contribute to their sense of them being older than they are?

In addition, when the views of others are expressed this is also a moment when the problem cannot be avoided. It may however, be easier to rationalise than something concrete like clothes size as other peoples’ thoughts are more abstract than numbers. Being called names and being teased are common experiences for overweight/obese children; an emotional reaction occurs in the individual because the problem is pointed out, it cannot be ignored and the child is unfairly judged based on the assumptions of others.

Getting on the scales: ‘I need to go on a diet!’

**Memo: Communication in families - talking about weight.**

As previously mentioned the way in which parents and children interact can have a large impact on the child’s wellbeing. Understandably, weight/obesity may be an emotive topic within families possibly due to the influence of wider societal beliefs around obesity (i.e. negative stereotypes and stigma). The way in which these emotions and beliefs are shared in families may have an impact on family functioning as a whole (for example, by increasing or decreasing stress), as well as individually (for example, reducing self-esteem). Factors that could affect a conversation around weight may include the parent’s ability to consider the child’s perspective, especially in light of the largely adopted beliefs that obesity is within a person’s control; as well as the ‘typical’ ways of interacting within the family for example whether they are usually expressive about emotions (externalising them), or they prefer to internalise emotions. How parents talk to children about their weight has not yet be explored, unlike conversations around other challenges that may be faced in childhood for example having a low weight or eating disorder (e.g. anorexia nervosa).

Understanding how childhood obesity is experienced by parents may therefore help to shed some light on the way in which families communicate about it, having important implications on how a child’s weight is understood within a family and how treatment is then approached and taken up by families.

|  |  |  |
| --- | --- | --- |
| **Focused coding**  **Appendix 11: Section of interview transcript** | **Open coding** | **Participant 01** |
| COMPARING CHILD’S SIZE TO OTHERS  SPOILING CHILD  CHILD GETS WHAT THEY WANT / HARD TO SAY ‘NO’  THE CHILD DECIDES / POWERFUL CHILDREN / CHILD IN CONTROL  CHANGING WHAT IS BOUGHT / RESTRICTING FOOD OR WHAT IS AVALIABLE FOR CHILD TO CHOOSE  ALWAYS GIVE IN  EMOTIONAL NEEDS OF CHILD/ AFRAID OF DEPRIVING CHILD  ENSURING CHILD HAS A POSITIVE CHILDHOOD /  GIVING EVEREYTHING /  PARENTING INFLUENCED BY OWN EXPERIENCES AS A CHILD  AVOIDING THE PROBLEM  MINIMSING  FACTORS THAT LIMIT ACTIVITY  WORRY ABOUT WEIGHT  (INTERNAL / EXTERNAL FACTORS FOR CHILD)  HIDDEN FEELINGS / THINGS UNSAID  INDENTIFYING MOMENTS  WANTING TO PROTECT CHILD FROM NEGAT | Losing weight as an adult (parent)  Noticing different sizes of children bigger or smaller  Comparing shapes  Takes after her Dad  Being a chubby toddler  Spoiling her  Spoiling her because it’s the only daughter  Mums job to spoil  Searching for answers  She gets what she wants  Blaming baby food  No fruit and veg as baby  Gave her what she wants – child deciding what they need  Difficulties saying no  Difficulties not buying what [food] they like  Helping themselves to food  Never having to worry before  This is how we are  A cupboard filled with snacks  She just helps her self  If it’s there she’ll eat it  Different to brothers  Being too soft can’t say no  Always giving in -  Not wanting to deprive children by saying ‘no.’  She can have anything…trying to do more for her/youngest/the girl  Giving the youngest more (?guilt?)  (Child she most identifies with? )  Making sure the children have everything they need  Not wanting to deprive  Always wanted a girl  Spending money one children not self  Having everything  Making sure there is enough space in the house for them  Make sure they have lots of toys [everything they need and more]  Worries about money in the past – being poor growing up and not having everything she wanted – doing the opposite / Things were hard for me as a child / Protecting children from poverty / the feeling of wanting something and not getting it / being deprived/I go out of my way now for the children / Weight wasn’t a problem at first/ Its ‘baby fat’ – Labelling child being overweight as ‘baby fat’ – label doesn’t disappear with age – different views from parents – Mum helping Dad to see weight as a ‘problem.’ Starting to ‘watching the weight’ / monitoring the weight/ Keeping an eye on the weight – Being observers. Losing weight harder when its cold outside - the kids don’t like walking – trying to be active  Trying to be active  Dislike of walking  Exercise as part of daily life  Worry about her weight  Worry about her worry about weight / Weight reducing friends she has – limiting social life – being judged – not being able to what other children do – being viewed by other as ‘fat.’ Other people views upsetting to child  Worry that other children judge her for being overweight  *Thinking* that she must be upset / Child doesn’t know Mum worries about her – Mum keeping worry to herself | A: Um so who in the family is overweight at the moment?   1. P: Just S, well it was me and S but I’ve stated running and doing quite well <laughs> so just S.   A: So how do you know that she’s over weight?   1. P: She’s quite big but all my children are quite small and she’s the biggest you know. I’ve never had big children all my boys are quite really slim they go to the gym to get big but umm she’s umm I dunno. 2. She takes after her Dad he’s quite big and all his family side are quite big too.   A: So she’s six now and um when did you did you start to notice that she was becoming over weight?   1. P: Umm she was about three I think it’s quite a while ago; yeah she was quite a chubby toddler. 2. But I don’t know if ‘ me spoiling her really, I think I did spoil her quite a lot cos as a Mum, as my daughter, my only daughter I think I did spoil her a bit really…..   A: Ok, in what way?   1. P: Oooh she gets what she wants S <laughs> 2. and ummm in feeding her I went wrong I think when she was young cos it was like giving he baby food and stuff and I didn’t give her enough fruit and veg I think. 3. I just gave her what she wants and I don’t think that’s always the right thing.   A: What do you think was behind giving her what she wanted?   1. P: she likes a lot of cakes and biscuits and stuff like that and I would say ‘alright’ and she would say ‘oh can I have another one mummy…’ and it was *really* what I should say is ‘no’ or I shouldn’t buy the biscuits and stuff but you see in my house this is how we are, we are….because I’ve never had to worry about weight before we’ve always had it, we’ve always had packs of crisps in we’ve always biscuits in I’ve got a cupboard filled with snacks and they will just help themselves and because the rest of the boys were all quite small it wasn’t a problem until S come along, because she so I think she just saw things and thought ‘OH MY GOD ITS THERE’ and she would just help herself.   A: So what was difficult about saying no to her?   1. P: errr I don’t know, I find it really hard sometimes, I’m quite soft really, I do get hard when they really push it but I’m quite soft and quite often I just say ‘alright then, just one…’ but one sometimes leads to ‘oh can I have another one!?’ and instead of going for the healthy option (bit of fruit)..it was …   A: What do you think would happen if you said no?   1. P: Umm I dunno I just didn’t what to deprive her of anything really.   A: Ok, why do you think that is?   1. P: I just thought oh, she’s my daughter she can have anything, it’s really….I mean I try and do more, I try and be more there for her than the other boys I suppose.   A: Why is that?   1. P: I don’t know I’ve always wanted a girl really. 2. I went and put a conservatory outside, I did it for the kids, because they didn’t have anywhere to play, they’ve got all their toys in there and cos I’ve only got a three bedroom house, I didn’t want anything in the sitting room, so I spent the money and bought a conservatory and I bought a load of toys for it too. And people always say ‘my god, why wouldn’t you put a nice dining table and chairs in there?’ And I say ‘no it’s for the kids, I do it for the children, I want them, to be comfortable.’ 3. I never had all of this you see, when I was growing up there was nine of us and only my dad worked so we didn’t have, it was like one doll, we had one doll for Christmas and that was it really for the girls. There was six girls and thee boys. The boys had a car. There wasn’t, I never had anything really because we were quite poor really. My Mum made sure we had a proper meal in us and proper shoes and clothes and stuff but things were really hard. We didn’t have you know, buggies, some people have prams with their dolls, we didn’t have. Or maybe like two, three, four dolls, I didn’t I had one doll and then every year I’d maybe get another one. But you know it wasn’t like, how it is now, things were a lot harder so I think I go out my way a bit now with my children.   A: Ummm so you kind of noticed that S was becoming a bit bigger when she was about three-ish, how did you feel about her weight?   1. P: It wasn’t a problem and the Dad, I talked to that Dad about it and he said oh, it’s only baby fat it will go that’s what we kept saying ‘its only baby fat’ 2. And he says it now and I said ‘NO, if we don’t watch this she gona get really big!’ so we’re watchin it now!   A: How do you feel about her size and weight now?   1. P: <sigh> Ummmm its, she started….well since July/august we’ve started going to the park a lot, doing a lot of exercise, we were running up and down, she found it hard but she started losing weight but it’s like she’s slowed down now it’s got colder, we do go to the park but it’s about playing and not running cos it’s so cold and the grass is wet, so she’s started to slow down a bit. 2. They’ve got bikes, but their bikes are quite big, their Dad bought them bikes last year and they’re still quite big and they’ve got scooters, they don’t like walking but if it’s to X I’ll make them walk or jump on our scooters and they’ll go on their scooters, just a part of exercise really and if its further than X we usually jump on the bus.   A: How do you feel about her weight?   1. P: About S’s weight?   A: Yes   1. P: It worries me, it does, it worries me in the ways, in that, I think the way it worries her and so it worries me. 2. I’m sure she would have more friends if she lost a bit of weight cos she can’t run around as much as the other children, I’m sure children probably look at her as if to say ‘god you’re a bit fat,’ which I think upsets her a little bit.   A: Do you think that she knows that you worry about her?   1. P: No….no…. |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Categories**  **Appendix 12: Coding frequency table** | **Focused codes** | **Themes raised across participants (line number of quote)** | | | | | | | | | |
|  |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **1) Trying to be a 'good' parent** | **1.1 Being a**  **dedicated parent** | 83, 59, 149, 187 | 10, 47 | 20 | 17, 20, 21, 22, 23, 25, 26, 112, 113, 114, 115, 116, 32 | 28, 29, 30, 31, 32, 25 | 25, 84 |  | 59, 74, 75, 76, 30, 31 | 4, 87, 22, 87, 88, 89, 15, 110, 111, 112 |  |
|  | **1.2 Satiating the child's needs** | 70, 75, 115, 137, 73, 75, 122 | 6 |  | 68, 37, 38, 39, 40, 41 |  | 52, 53, 54 | 89, 86, 64, 79, 112, 68, 71, 63 | 112 |  | 13 |
|  | **1.3 Negotiating parental boundaries** | 76, 12 | 48, 113, 131, 45, 49, 73 | 21, 26, 61, 57, 59 | 44, 29 |  |  |  | 124 | 16, 30 | 8, 9, 10 |
|  | **1.4 Past experiences influencing parenting** | 84, 189, 192 | 46 |  |  | 152, 153, 154 | 83 | 69 | 96, 102, 105 | 24, 15, 82, 83, 86, 87 | 36 |
| **2) Child characteristics** | **2.1 A powerful child** | 73, 160, 153 | 12, 3, 43, 55, 14 | 16, 71, 17, 67, 95, 34, | 47, 48, 41, 68, 70, | 6, 7, 13, 89, 90, 148, 152, |  | 45, 21, 23, 48, 49 | 85, 46, 24, 25, 26, 27, 28, 29, 30, 58 | 52 | 50 |
|  | **2.2 Physically and socially mature** | 146, 143, 180, 182, 147, 145 | 22, 11, 109, |  | 71, 73, 74 | 122, 123, | 77 | 118, 19, 20, 36, 18 | 39, 40, 41, 42 | 96, 100, 101, 52 | 51, 52 |
|  | **2.3 Preoccupied by food** |  |  | 38 | 45 | 156, 194 | 88 | 76, 82, | 19, 20, 126 | 67 | 43 |
|  | **2.4 Emotionally sensitive** |  | 42, 104, 106 | 76 | 75 | 115, 26, 27 |  | 40 | 17, 55, 56, 72, 44 |  |  |
| **3) Experiences in which weight is identified as a**  **problem** | **3.1 Difficulty finding clothes that fit** | 95, 182 | 66 | 44 | 102, 103, 104 | 113, 114, 105, 106, 107, 108, 109, 111 |  | 101, 72, 151, | 132, 133 | 39, 40, 41, 44, 45, 46, 47, 50, | 40, 44,45, 46, 47, 48 |
|  | **3.2 External source highlighting weight as an issue** |  | 61, 77, 64 | 48 | 8 |  | 71, 72, 73, 28, 29 | 55, 110 |  | 39, 59, 37, 38 | 25, 18, 19 |
|  | **3.3 Family teasing** | 175 | 82, 84 | 66 |  |  | 75 | 73 |  | 56 | 23 |
| **4) Parent's experience of child's obesity** | **4.1 Feeling responsible for child's weight gain** | 73, 75, 91 | 76, 38, 59, 142, 80, 90, 63, 76 | 41 | 62 | 62, 57 |  | 96 | 92 |  |  |
|  | **4.2 Worry about the health & social implications for child** | 167, 169 | 69 | 48, 45, 49, 51 | 53, 56 |  | 39, 40, 41, 42, 30 | 99, 60, 38 |  | 34, 61, 108, 119 | 49 |
|  | **4.3 Worry about the future** |  | 83, 62 | 47, 52 | 49, 107, 108, 109 | 167 |  | 100 |  | 74, 32 | 39, 40, 18, 19 |
|  | **4.4 Worry about the views of others** | 123, 108, 109, 110, 125 |  | 54 | 63 | 58, 57, 160, 161, 162, 163, 164, 77 |  | 85, 116 | 120, 123, 85, 119 | 139, 146, 37, 38, 62, 63, 64, 58, 128, 130, 131 |  |
|  | **4.5 Feeling frustrated** | 22, 31 | 64 | 96 | 60, 61 | 103, 104, | 35, 68, 69, 57, 58, 59, 60 | 75, 74, 95, 4, 5, 7 | 130, 131, 51, 52, 47 | 11 |  |
|  | **4.6 Tying to make sense of child's weight** | 75, 4, 69, 5, 70, 179, 25, 33, 112, 118 | 54, 57, 72, 88, 68, 93, 92, 95 | 39, 36, 50, 12, 42 | 43, 97, 9, 11, 100, 101 | 54, 56, 66, 198, 190, 191, 192 | 32, 33, 34 | 89, 67, 149 | 83, 91, 109, 141, 20, 7, 51, 52, 47 | 69 | 17, 55, 27 |
| **5) Attempting change** | **5.1 Talking and planning for change** | 106, 97 |  |  |  |  |  |  | 111, 112, 79 | 55 |  |
|  | **5.2 Trying to adopt healthier habits** | 111, 120, 98, 99, 8, 116, 87 | 65 | 56 | 45 | 85 | 44, 47, 51 | 77, 63 | 89 | 75, 65 | 14, 38, 25 |
|  | **5.3 Paying more attention to weight** | 86 | 81 |  |  |  |  |  |  | 137 |  |
| **6) Barriers to change** | **6.1 Lack of motivation or willingness** | 30, 87, 126, 88 | 74, 75 | 74, 40, 64, 38, 40 | 50 |  | 65 |  | 125 | 8, 60 | 11, 16 |
|  | **6.2 Delaying action** | 82, 83, 103, 104 | 67, 76, 71 |  |  | 61 | 31, | 98 | 88, 90 | 71, 72 |  |
|  | **6.3 True feelings**  **about weight are hidden** | 165, 90, 176 | 67 | 40, 38, 47, 52, 45 |  |  |  | 30, 110 |  |  | 18 |
|  | **6.4 Conversations about weight are difficult** |  | 60 |  | 66, 67 | 70 |  | 102, 103, 129, 59, 97,141, 142, 114 | 92 | 51 | 24 |
| **7) The emotional context of the family** | **7.1 A happy and close family** | 149, 157, 186, 187, 11, 134, 152, 186, 185, 28, 132, 133 | 149, 143 | 93 | 90, 30 | 121 | 81 | 15 | 10, 12, 13, 40 | 123, 8 | 57, 30 |
|  | **7.2 Communication viewed as 'open'** | 99, 139, 136, 65 | 112, 37, 108 | 94 | 41 | 88 |  |  |  | 124, 116 |  |

1. Differences in the attendance of mothers and fathers to the groups from which participants were recruited from is further reflected upon in the research diary (Appendix 1). [↑](#footnote-ref-1)
2. The disparity in duration of interviews is further considered in the research diary, Appendix 1 [↑](#footnote-ref-2)
3. Words placed within square brackets (i.e. *[the children])* have been added by the researcher so that the extract can be easily understood. A string of dots (….) denotes that a section of the extract has been removed to promote the clarity of the quote. [↑](#footnote-ref-3)