CHILDHOOD OBESITY: THE PERCEPTIONS & EXPERIENCES of OVERWEIGHT CHILDREN & THEIR PARENTS

A thesis submitted to the University of Manchester for the degree of Doctor in Clinical Psychology in the Faculty of Medical and Human Sciences

2013

TRACY GEMMELL

SCHOOL OF PSYCHOLOGICAL SCIENCES
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A Meta-Synthesis of Qualitative Research Exploring What Affects How Parents Manage their Child’s Difficulties with Obesity

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Abstract

Childhood Obesity: The Perceptions and Experiences of Overweight Children and their Parents

Tracy Gemmell, University of Manchester, Doctor of Clinical Psychology

12/07/2013

Childhood obesity continues to grow in the UK despite multiple prevention and intervention strategies. Research on childhood obesity has tended to focus on quantitative research with parents of overweight children, however recently there has been some qualitative studies done with parents and research is beginning to emerge with overweight children themselves. The purpose of this thesis was therefore to draw together the available qualitative research with parents and to undertake an original piece of qualitative research with overweight children.

Paper one is a meta-synthesis of qualitative papers examining parents’ perceptions, experiences, beliefs and attitudes to parenting their overweight child. This review involved four phases; systematically searching the literature, applying inclusion/exclusion criteria, undertaking a quality appraisal of the studies and synthesising the findings. Thirteen studies met the inclusion criteria and two over-arching themes were identified; ambivalence and responsibility. Ambivalence encompassed the sub-themes recognition, parents’ own weight history, uncertainty, and feeding and emotion. The sub-themes resources, attribution and parenting difficulties formed the over-arching theme of responsibility. These findings are discussed in relation to the importance of including parents in childhood weight management interventions and suggestions about what these programmes should focus on in order to be effective.

The second paper is an original research study which explored overweight children’s perceptions of their size, and how this affected their self-view. Six participants, aged 8-12, were interviewed and the data was analysed using a combination of Thematic Analysis and Interpretative Phenomenological Analysis. Four themes labelled; recognition, self-view, beliefs about exercise and weight loss, and making sense of eating were identified. The over-arching theme labelled minimisation was found to run through the other themes. These finding are discussed in relation to previous studies, along with their clinical implications and the possible directions for future research.

The final paper is a critical appraisal which outlines my experiences of carrying out qualitative research with overweight children and their families. It outlines why I chose this project, and my observations and reflections on undertaking the study. It also discusses what I have learnt from the experience and what I will take forward into my career as a clinical psychologist. Finally it discusses the findings from the thesis as a whole and the possible clinical implications and directions for future research.
Declaration

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Acknowledgements

I would like to thank Dr John Fox and Professor Alison Wearden for their invaluable guidance while supervising my thesis. I would also like to thank the children who took part in the study and gave up their time to tell me about their lives. The project would not have been possible without the help of the group leaders at the MEND programmes.

A special thank you goes to my family and friends for their support and encouragement over the last few years.
Paper 1

A Meta-Synthesis of Qualitative Research Exploring
What Affects How Parents Manage their Child’s
Difficulties with Obesity

Prepared in accordance with requirements for submission to *Clinical Psychology Review* (Appendix 1)

Word Count: 8068
Abstract

Objectives: The aim of this paper was to review and synthesise the qualitative research available on parents’ perceptions, experiences, beliefs and attitudes to parenting their overweight child.

Method: A meta-synthesis was carried out which involved systematically searching the literature, applying inclusion/exclusion criteria, undertaking a quality appraisal of the studies and synthesising the findings.

Results: 13 studies were identified which included the views of 290 parents of overweight children aged 1 to 16. From the synthesis of these papers two overarching themes were identified; ambivalence and responsibility. The theme of ambivalence encompassed recurring sub-themes of recognition, parents’ own weight history, uncertainty, and feeding and emotion which all appeared to contribute to parents being unsure of how, and when, to intervene to help their child lose weight. The sub-themes resources, attribution and parenting difficulties formed the overarching theme of responsibility. These all related to where parents felt their child’s weight difficulty had come from and where the responsibility for managing this lay.

Conclusion: These findings are discussed in relation to the importance of including parents in childhood weight management interventions and suggestions about what these programmes should focus on in order to be effective. Future research directions are also discussed.

Keywords: Meta-synthesis, parenting, childhood obesity, weight management.
Introduction

Recent research in the UK suggests that around 30% of boys and girls, aged 2-15 years old, are classed as overweight or obese (Health Survey for England, 2010). This is particularly concerning as overweight children have a greatly increased risk of becoming overweight adults (Freedman et al, 2005) and obesity in adulthood is associated with several serious diseases such as Type II Diabetes, cardiovascular disease and cancer (Must et al, 1999). These overweight children are also at immediate increased risk of psychological and behavioural difficulties (Reilly et al, 2003).

To help protect these children from obesity related complications it is recommended that interventions to establish healthy eating and activity behaviours begin early in life (Barlow, 2007). It therefore appears obvious that it would be beneficial to engage parents in weight management programmes and indeed research has shown that parents are vitally important in the treatment of childhood obesity (Golan & Crow, 2004 and Grimes-Robinson & Evans, 2008).

In order for parents to effectively support their children to manage their weight issues they first have to recognise, and acknowledge, that their child is overweight (Hodges, 2003). The plethora of quantitative literature on this subject, as described in two recent systematic reviews, however suggests that parents of overweight children tend to underestimate the weight of their child and do not perceive their excess weight as a health concern (Doolen, Alpert & Miller, 2009 and Towns & D’Auria, 2009). The majority of studies included in these reviews investigated this by asking parents to choose which weight category they thought their child was in, and asking them to rate how concerned they were about their weight. These findings
were consistent across studies regardless of the age group of children included, or
country the study was conducted in. This body of research has also suggested that
low maternal education levels (Genovesi et al, 2005 and Baughcum, Chamberlin,
Deeks, Powers & Whitaker, 2000) and parents being overweight themselves
(Boutelle, Fulkerson, Neumark-Sztainer, & Story, 2004) may make it more likely
that they will fail to recognise their child is overweight.

Recently qualitative studies have begun to use focus groups to gain a more in-depth
understanding of parents’ perceptions of childhood obesity. One such study in the
UK (Jones et al, 2011) investigated general parental perceptions of weight status in
children. Parents in this study were aware that childhood obesity was a problem
nationally, however, had limited understanding of how this was defined, and tended
to rely on visual assessments, and comparisons with extreme cases. The findings
from this study are consistent with two Australian studies looking at parents’
perceptions of childhood obesity (Paganini, Wilkenfeld, King, Booth & Booth, 2007
and Booth, King, Pagnini, Wilkenfeld & Booth, 2009). Parents in these focus groups
also reported that they relied on physical appearance to determine a child’s weight
status, and appeared conflicted about issues related to childhood overweight.

From the literature described above it is clear that parents have a key role in the
weight management of their overweight child, it is also clear that many parents do
not recognise that their child is overweight, and even if they do tend to see this as of
little concern. Factors such as maternal education levels, parental weight history,
and a lack of understanding about how weight status is defined, have all been
highlighted as impacting on this. The ability to recognise obesity in their children
however is, although an important factor, only one factor, in our understanding of
what affects how parents manage their child’s weight difficulties.
The exploration of possible additional factors has begun to be investigated by qualitative researchers such as Druon, Fraser and Alexander (2008) who looked at mothers’ knowledge, beliefs and attitudes towards their obese and overweight children. Using in-depth semi-structured interviews they found that these mothers gave several reasons for the cause of their child’s excessive weight, such as poor motivation, eating in response to stress and low self-esteem. They also described barriers to helping their child lose weight, such as worrying that implementing weight control strategies would hurt them physically or psychologically and that they lacked the time, or money, to increase their physical activity levels. Although this is a small study offering limited information, it does suggest that there may be a complex range of factors which influence how parents manage their child’s difficulties with obesity.¹

A review by Pocock, Trivedi, Wills, Bunn and Magnusson (2010) investigated this question from a different angle by reviewing the available qualitative literature on parental perceptions about healthy behaviours to prevent overweight and obesity in young children. From this they found that parents perceived prevention to be affected by several factors including child factors, family dynamics, parenting, knowledge and beliefs, and resources and environments. The authors highlighted that although parents suggested ideas to promote healthy living behaviours many of the views expressed in the studies related to perceived barriers to implementing these. This review focused solely on parental perceptions of healthy behaviours to prevent childhood obesity and therefore offered limited information about what other factors affect how parents manage their child’s weight. This review also included

¹ This study was not included in the meta-synthesis as very limited detail was provided in the paper about their analysis and results therefore meaning that it did not meet the inclusion criteria.
only three studies which looked at the perceptions of parents who had an overweight child and thus tells us little about this important group of parents.

A more recent review by Lachal et al (2013) aimed to provide a coherent view of child and adolescent obesity by synthesising the available qualitative literature from children and adolescents, parents and healthcare providers. This large review suggested that there were three axes of experience common to the three groups: seeing others, seeing oneself, which referred to the processes by which participants defined obesity and their awareness of it as a problem; understanding others, understanding oneself, which described how participants tried to explain the origin of the obesity and the factors perceived to be related to it; and treating others, treating oneself which included themes about understanding the overall care system and evaluations of this. In the seeing others, seeing oneself axis, they found that parents tended to underestimate or minimise their child’s weight and did not use medical criteria to define this. They also highlighted that when parents were aware of their child’s weight problem they faced problems in how to discuss this with their child without hurting or annoying them. In the understanding others, understanding oneself axis, they found that parents who were overweight tended to offer explanations for this such as genetics, slow metabolisms or bad eating habits. Under the treating others, treating oneself axis, they noted that parents appeared ambivalent in their attitudes to treatment as they seemed caught between the desire to intervene and the fear of the consequences of this.

Although this is an extensive review its attempt to synthesis such a large topic area may have resulted in it providing limited interpretations of the themes highlighted in each of the groups. By doing this it gives a sparse understanding of each of them individually and offers little analysis of what the themes highlighted mean, and why
they may occur. Sandelowski, Docherty and Edmen (1997) suggest that an overly large sample size tends to impede deep analysis and therefore threatens the interpretative validity of findings. This review also investigates parental perceptions of childhood obesity generally, and parents perceptions of weight management interventions, along with studies focusing solely on parents of overweight children’s experiences, and perceptions of managing their child’s weight. This is another potential limitation of the paper as these three types of studies are focusing on slightly different aspects of parents’ views on childhood obesity which may lead to different themes, and conclusions being reached than if the review had focused solely on parents of overweight children’s experiences of parenting their child.

The objective of the current paper was therefore to review, and synthesise, the qualitative research available on parents’ perceptions, experiences, beliefs, and attitudes to parenting their overweight child. The aim of undertaking this was to allow a better understanding of why parents of overweight children may struggle to help their child lose weight. The specific research question it aimed to answer was ‘what affects how parents manage their child’s difficulties with obesity?’. This question was chosen because these parents are vitally important in helping to reduce childhood obesity, and thus gaining a greater understanding of why they may struggle to help their children lose weight may help improve childhood weight management interventions.
**Method**

A meta-synthesis was considered to be the most appropriate method to meet these aims as it allows for the integration of results from a number of different but inter-related qualitative studies (Walsh & Downe, 2005). There were four stages to this meta-synthesis: systematically searching the literature; applying inclusion/exclusion criteria; undertaking a quality appraisal of the studies, and synthesising the findings.

**Systematic Literature Search**

An initial search of Google, and Google Scholar, was carried out to identify if any similar reviews had already been conducted. As this did not identify any qualitative reviews on the subject, a formal systematic search of the following databases was carried out: CINAHL Plus, Embase, Medline, Psychinfo, Pubmed and Web of Knowledge. The reference section of relevant research was also checked and followed up for other potential relevant studies.

To maximise the number of potential studies identified four categories of search term were used: terms related to study design; terms related to experience; those related to perspective; and terms related to obesity. The full list of search terms can be found in Table 1. The search was undertaken by entering the search terms into the databases as (qualitative or focus group or interview) and (experiences or beliefs or perceptions or attitudes) and (obesity or overweight or weight) and (parents or parental or maternal). This use of broad-based search terms along with more specific thesaurus terms has been shown to be an effective method of literature searching (Fleming & Briggs, 2007).
Table 1. Key Terms for Systematic Literature Search

<table>
<thead>
<tr>
<th>Terms Related to Study Design</th>
<th>Terms Related to Experience</th>
<th>Terms Related to Weight Status</th>
<th>Terms Related to Perspective</th>
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<td>Qualitative Focus Group Interview</td>
<td>Experiences Beliefs Perceptions Attitudes</td>
<td>Obesity Overweight Weight</td>
<td>Parents Parental Maternal</td>
</tr>
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### Inclusion/Exclusion Criteria

Studies were included in the meta-synthesis if they focused on parents with at least one overweight child, and investigated the perceptions, attitudes, beliefs and/or experiences of these parents. To be included studies had to use qualitative methods to investigate the above and be published in English, prior to September 2012 when the search took place.

Studies were excluded from the review if they focused on parents without an overweight child, looked at parents’ perceptions of childhood obesity generally, or focused on the general population’s perceptions of childhood obesity. Pieces of work were also excluded if they were book reviews, opinion pieces, unpublished theses, poster presentations, short reports providing very limited detail, or published in non-peer reviewed journals. These inclusion and exclusion criteria can be seen in Table 2.
Table 2. *Inclusion & Exclusion Criteria*

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<th>Exclusion</th>
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<td><strong>Sample/Population</strong></td>
<td>Studies focusing on parents with at least one overweight child</td>
<td>Studies focusing on parents without an overweight child.</td>
</tr>
<tr>
<td></td>
<td>Studies focusing on the perceptions, attitudes, beliefs and experiences of parents with an overweight child</td>
<td>Studies focusing on parents’ perceptions of childhood obesity generally</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Studies focusing on the general population’s perceptions of childhood obesity</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td>Studies published in English only</td>
<td>Studies not published in English</td>
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<tr>
<td><strong>Study Type</strong></td>
<td>Qualitative methods (eg interviews and focus groups)</td>
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<td></td>
<td>Primary research</td>
<td>Book reviews, opinion pieces, unpublished theses or poster presentations, short reports providing very limited detail and non-peer reviewed journals</td>
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The procedure for rejecting studies is outlined in Figure 1 and involved applying the inclusion/exclusion criteria to the title, then abstract, then the full text of identified papers and removing irrelevant or unsuitable studies at each stage. The reference sections of included studies were then checked for any further suitable papers. From this procedure 13 studies were included in the meta-analysis which is in keeping with the suggestion by Sandelowski et al (1997) that the optimal number of studies which can be included in a good quality meta-synthesis is around 10.

**Quality Appraisal**

The quality of the studies was critically appraised using a combination of the Walsh and Downe (2006) Quality Appraisal Check List, and the Critical Appraisal Skills Programme Tool (2002). This can be found in Appendix 2. This allowed studies to be rated out of 10 based on their design, analytic approach, interpretation of findings, and the relevance and transferability of the research. The full ratings can be seen in Appendix 3. The author and an independent researcher rated the studies using the quality appraisal system and initially there were minor discrepancies found between the scorings on 5 of the papers. The author and the independent rater discussed their use of the quality appraisal checklist and the discrepancies. This allowed a consensus to be reached on the quality of each of the papers. Although no studies were excluded on the basis of quality it allowed the author to assess and reflect on the methodology, qualitative analysis and findings of the papers which aided the interpretation of their results in the meta-synthesis.
Figure 1. Flow diagram of search strategy and identification of studies included in the meta-synthesis.
Synthesis

The method employed to synthesise the studies was that suggested by Noblit and Hare (1988), which was updated by Walsh and Downe in 2005, and includes steps relating to how to conduct the meta-synthesis. This was chosen as it is the most widely used approach to synthesis qualitative findings (Bondas & Hall, 2007) and because it allows all types of qualitative research to be included.

To synthesise the studies in this way a list of key concepts was attempted to be created from each study however this was made complicated by the fact that some of the studies did not define themes, per se, but rather grouped quotes under a description. This is a difficulty which has been noted by Walsh and Downe (2005) who suggest that in cases where authors give descriptive rather than interpretative accounts of their data the study should either be left out of the synthesis, or loosely summarised to draw inferred themes and concepts from the narrative account. This process should preserve the meaning from the original text (as interpreted by the author or as raw data) as far as is possible. In keeping with this, the current author initially read the descriptions of the reported themes and supporting data given in each of the studies several times before deciding upon what the inferred concept from each of these was. For example in study 2 their first theme was labelled

‘Parents generally think that other people’s overweight children are lazy and do not exercise. However, two contrasting ideas emerge when parents are asked about their children; either that their children do not exercise enough, watch too much TV, or play too many video games; or that their children are active, but still seem to gain weight.’ This passage was thought by the current author to describe a concept about what parents believed had caused their child to be overweight and after looking at
this passage in relation to concepts identified in other studies it was deemed to form part of the sub-theme about attributions. Several of the papers also described themes which were considered by the current author to be aspects of the same theme and were therefore treated as such for the purposes of the meta-synthesis. For example in study 5 they reported several separate themes including; ‘children are not considered overweight as long as they are active, playful, happy, and have good appetites’ and ‘children are considered overweight if they are seen as inactive, lazy, or are teased’ which were all placed in the “recognition” sub-theme by the current author. The original themes and their allocated sub-theme for the purposes of the synthesis can be seen in appendix 4.

Once this had been done the author attempted to translate these key concepts across the studies into one another by creating sub-themes where possible, and retaining concepts that it was not possible to do this with. Clusters of sub-themes were then identified and refined to allow over-arching themes to be identified.
Table 3. Characteristics of Included Studies

| Study                        | Country  | Principal Experiences Explored                                                                 | Perspective                                      | Age of Child | (n) | Definition of Weight Status                  | SES\(^2\) of Family | Ethnicity of Family | Data Collection | Analysis                          | QR  
|------------------------------|----------|-----------------------------------------------------------------------------------------------|-------------------------------------------------|--------------|-----|-----------------------------------------------|----------------------|---------------------|------------------|------------------------------------|------  
| Curtis et al 2011 (Study 1) | England  | Parents’ explanation for, & their understandings of, their child’s weight & body size, the factors that have influenced their help seeking behaviour & perceived support needs. | Parents (mothers, fathers & stepfathers)         | 8-14         | 25  | Attending an obesity intervention programme. | Majority from most deprived city wards | Not Stated | 2 Semi-structured interviews | Thematic Analysis (Mason, 2005) | 7.5     
| Davis et al 2008 (Study 2)  | USA      | Attitudes concerning childhood obesity, the barriers they face in helping their children attain a healthy weight status & the paediatric weight loss services available in their area. | Parents                                          | 3\(^{rd}\) to 5\(^{th}\) Grade | 21  | BMI over the 85\(^{th}\) percentile (parent report of weight & height) | Mixed                | Not Stated | Focus Groups via a live, interactive video conference | Qualitative analysis not specified | 7       

\(^2\) SES = Socio-economic Status  
\(^3\) QR = Quality Rating
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Title</th>
<th>Participants</th>
<th>BMI Cutoff</th>
<th>Methodology</th>
<th>SES</th>
<th>Sample Description</th>
<th>Analytical Approach</th>
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<tr>
<td>Gronbaek 2008 (Study 3)</td>
<td>Denmark</td>
<td>Families’ insight regarding their child’s overweight, the development of obesity &amp; motivational factors for taking action in relation socio-demographic conditions.</td>
<td>Parents &amp; Children</td>
<td>10-12</td>
<td>40% above the median weight-to-height ratio for Danish children – close to 99th percentile</td>
<td>Mixed</td>
<td>Not Stated</td>
<td>Semi-structured interview &amp; demographics questionnaire.</td>
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<tr>
<td>Haugstvedt et al 2011 (Study 4)</td>
<td>Norway</td>
<td>Experiences of parenting an overweight child.</td>
<td>Parents</td>
<td>4-11</td>
<td>BMI above the 90th percentile</td>
<td>Not stated</td>
<td>Not stated</td>
<td>Focus Groups</td>
</tr>
<tr>
<td>Hughes et al 2010 (Study 5)</td>
<td>USA</td>
<td>Mothers’ perceptions about how children’s weight is related to their health, how they determine when a child is overweight, &amp; why they think children become overweight.</td>
<td>Mothers</td>
<td>2.5-5</td>
<td>BMI at or above 90th percentile</td>
<td>Low SES</td>
<td>14 White Americans &amp; 7 African Americans</td>
<td>Interviews</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Research Question</td>
<td>Participants</td>
<td>Age Range</td>
<td>Sample Size</td>
<td>Definition of Overweight/Obesity</td>
<td>Analysis Method</td>
<td>Data Collection Method</td>
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<tr>
<td>Jackson et al 2005 (Study 6)</td>
<td>Australia</td>
<td>Mothers’ views of their child’s overweight or obesity</td>
<td>Mothers</td>
<td>1-15</td>
<td>11</td>
<td>Defined by researchers after reviewing a recent photo &amp; asking about clothes size in relation to age</td>
<td>Not stated</td>
<td>Semi-structured interview</td>
</tr>
<tr>
<td>Jackson et al 2007 (Study 7)</td>
<td>Australia</td>
<td>Experiences of mothering an overweight or obese child</td>
<td>Mothers</td>
<td>1-15</td>
<td>11</td>
<td>Defined by researchers after reviewing a recent photo &amp; asking about clothes size in relation to age</td>
<td>Not stated</td>
<td>Semi-structured interview</td>
</tr>
<tr>
<td>Jain et al 2001 (Study 8)</td>
<td>USA</td>
<td>How low-income mothers determine when a child is overweight, why children become overweight &amp; what barriers exist to preventing or managing childhood obesity.</td>
<td>Mothers</td>
<td>2-5</td>
<td>18</td>
<td>Weight-for-height ratio over the 90th percentile (3 of the focus children were below this)</td>
<td>Low SES</td>
<td>Focus group</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Title</td>
<td>Participants</td>
<td>Methods</td>
<td>Measures</td>
<td>Data Analysis</td>
<td>Notes</td>
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<tr>
<td>Lindelof 2010 (Study 9)</td>
<td>Denmark</td>
<td>Obese adolescents’ and their parents’ views on the former’s obesity including barriers and motivational factors that influence adolescents’ ability to lose weight.</td>
<td>Parents &amp; adolescents</td>
<td>14-16</td>
<td>15</td>
<td>Attending weight loss camp – no measurements or definition discussed</td>
<td>Mixed</td>
<td>Not stated</td>
</tr>
<tr>
<td>Lorentzen 2012 (Study 10)</td>
<td>Denmark</td>
<td>Dietary change experiences of overweight children and their families.</td>
<td>Families (Parents, focus children &amp; siblings)</td>
<td>9-14</td>
<td>6</td>
<td>No measurements or definition discussed – children already participants in a weight loss study</td>
<td>Not stated</td>
<td>Not stated</td>
</tr>
<tr>
<td>Pescud &amp; Pettigrew In Press (Study 11)</td>
<td>Australia</td>
<td>Factors affecting low socio-economic parents’ child-feeding practices.</td>
<td>Parents</td>
<td>5-9</td>
<td>37</td>
<td>BMI equal to or over 91st percentile (Cole et al 2000)</td>
<td>Low SES</td>
<td>Not stated</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Objective</td>
<td>Participants</td>
<td>Age</td>
<td>BMI Cutoff</td>
<td>Methodology</td>
<td>Sample Characteristics</td>
<td>Data Collection Method</td>
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<tr>
<td>Southwell &amp; Fox 2011 (Study 12)</td>
<td>England</td>
<td>Mothers’ perceptions of their child’s weight, beliefs about what influences their child’s weight and their responsibility and concerns about managing their child’s weight.</td>
<td>Mothers</td>
<td>6-13</td>
<td>12 BMI equal to or over 91st percentile (Cole et al 2000)</td>
<td>Mixed</td>
<td>Not stated</td>
<td>Semi-structured interview</td>
</tr>
<tr>
<td>Styles et al 2007 (Study 13)</td>
<td>USA</td>
<td>Family problems and coping needs related to children’s eating habits, weight and exercise.</td>
<td>Parents &amp; Caregivers (e.g. Grandmothers)</td>
<td>5-8</td>
<td>54 Weight problem identified by either parent or doctor.</td>
<td>Mixed</td>
<td>Black, White &amp; Hispanic</td>
<td>Focus Groups</td>
</tr>
</tbody>
</table>
Results

Characteristics of Studies

There were 13 studies included in the meta-synthesis, 11 of these were distinct research projects, and the other 2 appeared to use the same sample and methodology. These 2 papers (Jackson, McDonald, Mannix, Faga & Firtko, 2005 and Jackson Wilkes & McDonald, 2007) were deemed appropriate to be included in the meta-synthesis as they described the analysis of different data sets. The studies were conducted in a range of countries including: England, the USA, Denmark, Norway and Australia, however the ethnicity of the participants was only reported in 3 of the papers. The majority of the studies included parents from low socio-economic or mixed backgrounds however 4 of the studies did not report any information on this. The included studies described the views, and experiences, of 290 parents of children aged between 1 and 16. Six of these studies focused solely on mothers, and three investigated the views of children and parents, however only the findings relating to parents were included in this paper.

The method employed for defining weight status differed between the studies and ranged from researchers deciding upon it based on reviewing a recent photo, and asking parents about their child’s clothing size, to the more accepted definition of a body mass index (BMI) equal to, or above the 91st percentile (Cole, Bellizzi, Flegal, & Dietz, 2000). The data collection methods also varied between the studies from focus groups, and semi-structured interviews, to field observations, and self-introspection diaries. One study used a live interactive video conference to conduct a focus group (Davis, James, Curtis, Felts, & Daley, 2008).
Another key feature which varied between the studies was the qualitative analysis method employed. The highlighted methods used were Thematic Analysis, Analytic Strategic Mix, Grounded Theory, a Narrative Based Approach and Structural Analysis. Five of the studies did not define a specific qualitative methodology and merely described how they had identified themes in the data.

Despite these differences no studies were excluded on the basis of their qualitative methodology, or data collection techniques. The studies’ key characteristics are presented alphabetically in Table 3.

**Synthesis**

Through synthesising and translating the studies, two over-arching themes which appeared to affect how parents managed the weight of their overweight child were identified. These were ambivalence and responsibility which both contained several sub-themes as shown diagrammatically in Figure 2. These over-arching themes, their corresponding sub-themes and the relationships between them are discussed in detail below.

**Themes and Related Sub-Themes**

**Ambivalence**

Across the studies it appeared that there was a recurring theme around parents wanting their children to be healthy, and happy, but seeming ambivalent about
implementing weight management strategies to achieve this. Several factors appeared to contribute to this ambivalence and these are outlined below.

Parents’ Own Weight History

Three of the studies found that a parent’s own experience of being overweight was a prominent theme in their data, with many parents who were trying to support their child with obesity also experiencing long standing weight issues. Some mothers were concerned about the affect their weight status, and attitude to food, would have on their children, while others appeared more ambivalent about their own, and their child’s size.

These parents’ own difficulties, and struggles, to control their weight appeared to affect how confident they felt in supporting their child to do this. It appeared that this left some overweight parents feeling quite hopeless about their ability to change things for their child which can clearly be seen in the quote below.

*I’m a failure. Because, you know, I thought this is up to me to sort him out. I’m his mother. I’m supposed to be able to sort him out and I can’t. You know because I can’t sort me out.* (Study 1).

Although parents may recognise that their child is overweight it appears that their own experiences of struggling to manage this may leave them feeling powerless to help. Curtis et al (2011) described how seeking to support their child to lose weight challenged overweight mothers’ sense of self-worth and reinforced a perceived cycle of failure for them. This perceived sense of hopelessness, and helplessness, may
Figure 2. Model of Themes
make it hard for parents to implement and maintain healthy lifestyle changes which they themselves have struggled with.

Parents’ own experiences of how others reacted to their weight status also appeared to have an impact on their perceptions and beliefs about helping their children to lose weight. Many had experienced bullying about their weight as a child and therefore felt that it was more important to build up their child’s self-esteem than to manage their weight. Jain et al (2001) noted that this was often proposed as an approach rather than trying to prevent obesity. This may be linked to beliefs that they are more equipped to build up their self-esteem than to help them lose weight.

Parents’ own weight status also appeared to be linked to their recognition of obesity in their children and this is discussed in more detail below.

**Recognition**

The way that parents defined and recognised obesity was identified as a theme in three of the studies. It appeared that mothers did not define a healthy weight by measurements, or by standardised growth charts, in the way that professionals tend to, but instead they relied on appearance, clothes size, activity levels and their child’s mood. Children were not considered overweight if they were active, playful and happy whereas they were considered overweight if they were inactive, lazy or being teased about their weight.

“I would worry about her weight if she got inactive. And if she started eating a lot and just didn’t get involved with anything.” (Study 5)
Some of the discussions also suggested that parents did not tend to see weight as a problem until it was at quite extreme levels.

“Obese to me [means that a person] can barely walk.” (Study 8)

“Obese means [a] guy needs to come out with a tow truck [in order to move the individual].” (Study 8)

“My child has been put on a diet, and he is so thin and they told me that he is not growing but that he is fat. But I don’t see his fat.” (Study 13).

This apparent lack of recognition of obesity in their children may be linked to the parent’s weight status. If parents are themselves overweight, this may affect what they see as normal for their child, and the parameters they set for this. They may also, due to their own experiences, want to protect their child from receiving this label which they believe will affect their self-esteem levels. This would suggest that recognition of obesity is affected both by parents’ own weight status, and by parents’ desire to protect their child’s self-esteem, which is discussed in more detail in the next sub-theme.

Uncertainty

A recurring theme across the studies was parents’ uncertainty about how to manage their child’s weight. Parents appeared torn by wanting to implement changes to help their child lose weight, and wanting to protect their child’s self-esteem. They appeared to feel unsure about how to bring up issues around weight and worried that discussing this may make it worse in some way. They worried that setting restrictions on the amount they ate would affect the child’s relationship to food, or
lead to an eating disturbance. Parents were aware of the teasing that children experienced about their weight, and did not want to make the home another place for them to feel anxious about their size. Although they were aware of the need for their child to lose weight they also wanted them to be happy with themselves and show that they accepted them for who they were.

“I worry that she’s going to get hurt by other people. I keep thinking, I don’t want her to get hurt. What I want to do is help her build up, be strong in her approach to life. That’s my worry as a parent.” (Study 7)

“You don’t want to teach them not to like themselves like they are, but yet they do need to take off the weight.” (Study 2)

In families where parents themselves are overweight these worries about affecting their child’s self-esteem may be more apparent due to their own experiences of being bullied as a child and struggling to manage their weight. As noted in the first sub-theme, ‘parents’ own weight history’, these experiences may make protecting their child’s self-esteem a priority as they do not want them to feel the same way they did as a child.

This dilemma of wanting to protect their child’s self-esteem, yet encourage them to lose weight appears to be unresolved for many of the parents in the studies resulting in ambivalence about intervening. This at times appeared to lead parents to avoid the issue all together in the hope that it may go away itself, or that the child would take responsibility for this.
“Who knows what she is going to be like at 10 – she might not even eat at 10. She might lose this weight later on, you don’t know – here’s hoping.” (Study 7)

Feeding and Emotion

It was apparent from many of the studies that the way parents feed their children was closely related to their own, and their child’s emotions. In three of the studies parents articulated concerns about cutting down their child’s intake due to worries about them experiencing hunger. Preventing hunger appeared to be seen by some as a higher priority than ensuring their children ate healthy foods.

“I’ve been feeling guilty about passing through the drive thru and being seen by the people there and them thinking I’m a bad mother because I’ve passed through there so often in the last couple of weeks. I don’t know what else to do. I don’t have time to cook and I don’t want my kid to be hungry. I’d rather he be full and happy than starving. I don’t want my kid to starve, that’s worse.” (Study 11)

The act of withholding food from their children or reducing their portion size had a clear emotional impact on the parents, and some thought it went against their role as a parent. This can be seen in the highly emotive use of language in the quote above, which demonstrates how extreme this fear of being seen as a bad parent can be.

Pescud and Pettigrew (In Press) reported that the antecedents to participants’ fears were not readily available but this may be linked to a sub-theme identified by Southwell and Fox (2011) who found that some mothers evaluated their worth against what they could provide for their child in terms of food.
“...when I was feeding, when he was a baby, that was a great comfort to me because I was doing something good.” (Study 12)

Another aspect of this theme was parents’ use of food to secure their child’s affection. Parents enjoyed giving their child pleasure through food treats and appeared to worry that their children wouldn’t like them if they gave them only healthy foods.

At the shops, if they come with me, they know they’ll get a treat (laughs). It’s expected. “Mum, can we get a treat?” “Yep you can”, and I think it’s my thing. It’s my naughty thing, I think, because I love them. So I love to make them happy and I think that’s the trap that I fall into, which is bad because I don’t have to give them treats for food, you know? If I just got them some stickers, that would be perfect. I do that so I think I’m making them happy, where it shouldn’t be that at all. (Study 11)

This sub-theme suggests that a parent’s fear of their children experiencing negative emotions as a result of them reducing their intake of unhealthy foods discourages them from doing this. Some parents also appear to use food as a way to secure their children’s affections and therefore are concerned about stopping this in case their children resent them for it. This fear of being viewed as a bad parent by their child due to enforcing healthy living practices appeared to outweigh the emotional aspects of being a good parent in helping them to lose weight.
Responsibility

Through the studies there appeared to be recurring discussions around where the responsibility lay for children being overweight and for who had the main role in helping them to lose weight. This appeared to be influenced by what parents saw as the cause of their child’s obesity, the perceived resources they had available, and issues around parenting.

Attribution

A recurrent theme in many of the studies was parents’ discussions around the reasons that their child was overweight. The attributions that parents gave for this ranged from genetics, hereditary factors, and previous illnesses, to modelling of poor eating habits, low activity levels and unhealthy diets. Some parents also seemed unclear about what may have caused it and felt that the reasons were incomprehensible.

Another aspect to this sub-theme was where parents placed the blame for their child’s weight difficulties. If a parent viewed the problem as being the result of genetic factors, the blame for this tended to be attributed externally, and seen as out with their control. If however they viewed the reason as being poor diet, or exercise levels, the blame tended to be attributed either to themselves, or to their child. For example the first quote below suggests that the blame lies with the parents due to their modelling of unhealthy eating habits whereas the second, and third quote, appear to attribute the blame to the child.
“Nine times out of ten your child is going to go with whatever you go with. If you eat junk food all day, potato chips, cookies, pop, that’s what they’re going to do.” (Study 8)

“We have done everything at home. We do not have butter, white bread…If she (child) is not motivated…I mean, we cannot lose weight for her.” (Study 9)

“You know, I have done everything I could. It is up to her (child) now; she needs to be motivated. She really needs to want to lose weight.” (Study 9).

From the data presented in these studies attribution appears to be a key theme which affects whether parents adopt, and encourage children, with healthy lifestyle changes. For example the quote below suggests that this mother believes there is no point in changing things as her child is destined to be overweight.

“When you got a fat gene, you got a fat gene, and there’s nothing you can do about it.” (Study 8).

Whereas this mother appears to be able to identify what may have contributed to the problem and therefore may be able to see things they could change.

Yes, well, I can easily see how it’s our diet – we’d just have a little cake now and then, and Coke and stuff like that, and sweets on Saturdays”. (Study 3).
This sub-theme may be linked to the previous sub-theme of parents’ own weight history, in that if they themselves are overweight, and their child is, they may be more likely to see this as the result of genetic factors therefore making it feel harder to change. Attributing their child’s weight difficulties to an external cause may also be a means of helping to protect their own, and their child’s self-esteem, and is in keeping with the sub-theme, uncertainty, which discusses the importance parents place on protecting their child’s self-esteem.

This data would suggest that what parents see as the cause of the child’s weight problem, and where they attribute the blame for this, may be important in understanding the way they manage their child’s weight. If they view this as due to uncontrollable factors such as genetics, or as their child’s fault, they may see little point in adopting healthier eating practices.

**Resources**

This theme came up across several of the studies, particularly in relation to barriers to helping their child lose weight. Parents cited financial pressures, time scarcity, and a lack of resources in their local area, as reasons for why it was difficult for them to implement healthy eating advice. It appeared that although parents expressed a desire to provide healthy meals, buying and serving unhealthy food was seen as an unavoidable response to a lack of time, and money.

“I also find when I’m grocery shopping and I’m looking for healthy snacks they are so much more expensive than the other ones that it is very frustrating to go to the
“grocery store and think you’re buying healthy stuff and then your grocery bill is so high.” (Study 2)

“I’m pretty slack with their meals and that’s because working is hectic.” (Study 11).

Encouraging children to increase their activity levels was also seen as expensive, as parents tended to view this as meaning they had to attend sports clubs or gyms. They also appeared to struggle with motivation to keep up these activities and reported to stopping them after a short time.

“We started a program, a walking program, her and I did that for a while but then like I said we each get busy and we don’t get it done.” (Study 2)

There appeared to be a lack of knowledge on what constituted healthy living practices making it difficult for parents to make the right choices. Parents described difficulties with understanding the nutritional value of foods, and found labels confusing, and misleading. They were also unsure what were appropriate activity levels for their child and what would contribute to this.

The majority of the discussion around resources in the studies appeared to suggest that parents felt many things were out with their control and that the responsibility to provide them lay with others such as local government, education, and food manufacturers.
Parenting

Several of the papers highlight the difficulties parents experienced in trying to control their child’s eating habits and set limits on their intake of ‘junk food’. Many parents appeared to have good intentions, however struggled to implement these in the face of protests from their child or the stress of busy lives. Parents also reported using food to calm down children who were misbehaving or to avoid a confrontation and other parents reported giving up if their child did not stick to the limits they tried to enforce.

Some parents appeared to resent having to alter their own behaviour in order to be a good role-model for their children and found this difficult to do given the other demands of parenting. This was often seen as the role of the mother in families which when added to their other daily responsibilities appeared to add to their experience of it being a burden.

“If I get on the treadmill I don’t want to get on thinking, this isn’t a choice I’m making about me, this is about the fact I’ve got this little nine-year old watching me. So something that is supposed to be for me becomes yet again an extension of parenting, and I am really tired of extensions of parenting.” (Study 7)

In some of the studies parents discussed that although they were trying to encourage their children with healthy eating other family members would challenge them on this, making it difficult to enforce change. It appeared that it was often fathers, and grandparents, who challenged mothers’ decisions on this resulting in children receiving an inconsistent message on the importance of healthy eating.
“When I say she can’t have it, her daddy gives it to her.” (Study 8)

“They all get something to eat before they go to bed, which we tell them no, but she [grandmother] gives it to them anyway.” (Study 8)

**Discussion**

The purpose of this paper was to review, and synthesise, the qualitative research available on parents’ perceptions and beliefs about parenting their overweight child. It aimed to answer the question, ‘what affects how parents manage their child’s difficulties with obesity’. From searching the literature 13 papers were found which used qualitative methods to explore this subject. The meta-synthesis of these papers identified two over-arching themes; ambivalence and responsibility, and several sub-themes.

The first over-arching theme of ambivalence encompassed the recurring sub-themes of recognition, parents’ own weight history, uncertainty, and feeding and emotion.

These four sub-themes all appeared to result in parents being unsure about how, and when to intervene, to help their child lose weight. Parents did not tend to see weight as a problem until it was at extreme levels, and therefore may be unlikely to implement weight loss strategies when told by professionals that their child is overweight. Where parents were also overweight they often felt quite hopeless about helping their child to lose weight or due to their own experiences did not acknowledge the need for them to lose weight. Although some other parents did appear aware that their child was overweight, they avoided raising this issue as they
were worried about affecting their child’s self-esteem. The predominant issue that runs through these four sub-themes is that although parents wanted their child to be healthy, a difference in how they defined weight status, concerns about their ability to do this, and/or worries over making the situation worse tended to result in ambivalence about intervening. This appeared to lead to parents either avoiding the issue, or doing little to implement healthy living strategies.

These findings are consistent with the quantitative literature which found that parents tend to underestimate the weight of their child and do not perceive their excess weight as a health concern (Doolen, Alpert & Miller, 2009 and Towns & D’Auria, 2009). It is also consistent with the research by Boutelle et al (2004) which found that non-overweight mothers were more likely to be accurate in their assessment of adolescent weight status. This meta-synthesis however adds extra information about what the reasons behind why parents struggle to identify obesity in their children and why being overweight themselves may make this more likely.

The second overarching theme which came out from the studies was that of responsibility. The three sub-themes of resources, attribution, and parenting difficulties all discussed where parents felt their child’s weight difficulty had come from, and where the responsibility for managing this lay. It appeared that if parents perceived the cause of their child’s obesity to be outwith their control, or the resources needed to affect change to be unavailable they had less motivation to change to healthier living practices. Some parents also appeared to want to make changes however struggled to implement these in the face of stressful lives, protests from their children, or conflicting messages from others in the family.
These findings are in keeping with the review by Pocock et al (2010) who found that parents perceived prevention of obesity in children to be affected by child factors, family dynamics, parenting, knowledge and beliefs, and resources and environment. They also noted that many of the parents’ comments related to perceived barriers to implementing healthy living practices.

Although this meta-synthesis adds to our understanding of why these parents may appear to do little to implement healthy living strategies it does have some limitations. The number of studies included in the meta-synthesis is quite small, and each of the papers focuses on a slightly different aspect of parenting an overweight child. The studies also used different data collection methods and employed varying qualitative analysis techniques which in some cases were poorly utilised and explained. In one study the themes described were merely the interview questions and in others there was no interpretation of the data but instead what appeared to be grouping of similar statements. In order to include these studies in the meta-synthesis the current author therefore had to decide upon the inferred concept from the description of themes and supporting data provided and in some cases rename lengthy themes to make them more practical. As the current author did not have access to all the data for these categories it may have resulted in the renamed sub-theme having a slightly different meaning from what the original author had intended.

Another limitation of the literature included in this meta-synthesis was the limited demographic information provided about participants included in the studies. This
makes the transferability of the findings difficult to assess and is particularly important in this area of research as socio-economic status and cultural beliefs are known to be associated with obesity (Doolen, Alpert & Miller, 2009 and Towns & D’Auria, 2009).

Despite the limitations of the existing literature, this synthesis highlights the importance of including parents in childhood weight management programmes as has been demonstrated in quantitative research (Golan & Crow, 2004 and Grimes-Robinson & Evans, 2008). This review would suggest that interventions need to focus on more than just healthy lifestyle changes to be effective, and that they may benefit from including advice on general parenting strategies as well as being based on a self-esteem promoting approach. This approach has already begun to be included in some parenting based interventions such as The Lifestyle Triple P Programme (West & Sanders, 2010 and West, Sanders, Cleghorn & Davies, 2010) which focuses on nutritional education, physical activity strategies and positive parenting. This also looks at how to increase children’s self-esteem levels early on in the programme. In addition to this it may be beneficial for interventions to acknowledge, and allow space for discussion around the possible emotional consequences of changing children’s lifestyles and how parents own experiences affect this.

The results of this meta-synthesis would suggest that future qualitative research in this area should focus on the emotional aspects of why parents struggle to manage their child’s weight problems. It should also look at how a parent’s experience of managing their own weight may affect this process. These studies need to employ
an appropriate qualitative methodology, and include participants from varying social and cultural backgrounds.

In conclusion this synthesis adds to our understanding of the complex processes which may lead parents to struggle to implement, and encourage their overweight children with weight management strategies. It also sheds light on the factors which lead to ambivalence around helping their children to lose weight and suggests where parents may see the responsibility for supporting both themselves, and their child to do this.

References


**Paper 2**
How do Children Accessing Weight Management Services Perceive their Body Size?

Prepared in accordance with requirements for submission to *Qualitative Health Research* (Appendix 5)

Word Count: 8481

Abstract
The objective of this study was to investigate how overweight children, who are attending a weight management group, perceive their size, and how they experience this in their daily lives. It aimed to explore how these children made sense of their experiences and how this affected their self-view. Semi-structured interviews with 6 children, aged 8-12, who were attending a MEND weight management intervention, were recorded and transcribed. These were analysed using a combination of Thematic Analysis and Interpretative Phenomenological Analysis. Four themes labelled; recognition, self-view, beliefs about exercise and weight loss, and making sense of eating were identified. One over-arching theme labelled minimisation was found to run through these four themes. Results are discussed in relation to previous research and what they add to our knowledge of overweight children’s experiences. Directions for future research and possible clinical implications are also discussed.

Keywords: Children; Obesity/Overweight; Qualitative Analysis; Self

Introduction
Around a third of children, aged 2-15 years old, in the United Kingdom are overweight or obese (The NHS Information Centre, 2011 and The Scottish Government, 2011) and this number is predicted to continue to rise (Stamatakis, Zaninotto, Falaschetti, Mindell, & Head, 2010 and Foresight Report, 2007). Along with the long term physical complications associated with childhood obesity (Must et al, 1999) these children might also be at immediate risk of psychological difficulties such as low self-esteem and behavioural problems (Reilly et al, 2003). This risk might be increased in children from low socio-economic backgrounds as low socio-economic status (SES) is believed to be linked to negative self-perceptions (Muldoon, 2000).

As children have limited control over their environment, and are heavily influenced by their parents’ behaviour, research has tended to focus on the views of parents of overweight children. Quantitative literature has suggested that these parents often underestimate the weight of their child and do not perceive their excess weight as a health concern (Doolen, Alpert & Miller, 2009 and Towns & D’Auria, 2009). Building on this work, Southwell and Fox (2011) undertook a qualitative study and found that how mothers perceived themselves, and how they felt they were perceived by society influenced their feeding practices. They also found that mothers attempted to minimise the severity of their child’s weight to protect their esteem as a parent. A recent qualitative review of similar papers found that parents appeared ambivalent about intervention, as they seemed caught between a desire to intervene, and fear of the possible consequences of this, such as damaging their child’s self-esteem (Lachal et al, 2013).

This suggests that parents may minimise the importance of their child’s overweight status to protect their own, and their child’s self-esteem. They may do little to
encourage their children to lose weight, and therefore give the impression that this is not a concern. This raises important questions about how overweight children interpret these messages and highlights the importance of exploring these children’s experiences.

A systematic review by Rees, Oliver, Woodman and Thomas (2011) aimed to bring together the views of young children (aged 4-11) in the UK about obesity, body size, shape and weight. Their review identified that children viewed being overweight as a problem because of the social impact it could have, such as being less popular or bullied, rather than due to health concerns. They also found that children often blamed overweight people for their size, and that size was viewed as something that was within an individual’s control. Of the 28 studies included, only 3 of them aimed to explore the views of overweight children, and very few were judged to be of good quality. They also highlighted that children’s ethnicity and SES was frequently not stated, making it difficult to assess the impact of these factors. The SES of participants is particularly important as levels of obesity are rising most rapidly in low SES groups (Stamatakis et al, 2010) and as already mentioned low SES is associated with low self-esteem (Muldoon, 2000).

Despite these limitations the Rees et al’s (2011) review suggested that overweight children were likely to be experiencing social difficulties due to their size, and may feel blamed by others for being overweight. However, research with overweight children is relatively scarce, so we know very little about the impact of these experiences on them.

One study which investigated the views of overweight children was that by Murtagh, Dixey and Rudolf (2006) who looked at 7-15 year olds’ views on levers and barriers
to weight loss. These children identified bullying and a desire to fit in as key motivators to change, but the decision to lose weight almost always required the influence of an external figure. The children also reported difficulties making sacrifices to achieve weight loss, low confidence and self-esteem levels and a perceived lack of control over their environment and behaviour. This study provided very limited demographic information on participants and presented little detail about their analysis and results, making it difficult to draw conclusions from it. As this paper focused on perceived barriers to weight loss, it also missed out vital information on how these children think and feel about their own weight and how this affects their self-view. Exploring how overweight children make sense of their experiences and how this affects their self-perception may be the key in helping them overcome perceived barriers to weight loss.

Snethen and Broome (2007) aimed to investigate overweight 8-12 year olds’, perceptions of weight, exercise and health. These participants were from ethnically diverse backgrounds. Using semi-structured interviews researchers identified four themes; intellectual disconnect, body image incongruence, social importance and exercise perspectives. These themes suggested that although children had a good knowledge of healthy eating advice they were not generally following this, and often did not identify themselves as being overweight. They also described a strong desire to fit in, and reported being bullied or teased about their weight. Although this study adds to our knowledge of the experiences of overweight children, it does not attempt to interpret how this affects their self-view or explore how they make sense of being overweight.

A study by Curtis (2010) offered some insight into the issue of how being overweight makes children feel by investigating overweight 10-17 year olds’
experiences within secondary school. These participants reported feeling under intense scrutiny from their peers, especially during physical education lessons, or when eating, and were acutely sensitive to any implied, or assumed criticism about their body, bodily performance or social practices. Almost all of the young people in the study reported being bullied at school, and many reported that they felt on the outside of local peer culture. This study provided no demographic information on participants and focused solely on their experiences at school.

The few studies that have explored overweight children’s experiences suggest that they have low self-confidence and self-esteem levels, experience bullying and scrutiny from their peers, and have a strong desire to fit in. However, these studies do not attempt to interpret how the children make sense of their experiences and how this affects their self-view. Undertaking this deeper level of analysis may help to identify why these children struggle to lose weight despite understanding healthy living advice, and the processes by which their self-esteem may become affected.

The lack of demographic information provided in these studies also leaves a gap in our ability to draw conclusions from them. This is particularly important for factors such as SES which has a strong relationship with levels of obesity (The NHS Information Centre, 2012). This combination of high body weight and low SES has been shown to increase the risk of having more negative self-perceptions (McCullough, Muldoon & Dempster, 2009).

The objective of the current study was therefore to investigate how overweight children from socio-economically deprived areas perceive their size and how they experience this in their daily lives. It aimed to explore how these children made sense of their experiences and how their perceptions and experiences of their size
affected their self-view. Investigation of these children’s experiences and perceptions of their weight might help to inform more effective long term weight management interventions.

Method

This qualitative study set out to use Interpretative Phenomenological Analysis (IPA, Smith, Flowers & Larkin, 2009) to analyse the interviews because it is particularly useful where the topic being studied is subjective, relatively under studied and where issues relating to identity, the self, and sense making are important (Smith, 2004). In IPA, the researcher typically puts themselves into the position of the participant and attempts to really understand the issues being spoken about from the participant’s unique perspective. In the present study it however became apparent that the content of some of the interviews with the children provided limited detail. It proved difficult for the researcher to interpret what the participants meant, and how they were making sense of their experiences, due to the way they presented their responses. This made the use of a standard IPA approach unfeasible and it was therefore decided to carry out a Thematic Analysis (TA, Braun & Clarke, 2006) supplemented, where the data allowed, by the more detailed interpretations typically reported in IPA (Smith et al, 2009).

TA is a method for identifying, analysing and reporting patterns across data. The methodology is not tied to any theoretical framework and therefore can be used within different theoretical frameworks (Braun & Clarke, 2006). Use of this would allow a pattern of meaning to be developed across the participants, including where less detailed accounts were provided. Where opportunities arose to undertake a deeper, IPA analysis, this was conducted upon the data. This allowed the researcher
to ‘get into the shoes’ of the participants, in an attempt to understand their internal world.

The study was approved by the local National Health Service (NHS) ethics committee (12/NW/0158) and the relevant research and development panels (Appendices 6-9).

The first author was a 30 year old woman, with a normal body mass index (BMI), who first became interested in the research topic while working as a Dietitian. This background in traditional scientific views might have meant she was more aware of how participants made sense of their weight and how this differed from professional views. Her experience in psychology however allowed her to reflect on how this fitted within the participant’s self-concept. The second author was a clinical psychologist within an eating disorder team who had experience of conducting qualitative research. The third author was a professor of health psychology who also had experience with qualitative methodologies.

This information is provided in the interests of transparency and to allow the reader to interpret the data and the researcher’s understanding of it (Elliot, Fischer & Rennie, 1999).

**Recruitment**

Participants were recruited from MEND (Mind, Energy, Nutrition….Do it!) 7-13 healthy living groups in two locations in the UK. MEND is a 10 week healthy lifestyle programme for children who are above a healthy weight, and consists of twice weekly sessions focusing on how to choose healthier foods and spend more time being active. The sessions contain a practical component such as swimming, or
bike riding, and whole families are invited to attend. MEND advertise locally, and the majority of families self-refer, although they can be referred via their GP or school nurse. The groups are manualised packages provided by MEND trained, public sector workers, through joint local authority and health funding.

Recruitment was carried out through MEND because these children had already been identified as overweight therefore negating the need for the researcher to undertake height and weight measurements, which may have affected a participant’s engagement with the interviews.

Group leaders handed out parent and child information sheets (Appendix 10 & 11) at around the third MEND session and this was followed up by a brief presentation from the principal researcher a week later. Both children and parents were present at these presentations. Interested families completed consent to be contacted forms (Appendix 10) and were then contacted by phone to arrange the interview.

Recruitment was very slow and the number of participants recruited was below that anticipated. This mirrors difficulties highlighted in recruiting families to weight management programs (Eckstein et al, 2006 and Rice, Thombs, Leach & Rehm, 2008) and may be related to inflexibility in making time for the interviews, concern over the interview upsetting their child or other family difficulties taking precedence. It may also be the case that children and their parents who chose not to participate did not see the value of the research, or alternatively felt that if the child took part in the research they would further reinforce the child’s identity as an overweight person. No information was sought from those who did not take part and therefore these hypotheses cannot be verified.

**Location**
This split site study had one recruitment location in South West (SW) Scotland (site 1), and one in North West (NW) England (site 2). These locations were identified by MEND headquarters due to their history of providing high quality groups and their stable funding provision. These locations were areas of high deprivation, with site one falling within the top 5% most deprived datazones in Scotland (Scottish Index of Multiple Deprivation, 2012) and site two falling within the top 50 most deprived local authority districts in England (English Indices of Deprivation 2010, 2011).

**Participants**

Only children aged 7-13 years old, who were attending a MEND group, and who had been identified as overweight as defined by a BMI above or equal to the 91st percentile for their age (Cole, Bellizini, Flegal & Dietz, 2000) were eligible to participate. This was important as several of the participants had siblings attending the MEND programmes who were not overweight. Participants also had to be able to comprehend spoken and written English, and have no known medical cause for their weight status.

Six participants (2 male, 4 female), aged 8 to 12, took part in the study. Three of the participants’ BMI fell within the overweight category (≥91st percentile) and three fell within the obese category (≥98th percentile). Two participants were recruited from site one and four from site two. Four participants were white British and two were of British Asian descent. These participant characteristics can be seen in Table 4.

Although the number of participants included was below that aimed for, Smith and Osborn (2007) suggest that there is no correct number of participants for a qualitative study and that, at least for IPA, sample sizes should be small to allow detailed analysis of each case. It is not unusual for published IPA studies to contain
only six participants; for example, the studies by Fox and Diab (In Press), Higginson and Mansell (2008) and Smith and Osborn (2007) all had six participants.

**Interviews**

Interviews were conducted towards the end of a participant’s 10 week attendance at MEND or just after it had finished.

Prior to conducting the interviews families were given a summary of the study before written consent was obtained from a parent and assent from each child. These forms are available in Appendix 12 & 13.

Interviews were conducted in the participant’s own home, on a one-to-one basis, with their parents easily accessible in an adjoining room. Children were given the option of having a parent present, however no child requested this. Before beginning the semi-structured interview the researcher engaged the child in a discussion about relatively unchallenging topics such as their hobbies, likes and dislikes, and their daily routine. This allowed the child to settle into the interview and gave the researcher an opportunity to build up a rapport with the participant and grasp the child’s communication style (Cameron, 2005). The main body of the interview was guided by a topic guide, which took the form of a semi-structured interview (Appendix 14) that encouraged participants to discuss their perceptions, and experiences of their weight in their own words. It began with less difficult questions about their experiences of attending MEND before asking more specific questions about their weight.

Table 4. *Details of Participants*
The questions were developed based on the aims of the project and were revised following the first interview to include a direct question about whether participants thought they were overweight. To avoid influencing the participant’s responses the researcher prompted children by repeating words used by them (DiCicco-Bloom & Crabtree, 2006) and utilising verbal, and non-verbal cues, to encourage continued discussion (Cameron, 2005). If participants struggled to answer the question further probe questions were used.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Sex</th>
<th>Site</th>
<th>Height (m)</th>
<th>Weight (kg)</th>
<th>BMI (kg/m²)</th>
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<td>10</td>
<td>M</td>
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<td>1.42</td>
<td>48</td>
<td>23.8</td>
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<td>11</td>
<td>F</td>
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<td>1.4</td>
<td>44.4</td>
<td>22.7</td>
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<td>British</td>
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<td>11</td>
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Interviews lasted between 13 and 56 minutes with the average being 30 minutes. This is comparable to interview lengths of around 20 minutes (Murtagh et al, 2006) and 30 to 60 minutes (Snethen & Broome, 2007) reported in similar studies.

Demographic information such as date of birth and ethnicity were also recorded and participants’ initial measurements were obtained from MEND, with prior permission from the participant, and their parent.

**Analysis**

Interviews were tape-recorded and transcribed verbatim by the principal researcher. As is common to both the procedure in TA (Braun & Clarke, 2006) and IPA (Smith et al 2009) the transcripts were read, and re-read several times to allow the researcher to become familiar with the data. During this stage initial thoughts and ideas on themes were written in one side of the margin. The transcripts were then re-read and an inductive approach, based on the principles of TA (Braun & Clarke, 2006), was used to identify codes which were strongly linked to the data. These were noted as short codes in the other side of the margin.

An IPA approach was then used to gain a deeper level of analysis which attempted to get into the shoes of participants. This was done by coding the language the participant used for example particularly poignant wording, the use of repetition suggesting that they were uncertain, and the use of metaphors. Where there were particularly rich, detailed descriptions of experiences and perceptions, the researcher also attempted to interpret the participants understanding of what they were discussing, and how they made sense of this by noting conceptual codes. The principal researcher kept memos of her reflections through these stages which were
then used to aid the next stage of analysis. The second and third author also carried out this process for one transcript each, and their coding were then compared with the first authors to ensure that the codes were representative of the data. A short extract of a coded transcript can be found in appendix 15.

A list of these preliminary codes was constructed, along with quotes from the original data which illustrated the code. The researcher then looked for connections between them and considered how they may combine together to form themes. Once themes had been identified they were then explored and developed to identify how they fitted together. During this process the researcher regularly returned to the original transcripts to check the interpretations against what the participant actually said and made use of her memos. The emerging themes were discussed with the research team on a frequent basis.

**Results**

From analysing the interviews four main themes relating to how the participants experienced, and made sense of their weight were identified; recognition, self-view, beliefs about exercise and weight loss, and making sense of eating. A further overarching theme, minimisation, appeared to run through the three themes. The relationships between these themes and their corresponding sub-themes are shown diagrammatically in Figure 3 and are discussed in detail below.
Figure 3. Model of Themes from Interviews
Recognition

All participants recognised at some level that they were overweight, and all but one could identify reasons for their excess weight, such as unhealthy or excessive eating, a lack of exercise and playing video games. Participant 3, aged 9, was the only child who did not appear to have an understanding of why he was overweight.

Although the children recognised that they were overweight the way they thought about this and their level of acceptance of it varied. For example participant 3 acknowledged that he was “kind of overweight” however later in the interview stated that he felt “that I’m dead skinny”. Participant 6 also recognised that she was overweight but never referred to herself as overweight and instead termed herself “just a little bit over average”. At times these two participants also appeared to avoid a discussion of their weight status, either by changing the subject when asked a direct question about their weight, or by moving the focus from themselves to other people.

From interpreting participant 3’s interview as a whole it seemed that he was comparing himself to more overweight children and therefore thinking that his weight was ok. He also seemed to be picking up on adults attempts to protect his self-esteem for example by saying people teased him because they were jealous. Although he was aware he was attending MEND because he was overweight, he was not receiving messages from the adults around him that his weight was a problem and therefore did not view this as a serious issue. As this participant’s interview provided fairly limited detail it may also have been that he was developmentally not as able to think about some of these more abstract concepts about his weight and therefore relied on what he had heard others say.
In contrast the children who recognised they were overweight were frequently being
told by both adults, and other children, that they were overweight. Their parents had
also suggested they go to MEND to lose weight.

“Well, I, my Mum saw that I wasn’t like I was being, I looked much heavier than my
other friends and said that you should, it’s better that you go and start getting a like
active and start doing something and instead of putting this weight on and then it
might not affect you when you go to high school or something, you don’t get
bullied.” (Participant 4, aged 10).

These children did not describe being given any supportive messages about their
weight, and from the hesitation seen in the quote above, it is hypothesised participant
4 was quite upset by his Mum’s view of his weight. It seemed that it was the
combination of constantly being told that they were overweight, particularly from a
parent, without any positive messages about their size that made these children
recognise their overweight status. In fact it appeared that this recognition was
actually an internalisation of other peoples’ views about their size and did not appear
to be a positive basis for weight loss. Instead it appeared to make the children feel
they were to blame for being overweight and confused about why they were
struggling to lose weight. It also seemed to make them feel quite low in mood.

This recognition is closely linked to self-view as discussed below.
Self-View

Negative

The predominant self-view of participants in the study was quite negative, and three of the participants talked in detail about how they disliked their size, or appearance, and how they compared themselves negatively with others.

Participant 2 described her weight as “atrocious” and stated she felt like a “big blob of jelly”. This very strong use of language appeared to reflect the derogatory view she held of herself, which at times verged on disgust. Likewise her repeated use of “fed myself rubbish” seemed to reflect her negative self-view. This participant blamed herself for being overweight and was very angry with herself about it.

These feelings were reinforced by the constant bullying she experienced and by her Mum’s quite flippant reaction to the bullying, which failed to recognise her daughter’s struggle to lose weight.

“And my Mum says well you just need to lose weight and then that willna happen” (Participant 2, aged 12).

It appeared that she was internalising others’ derogatory comments towards her, and chastising herself for not being able to change, and fit in. She seemed quite confused over how she felt about herself and appeared to be engaged in an internal struggle over this.

“.but sometimes to me I’m happy with myself cos I’m my own person but then as I said sometimes I’m unhappy because em I’m overweight for my age but I’m quite happy with myself so I am” (Participant 2, aged 12)
The sense from this interview was that she wanted to like herself and wanted in turn to be liked, and fit in, but her weight and negative feelings about herself were getting in the way. She talked in detail about her attempts to overcome her overweight status, the healthy changes she had made, and her subsequent weight loss. It appeared that she was trying to emphasise her attempts to change and gain praise. This could have been linked to trying to make herself feel better about who she was or to make others think of her in a positive light.

In a similar way participant 4 appeared to have quite a negative self-view and he again blamed himself for being overweight. Throughout his interview he described things that his Mum had said about what would happen if he was overweight, and comments that both bullies, and his friends, had made about his weight. From this participant’s use of language and description of how this made him feel it seemed that he had been ground down by the constant teasing, and was quite hopeless about the possibility that things could change.

“It just makes me feel sad and not wanting to like stay anymore and just want to like go, go away. Like it sometimes it makes me just wanna not want to be living anymore” (Participant 4, aged 10).

The teasing about his size appeared to have spread to all areas of his life and made him feel bad about himself generally. This seemed to have resulted in a general sense that people may not like him and were criticising him.

In contrast to these two participants, participant 5 discussed her dislike of her weight, and how this made her feel sad, but also described positive aspects of herself. This participant described frequent teasing about her weight, was upset that she couldn’t fit into the same clothes as others, and appeared to have internalised some negative
comments from others as shown by referring to herself as “fat”. The extreme self-dislike described above was however not apparent, and in fact she was able to say that she was good at sports and cleverer than her siblings. It appeared that she was more resilient to this bullying.

The participants’ self-view seemed to be closely related to what others thought of them and this can clearly be seen in the quote below from participant 6.

*I: Em, so how do you feel about your weight?*

*P: Mm sometimes em I’m a little worried about it because I might get teased but then again I’m alright about it cos people at my school they’re quite nice so mm they’re not judgemental on anybody so I’m alright with it.* (Participant 6, aged 11)

It appeared for this participant that if people judged her weight negatively her self-view may become more negative and her mood might drop. It seemed that this was a key factor in why she tried to present herself as a very active person, and avoided referring to herself as overweight.

**Resilience**

Although all of the participants described being bullied, disliking their size, or wanting to lose weight, the way that they reacted to this, and the effect it had on their lives appeared to differ. As described above participant 5 was unhappy with being overweight however this did not appear to affect other aspects of her self-concept and she was able to describe her positive attributes.

“*Because they, they are not more active but they’re faster than me but I’m clever.* (Laughs)” (Participant 5, aged 11).
It seemed that this resilience was related to being able to discuss her concerns with her Mum who reacted in a supportive, non-blaming way, and the acceptance from her friends.

“..what my friend says no matter what size you are no matter how big you are you’re still a friend you’re still here.” (Participant 5, aged 11)

This supportive atmosphere allowed her to see that being overweight did not mean that she was a bad person in the way that participant 2 and 4 appeared to think. This may put her in a better position to lose weight than those whose whole self-concept was affected by their size.

In a similar way participant 1 appeared to be less affected by the bullying and although she described being upset by this, it did not seem to affect her view of herself as a person, and in fact she described not believing what the bully said.

“Well it made me feel sad but then I, but then I didn’t feel very sad anymore because I knew it wasn’t true.” (Participant 1, aged 8)

This interview was not as detailed as the others, possibly due to her developmental stage, however there was a strong impression that she generally felt quite positively about herself and her potential to lose weight. It appeared that this was related to the non-blaming and supportive messages she received, and the way Mum suggested they go to MEND as a joint activity.

“Well, we both wanted to lose a bit of weight so, so we thought we might start it.” (Participant 1, aged 8)

Participant 3 also appeared to display a degree of resiliency, however in contrast to the above participants it seemed to be for quite different reasons. It felt that he
displayed little concern about his weight, and the need for him to change to lose
weight, due to adults around him downplaying the significance of his excess weight.
In turn it appeared that when he was bullied he became angry with the bullies, and
fought back, as he viewed them as having the problem. Although this allowed him
to maintain his self-esteem it did not appear to encourage him to lose weight.

**Beliefs about Exercise & Weight Loss**

All the participants talked about activity levels, and weight loss, and appeared to
hold several beliefs about these two things. Several were keen to talk about how
active they were, or how they wanted to become more active and what this would
mean. Participant 6 in particular talked frequently about how much exercise she did.

> “Em no I still still like em jump about on my bed, em have a good laugh, go on the
computer, play in the garden, run, run around to take a few laps in the morning. So
yea I’m doing good at home”. (Participant 6, aged 11)

It seemed that this participant was emphasising her high activity levels, and
minimising her weight status, in order to present what she viewed as a positive self-
image. This might have stemmed from internalisation of the bullying she had
experienced, or through internalising wider societal beliefs that being overweight is
negative. Thinking about herself in these terms may have helped her to keep a
positive self-view it however may also have contributed to her reluctance to take
responsibility for her unhealthy eating. This is discussed further in the minimisation
theme.
The participants all appeared to have an understanding that increasing activity levels would aid weight loss but some placed unrealistic emphasis on the effect this would have.

“..if you do have the food you're going to have to do more exercise because to burn that food off so then you're not really gaining you're losing something cos if you walk even more an run after a meal then you've actually got rid of that.” (Participant 4, aged 10)

This emphasis on the value of exercise may have been because it seemed an easier aspect of their lives to change than their eating did. It also appeared that participant 4 thought this may be a way that he could lose weight and continue to eat the foods that he really liked. Given the value that is placed on exercise, both in the MEND programme, and through the media, it is not surprising that the children viewed this as the way out of their difficulties.

With regards to losing weight nearly all of the participants held positive beliefs about being thinner, which were related to a desire to fit in and be more attractive, rather than improve their health.

“That's why I want to lose weight to get more nicer clothes”

“Em well what people say to me it affects but if I was thinner they wouldn’t call me anything” (both Participant 5, aged 11).

There appeared to be a sense from the participants that if they lost weight, and were slim, their lives would improve. This was particularly strong for the participants who held very negative views about themselves such as participant 4.
“I've just like when I look at myself I think I want to be slimmer and I wanna and I look at other people and I say well I wish I looked like, I was that slim, you know.”

“Well if you did, some people that are less weight, like, are better looking because, you know, it’s because people like like when people are much slimmer it makes them look better looking instead of like having to you know be really fat and it makes you feel like like unloved..”

(both Participant 4, aged 10).

These two quotes give a sense of the desperation the participant felt about wanting to be thin. Holding positive beliefs about being thin, but knowing that he was not thin, appeared to compound his negative feelings about himself.

**Making Sense of Eating**

The majority of participants in the study recognised that they were eating too much and/or unhealthy foods and that this contributed to their weight status. However most were uncertain why they were persisting with this style of eating. The following sub-themes are thought to reflect how the children made sense of their eating.

**Addiction**

Most of the participants described feeling that they could not help eating certain foods or that at times that they couldn’t control their eating. The availability, or presence, of foods that they liked appeared to make it harder for them to control what they ate and some felt that at times the desire for this food took over.
“Yea sometimes I can just say to myself like no you’ve had enough and I’ll leave it but sometimes I really I just get so really like, oh I just want that so much and oh I’ll just take it and then you know like and then you regret it after.” (Participant 4, 10)

Some participants described how they wanted to stop this pattern of eating but that it was out of their control.

“Em, I was trying to like, there were things going through my mind telling me to stop I was telling myself to stop but I was just like, I just like lost my mind and kept eating fatty foods.” (Participant 2, aged 12)

Participant 2’s use of “just like lost my mind” suggested that this participant knew her eating was unhealthy but felt that it was driven by something out with her control, which was almost compulsive. This seemed very confusing for her and labelling it as an “addiction” may have helped to make it more understandable.

Three of the participants described how they thought they were addicted to fatty foods, junk food and/or sugar. It appeared that these children were using the word addiction to explain why they overeat and why they found it difficult to stop themselves. This may have been a phrase that they had heard adults, or the media use, but it appeared they may not have fully understood what it meant.

This quite extreme, and dramatic, use of language may reflect how out of control they felt their eating was, or it may be a way of justifying why they overeat and minimising their responsibility. This appears to be the case for Participant 6 who likens her ‘junk food addiction’ to adult smoking and drinking addictions, and as such appears to suggest that this is out of her control and she therefore cannot be blamed.
“yea I sort of do cos all things that are bad for you they’re just soo good so you get a little bit addicted, like some adults get addicted to alcohol even though it’s bad for them and smoking. An like some kids just get addicted to junk food cos it’s good for, cos it might be bad for them it’s good like the things adults do with alcohol and smoking. So if you think of it like that you really can’t be blamed for that much.”

(Participant 6, aged 11)

Describing her eating as an addiction may be an attempt to minimise responsibility for her intake or it may also be a way to try and help people understand how difficult it is to lose weight. This might be a way of trying to reduce the likelihood that others will blame her for being overweight.

For participant 2 and 4 it also seemed that this idea that they were addicted, and therefore could not control their intake, despite being desperate to lose weight, might have had a negative impact on their self-view and mood. It appeared that after eating these foods they then felt bad about their selves and became angrier with their selves.

“So then I got angrier with myself knowing that I shouldn’t be eating but I still did it repeatedly.” (Participant 2, aged 12)

Taste

Most of the participants described how the taste of foods, such as crisps and chocolate, would make them want more, and how at times due to this they would eat even when full. The enjoyment that eating these foods gave the children appeared to be, in their minds, a sign that they were addicted.

“like I’m addicted cos of their taste, the cheese and onion crisps, like the cheese and onioness of them and the chocolate the goodness.” (Participant 2, aged 12)
“I think it’s just, mm, nothing else particularly I think it’s just the sugar and the way it tastes like and the different flavours that, em, that’s just pretty much the only reason how I found out about caramel.” (Participant 6, aged 11)

This again appeared to be a way of the children making sense of why they over ate when they wanted to be slimmer, and gave them something to blame.

Self-Forced Eating

Participant 2 talked in detail about how she felt she “forced” herself to eat even though she knew that this was unhealthy and did not want to. This appeared to be a very powerful factor in her weight difficulties and was closely linked to how she felt, and thought about herself.

“Yea it’s because I forced myself to eat rubbish when I knew I wasn’t supposed to, em, but I just repeatedly done it so I was getting angrier at myself so I was.” (Participant 2, aged 12)

This sub-theme seemed to differ to that of taste, whereby participants where giving in to something they enjoyed, and in contrast appeared to be linked to punishing herself. This sense that she was punishing herself fits with her very negative self-view. Sadly however it appeared that this self-forced eating only made her more disgusted with herself, and therefore perpetuated her negative self-view.

Minimisation

Running throughout the interviews was a recurring theme that suggested some of the participants were attempting to minimise the importance of being overweight, and
the impact that their weight had on their lives. For example participant 6 appeared to minimise, and down play her weight status throughout the interview. When asked whether it mattered whether you are overweight she also appeared to minimise and almost dismiss the importance of weight status.

“I don’t really think it does because sometimes it takes slower for some people to lose weight and em like I said the height does affect your weight as you grow taller you might gain some and plus the like the stuff that you eat some of it might be a little bit heavier” (Participant 6, aged 11)

As already discussed it seemed that this participant was trying to avoid being seen as an overweight person, and instead present herself as an active person which she thought held more positive connotations.

This minimising also appeared across participants’ descriptions of the bullying they experienced as shown below.

“..and it was just like I did get bullied yea but I just forgot about it and told my mum..” (Participant 2, aged 12)

“upset but it makes me laugh as well” (Participant 5, aged 11)

It seemed that this was a way for the participants to manage the unpleasant feelings associated with being bullied and allowed them to still feel part of the group. It however also appeared that this was related to the participants’ acceptance of bullying as a normal part of being overweight.

“Em, it makes me upset, I sometimes go home and just think about it in my bedroom but other than that it’s alright. I’m used to people calling me that but I don’t like it.” (Participant 5, aged 11)
Minimisation was also evident in participant 5’s negative discussions around how she viewed herself.

“Kinda horrible but (laughs) but now that I think about it, it was kinda funny but I hated the belly that I had when I was down in X so I did.” (Participant 2, aged 12)

It seemed that this minimisation was a coping strategy which helped the participants manage their feelings about themselves, and their weight. For example in the quote above it seemed that participant 2 did not want to engage with how horrible these experiences were, and therefore minimised the impact of this way by laughing it off to avoid re-experiencing the feelings.

**Summary**

Four themes were identified from the interviews; recognition, self-view, beliefs about exercise and weight loss, and making sense of eating. Recognition referred to the different ways the children thought about their weight status and their varying levels of acceptance of it. This was related to the self-view theme which described the negative self-view some participants held and the apparent resilience displayed by others. The beliefs that participants held about exercise and weight loss appeared to affect their self-view. The final theme labelled making sense of eating contained the sub-themes; addiction, taste and self-forced eating, which described the ways the children attempted to make sense of why they continued to eat unhealthy foods.

The over-arching theme labelled minimisation ran through these themes and described the ways that participants tried to minimise their weight status or the effect
that being overweight had on them. This appeared to be a coping strategy for the children.

**Discussion**

The aim of this study was to investigate how overweight children, from socio-economically deprived backgrounds, perceived their size and how this affected their lives. A combination of TA (Braun & Clarke, 2006) and IPA (Smith et al, 2009), was used to undertake a detailed analysis which explored how these children made sense of their experiences, and how this affected their self-view. Four themes labelled recognition, self-view, beliefs about exercise and weight loss and making sense of eating, and one over-arching theme, labelled minimisation were identified.

The recognition theme suggested that although the participants recognised they were overweight their level of acceptance of this, and the way they thought about it differed. Some appeared to minimise their overweight status, whereas others appeared to have internalised the negative views of others about their size. These findings differ from those of Snethen and Broome (2007) who described body image incongruence as a key theme in their data. In their study several of the participants reported that they were “normal weight” or “underweight” and those who did respond that they were overweight stated that this was “just a little”. The current study would suggest that overweight children do know they are overweight but they might not think it is important or want to identify with the label. It also suggests it is not helpful to emphasise to children that they are overweight because they are already likely to be receiving these messages and it might increase feelings of blame, which is unlikely to be a helpful basis for weight loss.
Linked to this was the strong negative self-view some participants held and the resultant self-blame and anger they felt. It appeared that participants might have been internalising derogatory comments and blaming messages from parents. The absence of other qualitative research which has explored overweight children’s self-view makes it difficult to verify this finding. However, it does fit with Puhl and Latner’s (2007) suggestion that obese children’s internalisation of societal stigma might influence their attributions about the causality of obesity and have negative implications for their self-esteem. It is also in keeping with Wardle and Cooke’s (2005) finding that weight-related teasing may be a mediator between obesity and low self-esteem and depression.

Some children in the study appeared more resilient to the bullying and were able to describe positive aspects of themselves. This might have been related to them internalising positive, non-blaming, messages from friends and family. This is in keeping with Pierce and Wardle’s (1997) finding that lower self-esteem was seen in children who believed they were responsible for their excess weight, compared with those who provided external attributions for their size. This apparent resilience was highlighted in the review by Wardle and Cooke (2005) who suggested it mirrored the findings from other stigmatising conditions, such as cleft palate or port wine stains, which do not typically lead to low self-worth or depression. Wardle and Cooke (2005) thought that this might be related to reassurance from family and friends sustaining the belief that the impact of their appearance is less severe than others view it. They however highlighted that this is an area which is under-studied. The findings regarding resilience also suggest that the relationship between BMI, low SES and negative self-perceptions are not simple and are likely to be mediated by several other factors, such as parenting styles.
Participants’ positive beliefs about what life would be like if they were thin, were in line with the findings from Rees et al (2011). Here they found that children generally thought being overweight meant you would be less popular, and get bullied, and that losing weight would improve things. Puhl and Latner (2007) suggested that overweight children were just as likely as average weight children to endorse negative attitudes, and stereotypes about obesity, and this might explain some of the views expressed in the current study.

Several of the participants described their eating as an addiction and felt that the taste of unhealthy foods, such as crisps and chocolate, meant they couldn’t resist eating them. To the authors knowledge this is a unique finding but it might help explain findings such as why children are able to describe healthy eating but are not following it (Snethen & Broome, 2007). The children in the current study appeared to use this label as a way to make sense of their eating however, although it reduced feelings of responsibility for some, it perpetuated others negative self-view.

A recurring theme throughout the interviews was participants’ attempts to minimise the importance of their weight and/or the impact this had on them. This was thought to be used as a coping strategy and although it has not been shown in other research with children it is similar to the finding from Southwell and Fox (2011) where parents minimised the severity of their child’s overweight status to protect their self-esteem as a parent. It might be that overweight children learn to minimise or avoid their difficulties with weight through observing their parents.

The minimising might also be related to the incongruence between the positive beliefs participants held about being thin and the fact that they were overweight. This would suggest that it is related to cognitive dissonance whereby there is an
inconsistency in people’s beliefs, attitudes or behaviours which cause psychological discomfort meaning that the individual has to change their beliefs or behaviours to reduce this discomfort (Festinger, 1957). This would therefore suggest that some of the children might be minimising their weight status, or the importance of it, in order to reduce their weight status’s incongruence with their positive beliefs about being thin.

**Limitations**

Although these findings add to our knowledge of how overweight children make sense of their weight, and how this affects their self-view, the results should be viewed with some caution. These children were recruited via a weight management group, meaning the family had already acknowledged the need for the participant to lose weight and therefore their views might differ from overweight children who were not receiving input. These participants’ responses might also have been influenced by the information received at MEND.

Another limitation might be related to the difficulties the authors experienced while analysing the interviews. Due to the differences in children’s thinking styles, and use of grammar from adults the interpretations made may not be what the participant was trying to express. The authors however took steps to limit misinterpretation such as undertaking careful reading and re-reading, independent coding of transcripts, and frequent discussion of emerging themes and interpretations. The interpretations made were firmly rooted in the data, and quotes have been used to evidence these interpretations, and help the reader follow the author’s thinking process.
Although participants were recruited from areas of low SES no measure of the SES of the family was undertaken. This meant that some of the children could have come from a more affluent household than the surrounding area would suggest. Future studies may benefit from including a measure of SES as part of their collection of demographic information.

**Clinical Implications & Directions for Future Research**

The results of this study suggest that those involved with overweight children, including teachers, health care professionals, and parents, have to be aware and sensitive to the messages that they are giving these young people. Overweight children are already likely to be experiencing bullying, and stigma from peers, and therefore, although they need support to lose weight, it is important that this is done in a non-blaming way. It also highlights that it is not enough for interventions to focus on healthy eating advice, and increasing activity levels, but that it might be more advantageous to spend time helping children develop a positive self-view.

Future research should explore in more detail the perceptions and experiences of overweight children who appear more resilient to help identify what factors contribute to this. Exploring this in overweight children from deprived backgrounds might be particularly beneficial given that some research has shown this to have a negative effect on self-perception (McCullough et al, 2009). Further studies should also attempt to engage overweight children who have not attended weight management interventions as these are the children who might be most at risk of becoming overweight adults.
Conclusion

The rate of childhood obesity continues to grow in the UK and we currently do not have sufficient effective strategies to prevent overweight (Muller & Danielzik, 2006) or effective interventions with proven long term benefits (Luttikhuis et al, 2009). It is therefore important to continue to carry out research with these overweight children to gain a clearer understanding of how their size affects them and in turn develop more effective weight management strategies.
References


Critical Review

My Experience of Carrying out Qualitative Research
with Overweight Children & their Families

Word Count: 5936
Introduction

This critical review describes my experience of undertaking a qualitative research study with overweight children and their families. It will begin by explaining why I chose this area for my project and why a qualitative methodology was chosen. It will then discuss my observations and reflections on recruiting from this client group, undertaking interviews, analysing the interviews and interpreting the results. It will finally discuss the findings from paper one and paper two and the possible clinical implications of these and directions for future research. Throughout this paper I will also reflect on what I learnt from these experiences and what I will take forward into my career as a qualified clinical psychologist.

My Interest in this Research Area

Prior to working in the field of mental health, and becoming a trainee clinical psychologist, I trained and worked as a dietitian in a busy general medical hospital. This experience allowed me to gain an insight into how difficult it was for individuals to manage their weight, and the complex relationships they often had with food. I also became aware of the rising number of children who were being referred for weight management interventions, and the similar difficulties to overweight adults they appeared to present with.

This interest in weight difficulties, and in particular childhood obesity, continued through my move into the field of psychology, where as part of my conversion MSc I undertook a quantitative research project investigating the relationship between body mass index (BMI), self-esteem levels and body dissatisfaction. This study
involved recruiting children, aged 10-12, from schools, who had varying BMI’s, and asking them to complete specific measures. Although this was an interesting project I felt that it allowed little opportunity for the children to express their thoughts and feelings, and therefore provided a limited picture of how BMI, self-esteem levels and body dissatisfaction may be related.

These experiences influenced my choice of large scale research project and it appeared a natural progression to undertake a qualitative project investigating overweight children’s perceptions of their weight. Undertaking such a study would allow me to gain experience of using a different research design, and analysis technique, and would allow me to build on my skills working with children. I also thought that this would complement my specialist 3rd year placement working in a looked after children team and therefore allow me to develop skills which would be useful in my future career.

**Rational for Project Design**

As discussed in my empirical paper there is a lack of good quality research available which focuses on the thoughts, and experiences, of overweight children and why they may be struggling to maintain a healthy weight (Rees, Oliver, Woodman & Thomas, 2011). Based on this it therefore appeared that the best way to bring new insights to this area of research was to undertake a qualitative project with overweight children. The one-to-one semi-structured interview design was chosen to allow an in-depth detailed discussion to take place. This approach was also considered to be in keeping with the idea that research should be with children rather
than on them and that children are experts on their own lives (Kellet and Ding, 2004).

**Recruitment**

**Gaining Access to Participants**

One of the first areas considered when planning this project was how best to recruit overweight children however, due to the high levels of childhood obesity quoted in the literature (Health Survey for England, 2011 and Scottish Health Survey 2010) I did not initially envisage that this would be a problem. The first steps towards this involved thinking about how to ensure recruitment was carried out in a sensitive manner and that only children who met the inclusion criteria were recruited. It was therefore decided that participants should be recruited via weight management programmes. This pathway was chosen because these children would already be identified as overweight or obese, and would be aware of their weight status. This meant that I would not have to take any measurements before undertaking the interview and would not have to inform children of their weight status. Other possible recruitment methods such as through schools, GP practices or local advertising were considered at this point however due to difficulties with identifying overweight children without stigmatising them, and/or having to undertake weight and height measurements, it was considered that recruiting from weight management programmes would be the most sensitive and efficient way to reach potential participants.

Once this had been decided I then began trying to identify weight management groups in the area who would be willing to take part in the project. Although when originally planning this study in 2011 there were several groups running in the area,
over the course of the project the number of groups, and how regularly they ran, reduced. Another difficulty was that several NHS trusts were conducting research studies and audits with their groups, and therefore did not want to participate in the project. This meant that there were fewer groups available to approach, and even where there were groups running I was not able to access them. Due to funding cutbacks the MEND interventions that agreed to take part also had to reduce the number of groups they ran each year.

I did attempt to overcome some of these difficulties by ensuring that I began making enquiries as early as possible, contacting weight management groups across a large area and networking with MEND headquarters who are a large provider of weight management groups in the UK. I also tried to maximise the potential of the groups who did agree to take part by ensuring I had built up a good relationship with the group leaders as their enthusiasm for the project helped to interest and reassure families. I also received ethical clearance to advertise the project at The University of Manchester in an attempt to recruit families who had a child attending a weight management group however no families came forward from this.

On reflection it may have been more efficient to recruit potential participants through schools however it was felt that this posed too many ethical dilemmas, such as how to identify children in a non-stigmatising way, and how to ensure that they had been informed they were overweight. Although this may have increased participation this could have been potentially due to families feeling obliged to take part as the request came via the school. It may also have influenced the interviews if the children perceived it was linked to education and the researcher was seen as a teacher-like figure (Fraser, Lewis, Ding, Kellett & Robinson, 2004).
Recruiting Participants

Along with the difficulties identifying weight management groups I subsequently encountered problems interesting families, and in particular parents, to take part in the study. This appeared to be related to several reasons including that many of the families attending the groups had quite complex difficulties, and therefore taking part in a research study was not high on their priorities. Another reason was that several children attending the groups had been referred via social services, and attended with a support worker, instead of a relative, making it more challenging to inform parents about the study. It also appeared that some families were put off by the time involved in arranging, and undertaking, a qualitative interview, and that they might have been more likely to participate in a shorter, quantitative study. As well as this some parents indicated that they may have taken part if an incentive, such as psychological therapy, was offered to their child after the interview.

This difficulty with recruiting families to the study is in keeping with problems identified in recruiting families to weight management programs. Eckstein et al (2006) found that parents were the biggest barrier to participation in youth weight-management programmes and this finding was supported by Rice, Thombs, Leach and Rehm (2008). Rice et al (2008) suggested reasons for this including denial that their child had a medical need that required attention, lack of willingness to change the home environment, unwillingness to talk with their child about their weight issue, inflexibility in making room in the family schedule for the program, and inability to consider that they had some responsibility for their child’s weight status. It may have been that some of these issues affected a parent’s willingness to allow their child to take part in the project. In particular it was suggested by a MEND
group leader that parents may have been apprehensive about their child discussing possible distressing effects of their size, and that they would rather not hear this. As no information was sought from families who did not wish to take part it is difficult to verify these possible reasons. Parental avoidance of discussing their child’s weight status in an attempt to avoid damaging their self-esteem was however a key finding from my meta-synthesis and may have contributed to a reluctance to take part in the project.

To overcome some of these challenges with recruitment I attended all participating MEND groups at least once so that parents and children had an opportunity to meet me in person and ask questions about the study. I however only attended the sessions for a brief period and no families were directly approached unless they requested to speak with me. I also ensured that the MEND group leaders had a good understanding of the project so that they could answer questions from potential participants. In order to try and minimise the concerns over the inconvenience, and time taken up by the research interviews, I offered to arrange interviews either at participants’ own homes or at the MEND group setting. I also arranged these interviews at times that were most convenient for the families.

This experience has shown me how difficult it can be to engage families, which is something that also comes up in my clinical work, and it has highlighted the complex interaction of factors which make it difficult for these families to engage. As well as this it has shown me the importance of trying to make services and participation in research as accessible as possible.

If I were to redo this project I may consider recruiting via schools in order to reach a larger number of potential participants. All aspects of this however would have to be
carefully thought through, and planned, so as to reduce the likelihood that potential participants felt stigmatised or coerced into taking part.

**Consent**

An area closely linked to recruitment which needed consideration when designing this project was the issue of who to seek consent from. This is an area where there are no definitive guidelines and researchers continue to debate the age at which children are thought competent enough to provide consent. Some researchers have put forward that young people under the age of 16 can give consent to take part in research if they are deemed to have enough knowledge to understand what is proposed, and enough discretion to be able to make a wise decision in light of one’s own interest (Alderson & Morrow, 2004). Alderson (2004) also suggests that the decision over when children are old enough to be deemed competent enough to consent should be based on each child’s own experience and confidence, the type of research, and the skill with which researchers talk with children and help them to make unpressured decisions. Kellet and Ding (2004) however state that all too often children are assumed to be not competent enough to give their informed consent and that this needs to be gained from a more competent adult and that assent (agreement to participate) is sufficient to seek from the child. They do however also acknowledge that it is desirable to have an adult gatekeeper involved in the consent process.

After considering these arguments, and reflecting on the relatively young age group of participants (7-13 years), it was decided that informed consent would be sought from parents and that assent would be sought from children. Despite this however, I tried to ensure that throughout the project potential participants felt included in this
decision making process and were given sufficient, appropriate, information about the project to consider whether they wanted to take part. This was done by introducing the project at the MEND group with parents, and children present, and providing both with further written information. The children’s information sheets were specifically designed to include age-appropriate language, were broken up into short sections, and followed a question and answer format to make them accessible for this age group (Alderson & Morrow, 2004). Immediately prior to undertaking the interviews I also went through with children that they understood what was involved in taking part and that they had a right to withdraw. I then asked both parents and children to complete written consent forms. During the interview I also monitored for signs that the participant was withdrawing their assent to participate by not engaging with the questions or becoming distressed, and had this happened I would have stopped the interview (Cree, Kay & Tisdall, 2002). These procedures aimed to help children feel that the research was being done with them, rather than on them, and therefore help to build engagement and rapport.

There were times during recruitment where it proved necessary to have sought both consent from parents and assent from children. For example there were occasions where a parent wanted their child to take part in the study but when I came to discuss this with them, and take assent, the child indicated that they did not want to take part and therefore the interview did not go ahead. There were also occasions when children indicated that they were keen to take part in the project however their parent’s did not want them to do this which unfortunately meant they could not take part.
Undertaking Interviews

Setting

To reduce the inconvenience of taking part in the project families were offered the choice of whether interviews took place in their own homes, or at the MEND groups, and the majority of families chose for these to be done at home. Although this flexibility did encourage participation in the project it also brought up its own set of issues and challenges. The main challenge in using the child’s own home as the interview location was in finding an area of the house with minimal distractions to conduct the interview. Many of the participants had other siblings in the house that also wanted to use this space or entered the room during interviews. In dealing with this I had to keep a balance between respecting my place as a guest in the family’s home, and the request for a quiet place to conduct the research. It was also important that this space was in an area of the house which was not too isolated so as parents were aware of what was happening and the child knew their parent was close by. Although children were allowed the option of having a parent present during the interview none of the participants requested this. This avoided the issue of their presence possibly affecting children’s responses.

The other issue that working in participants’ own homes brought up was around the risks of lone working. To minimise any potential risks from this MEND group leaders were aware of who had agreed to take part in the project and informed me of any risks of lone working in this home. I also followed Manchester University and local NHS Trust policies on lone working such as informing a designated person of where I was going and when I would be back. Potential participants were made aware that I would be following these procedures in the information leaflets.
These experiences of lone working in participants’ own homes are quite different from my clinical experience working mainly out of clinic rooms in a Child and Adolescent Mental Health Service (CAMHS). Here the rooms are specially designed to be quite, private and with limited distractions. This experience of not being able to control the interview setting allowed me to reflect on what it may feel like for children, and families, who attend clinic appointments.

**Engagement**

As part of my clinical work I often spend several sessions with children building up a relationship before I begin to focus in detail on the reasons for their referral. This is in contrast to the way I had to work in order to complete these one-off research interviews, meaning I had to reflect on, and adapt my style of working.

The first step in doing this was to make sure that children who were taking part in the study had met me on at least one occasion prior to undertaking the interview. This was another reason why I was careful to ensure that children were present during my presentation of the project at MEND. Doing this meant that children knew who was coming along to carry out the interview and hopefully relieved some of the possible anxiety around this. I also spent time before starting the interview chatting with the participant about their interests, and daily lives, and only formally began the interview once I felt the child was comfortable with me. During the interview I tried to allow the participant to take things at their own pace and monitored for signs of distress. If children did become upset I gave them the opportunity to stop the interview or take a break. I also regularly made use of non-verbal, and verbal, prompts to indicate that I was listening and wanted to hear more (Cameron, 2005). My use of these prompts was probably more frequent than in my
clinical work as I wanted to encourage the participants to tell their story in a short time frame, whereas clinically I can allow this narrative to develop more slowly.

Although I did these things to reduce the participant’s anxiety, and to engage them in the interview, the majority of participants were already very eager to begin the questions. Even in cases where participants became upset during the interview they were keen to continue and appeared to enjoy having the opportunity to tell their story. This may have been because the children were aware of what I was coming to talk to them about, and therefore felt this is what they should talk about, or it may have been because they were pleased to be asked for their views.

The interviews undertaken with the two youngest (8 & 9 years old) participants in the study were shorter, and less detailed, than the older participants interviews. There may have been several reasons for this including that they were not as affected by their weight, they did not fully understand the questions, or they were not developmentally able to think about some of the more abstract concepts, such as how others behaviour affected their feelings about themselves.

In hindsight it may have been useful to have asked these children to draw a picture of how they saw themselves and then asked them to describe this. These drawings could then have been used to promote discussion about how they thought and felt about their weight. Using drawings in qualitative research with children has been found to help them organise their own narratives, gain more control over the interview, and give them time to reflect on their own ideas (Miles, 2000).
One area which I found difficult in undertaking this project was asking participants questions that they found distressing, or that required them to talk about potentially distressing topics such as the bullying they had experienced. Although, as mentioned above, several of the participants were happy to continue with the interviews despite this, I still found this quite uncomfortable. On reflection I think this was related to the fact that it was a one-off research interview, and I was not asking the questions to provide the child with a psychological intervention to improve their situation. These feelings meant that although I had to be aware of risk in these discussions I also had to be aware that I did not step over into a clinical way of working and try to foster therapeutic change. It also made me consider whether I was avoiding asking about these important areas as I did not want to upset the child, in a similar way to why parents may avoid bringing up their child’s weight issue with them.

I also spent time after interviews where participants had become upset thinking about why they wanted to continue with the interview if it was distressing for them. This may have been because they felt obliged to, and did not want to upset me by stopping the interview, or because they did not fully understand that they could do this. On talking with the children after finishing the interviews however, I do not believe that this was the full explanation. After the interviews, or in some cases during them, participants reported that they wanted to help other people who were overweight or that they wanted other people to know what it was like to be bullied about your weight. Reflecting on these comments made me consider that these children may have continued with interviews because they genuinely wanted to tell
their story and wanted to help other people understand what it was like for them. Being able to stand back from these interviews, and consider what participants gained from taking part, allowed me to focus on why this type of research was important, and to sensitively continue to ask questions that may be upsetting.

**Risk Management**

Another area that I became aware was slightly different from my clinical work was that of managing potential risks. When working as part of a multi-disciplinary team in my placement and a risk issue comes up in a session I can immediately discuss this with colleagues, and jointly decide on a risk management plan based on the level of risk described. There are also very clear and structured policies in place for how to manage child protection or suicide risk issues. When carrying out these interviews however, I did not have the luxury of this team support and after gathering information had to make these judgements on my own. Although when this did come up I followed local policies and best practice, and discussed my decisions with my research supervisors as soon afterwards as was possible, I still ultimately had to make the choice about the best course of action on my own.

This experience allowed me to grow in confidence about my ability to manage these situations and to continue to develop skills as an autonomous practitioner which will be valuable in my role as qualified clinical psychologist. It also made me reflect on the value of team working and on the vital role of supervision in managing these situations.
Interpreting Interviews

Possibly the most challenging, but also the most rewarding, aspect of undertaking this study was analysing and interpreting the children’s interview transcripts. When I came to analyse these interviews it became apparent that at times the way the children structured their thinking and responses to questions was quite difficult to follow as shown in the two quotes below. In some instances sentences did not appear to make sense and it took several readings, and re-readings, to grasp what the participant was saying.

“Well I think I’m really active because I’m not good at running because after about 2 minutes I’m already out of breath but I’m good at all other sports like tennis, dodge ball and football.” (Participant 5)

“Yea and you’re not, you can’t just do something if you don’t, if you like it but if you don’t like it like if you don’t like doing something you just find some other sport to do and that’s also involving acting around.” (Participant 4)

At times they also appeared to talk at length without there being an obvious break or pause in their reply. In other places the pause appeared to come at a point which did not fit with the meaning of the sentence. This made transcribing, and interpreting, the children’s interviews quite difficult.

This is a difficulty which is recognised by researchers working qualitatively with children and is linked to full communication competence being unlikely to develop until around 10-12 years of age (Cameron, 2005). It is suggested that before this has
fully developed problems with children’s syntax and grammar usage may cause misunderstandings between the child and the interviewer (Cameron, 2005). In order to overcome this it became very important to read, and re-read, the transcripts several times to try and get a sense of what the child was actually saying, and what the salient points were within this.

In a similar way when I initially read some of the children’s transcripts it appeared that they were at times providing irrelevant answers to questions, or were losing the thread of the question during their response and veering off topic. On re-reading some of these transcripts, and looking for patterns through them, it appeared that in some cases these responses were not as irrelevant as they initially appeared, and may instead have demonstrated the child’s thought processes. For example when I asked participant two why she hated her weight she appeared to veer off this topic on to an incident with a teacher. On looking at the transcript as a whole however, and identifying emerging themes, it was hypothesised that this incident with the teacher formed part of a sense that she thought of herself as a target due to her weight, rather than it being irrelevant.

There were however also times during the interviews where participants did appear to lose track of what they had been asked and move away from the topic. For example participant four began to talk at length about going on holiday when asked why he thought he had gained weight. Although this was initially linked to the question, his thinking appeared to drift more into his experience of the holiday rather than its relevance to his weight gain. At these times it was important for me to bring the participant back to the question without making them feel that I was uninterested.
This was a particularly difficult balance to reach as many of the children appeared very sensitive to the reactions of others.

Use of Thematic Analysis & Interpretative Phenomenological Analysis (IPA)

As discussed in my empirical paper it became apparent that the participants’ interviews were not detailed enough, and therefore did not provide ‘rich’ enough data to allow a traditional IPA methodology to be utilised. After discussion with my supervisors it was decided that the most appropriate way forward would be to utilise thematic analysis (Braun & Clarke, 2006) and supplement this with aspects of IPA (Smith, Flowers & Larkin, 2009). As I did not have any previous experience of either qualitative methodology this appeared to provide a further layer of complexity to the analysis, and make the prospect of undertaking this seem even more challenging. During my reading and re-reading of the transcripts however I recognised that if only Thematic Analysis (Braun & Clarke, 2006) was used this may result in valuable pieces of information about what these thoughts and experiences meant for the participants being lost.

Due to the issues around combining these methodologies and the often confusing nature of the participants’ responses I initially found analysing the transcripts very difficult. After coding the first couple of the transcripts, and recognising that there were similarities in the coding, I began to feel more confident. I found that incorporating the aspects of IPA became easier when I went back over the memos that I had made while initially coding the data, as these helped to develop my thinking, and interpretation of what the participant was experiencing. Finally the use
of supervision was invaluable in allowing space to reflect on the analysis and discuss emerging ideas which appeared to make the developing themes become clearer.

Hopefully the combining of these two qualitative methodologies, although unconventional, has allowed a deeper interpretation of these participants’ interviews, and as such offered an insight into how they make sense of being overweight.

**Reflections on the Findings of Paper 1 & 2**

Paper one described the meta-synthesis undertaken on qualitative studies investigating parents of overweight children’s perceptions and experiences of parenting their overweight child. Form these thirteen studies two over-arching themes were identified; ambivalence and responsibility. The theme of ambivalence described how parents wanted their children to be healthy and happy but how they were ambivalent about making changes to help them lose weight. This ambivalence seemed to be affected by the sub-themes labelled; own weight history, recognition, uncertainty and feeding and emotion. These sub-themes appeared to reflect the way that a parent’s own experiences of struggling to lose weight, or being bullied about their size, and their desire to protect their children from negative feelings, resulted in them doing little to encourage their child to lose weight. The over-arching theme of responsibility contained the sub-themes labelled; attribution, resources and parenting. These sub-themes appeared to be related to where parents thought the responsibility for their children’s overweight status lay and the difficulties they experienced in helping them to lose weight.
Paper two explored overweight children’s perceptions of their size, and how this affected their self-view. Through using a combination of TA (Braun & Clarke, 2006) and IPA (Smith et al, 2009) to analyse the six interviews four themes were identified; recognition, self-view, beliefs about exercise and weight loss and making sense of eating. The over-arching theme labelled minimising was found to run throughout these four themes. This minimisation described participants’ attempts to minimise the importance of their weight status or the effect their size had on them.

Looking at the results of these two pieces of research together suggests that there might be some similarities in the way that overweight children and their parents perceive and experience the former’s difficulties with obesity. It appears that both might attempt to minimise the importance, or impact, of this as a way to help protect their self-esteem. At times this may result in parents giving their overweight child the message that their weight is not that important and therefore that they do not need to change anything.

The impact of bullying was also clearly very important to the way both thought, and felt, and seemed to affect not only the child’s self-view but also a parent’s willingness to intervene. As parents were very concerned about not making things worse for their child, if they thought they were being bullied they often did not want to bring up the need to lose weight with them. Again however this results in a situation where children are unlikely to be motivated to engage with weight loss strategies.

The children interviewed in paper two appeared very aware and sensitive to the messages that they received from others about their weight and this seemed to have an effect on their self-view. It appeared particularly difficult for the children if they
perceived that they were being blamed for their overweight status by their parent’s. Although the majority of the themes identified in paper one suggested that parents were worried about being seen in this way, and therefore avoided discussions about the need for weight loss, the attribution sub-theme did suggest that some parents blamed their children for being overweight. It is clear however that neither of these positions taken by parents were helpful in promoting weight loss in their children.

**Clinical Implications**

Looking at the results of these two studies together reinforces the importance of including both parents and children in weight management interventions. It however suggests that these interventions need to focus on far more than healthy eating and exercise advice. Instead they need to look at the emotional impact of the child’s overweight status for both the child themselves, and their parent’s, and discuss the reasons why it might be difficult to make changes based on this. It also seems important that interventions acknowledge the ambivalence that parents might feel and deal with this directly. If parents are allowed time to discuss these concerns they can be provided with reassurance and strategies to encourage healthy changes in a way that does not negatively affect children’s self-esteem. This will hopefully allow their esteem as a parent to be protected and make them feel more confident about implementing changes. This in turn should provide children with a clearer, more positive message about their weight status.

A key component of these interventions should also be building up a positive self-view in both children and parents and increasing their confidence levels. This is likely to improve their levels of self-efficacy meaning that they are more likely to work together to make healthy changes. This approach has already begun to be
included in some parenting based interventions such as The Lifestyle Triple P Programme (West & Sanders, 2010 and West, Sanders & Davies, 2010) which incorporate positive parenting strategies and self-esteem promoting approaches along with nutritional and physical activity advice.

Although it is vital to include parents in childhood weight management interventions (Golan & Crow, 2004 and Grimes-Robinson & Evans, 2008) the current research would suggest that programmes should not focus solely on parents. Instead they should be offered as programmes for the whole family so that it is seen as a joint activity and the overweight child is not singled out or viewed as the reason why parents have to go to groups.

Finally it appears that it may be helpful for schools to do more around bullying awareness and the acceptance of difference, along with healthy eating and exercise advice. The delivery of healthy living advice should be done in a sensitive way which is careful to be non-blaming because overweight children will be acutely aware of this.

**Directions for Future Research**

Future research would benefit from exploring the perceptions and attitudes of both the children who appear more resilient to bullying and the parents of these children. This would help to identify the parenting practices which may be most helpful in protecting children’s self-esteem, while helping them to lose weight. These could then be incorporated into weight management interventions.

Another avenue for future research might be exploring the perceptions and experiences of overweight children and their parent’s who do not access weight
management interventions. These might be the children who are most likely to become overweight adults and therefore it is important to develop ways to engage them.

Given the difficulties with analysing children’s interviews described in the current research it may be helpful for future research to consider including children in the analysis process. This might be through individual follow up sessions with participants to feedback interpretations of their interviews and to check if it fits with their intended meaning or through focus group sessions where themes from interviews were discussed.

Finally it is important that future research attempts to include children and parents from varying socio-economic groups and reports this demographic information in their results. This will allow any potential differences or resilience factors in these groups to be identified.

**Conclusion**

Although undertaking this research project has been a long and at times very challenging process, it has also been a rewarding one, which has allowed me to develop as a clinical psychologist. Writing this paper in particular has allowed me to reflect on why I chose to do this study and the benefits that it has brought me. It has also allowed me to think about the relationship between the findings in paper one and paper two and the possible implications of these for weight management interventions.
References


Appendix 1:

Clinical Psychology Review Guide for Authors
Clinical Psychology Review Guide for Authors

Use of Wordprocessing Software

It is important that the file be saved in the native format of the wordprocessor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the wordprocessor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns.

The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier: http://www.elsevier.com/guidepublication). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. See also the section on Electronic artwork.

To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your wordprocessor.

Article Structure

Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2009). Of note, section headings should not be numbered.

Manuscripts should ordinarily not exceed 50 pages, including references and tabular material. Exceptions may be made with prior approval of the Editor in Chief.
Manuscript length can often be managed through the judicious use of appendices. In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the online version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix.

Authors can direct readers to the appendices in appropriate places in the text.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential Title Page Information

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. Note: The title page should be the first page of the manuscript document indicating the author's names and affiliations and the corresponding author's complete contact information.

Abstract

A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone.
References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

**Graphical Abstract**

A Graphical abstract is optional and should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership online. Authors must provide images that clearly represent the work described in the article. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. See http://www.elsevier.com/graphicalabstracts for examples.

Authors can make use of Elsevier's Illustration and Enhancement service to ensure the best presentation of their images also in accordance with all technical requirements: Illustration Service.

**Highlights**

Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate file in the online submission system. Please use ‘Highlights’ in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). See http://www.elsevier.com/highlights for examples.

**Keywords**

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for
example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

**Abbreviations**

Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

**Acknowledgements**

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

**Footnotes**

Footnotes should be used sparingly. Number them consecutively throughout the article, using superscript Arabic numbers. Many wordprocessors build footnotes into the text, and this feature may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

**Table Footnotes**

Indicate each footnote in a table with a superscript lowercase letter.
Electronic Artwork

General points

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• Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.

• Number the illustrations according to their sequence in the text.

• Use a logical naming convention for your artwork files.

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If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply ‘as is’ in the native document format.

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formats (note the resolution requirements for line drawings, halftones, and
line/halftone combinations given below):

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TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of
300 dpi.

TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a
minimum of 1000 dpi.

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a minimum of 500 dpi.

Please do not:

• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these
typically have a low number of pixels and limited set of colors;

• Supply files that are too low in resolution;

• Submit graphics that are disproportionately large for the content.

Color Artwork

Please make sure that artwork files are in an acceptable format (TIFF, EPS or MS
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Please note: Because of technical complications which can arise by converting color figures to 'grayscale' (for the printed version should you not opt for color in print) please submit in addition usable black and white versions of all the color illustrations.

**Figure Captions**

Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (not on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

**Tables**

Number tables consecutively in accordance with their appearance in the text. Place footnotes to tables below the table body and indicate them with superscript lowercase letters. Avoid vertical rules. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article.

**References**

Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 1-4338-059-6, copies of which may be ordered from http://books.apa.org/books.cfm?id=4200067 or APA
Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK. Details concerning this referencing style can also be found at http://humanities.byu.edu/linguistics/Henrichsen/APA/APA01.html

Citation in Text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full.

Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web References

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

References in a special issue

Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

Reference Management Software
This journal has standard templates available in key reference management packages EndNote (http://www.endnote.com/support/enstyles.asp) and Reference Manager (http://refman.com/support/rmstyles.asp). Using plug-ins to wordprocessing packages, authors only need to select the appropriate journal template when preparing their article and the list of references and citations to these will be formatted according to the journal style which is described below.

**Reference Style**

References should be arranged first alphabetically and then further sorted chronologically if necessary.

More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication. References should be formatted with a hanging indent (i.e., the first line of each reference is flush left while the subsequent lines are indented).


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http://www.sciencedirect.com. In order to ensure that your submitted material is directly usable, please provide the data in one of our recommended file formats. Authors should submit the material in electronic format together with the article and supply a concise and descriptive caption for each file. For more detailed instructions please visit our artwork instruction pages at http://www.elsevier.com/artworkinstructions.
Appendix 2:

Included Studies Quality Appraisal Criteria
Included Studies Quality Appraisal Criteria (based on Walsh & Downe, 2006 and CASP, 2002)

1. Include parents with at least one overweight child and clearly state how this child’s weight status was defined.

2. A clear statement of the aims and objectives of the research; clearly states the question being investigated and the rationale for this.

3. Appropriate use of, and rationale for use of, chosen research design and qualitative methodology.

4. Appropriate recruitment strategy used for the aims of the research. Selection criteria should be described including an explanation of any disparity between planned and actual sample.

5. A clear and justified discussion of data collection methodology including if they used a topic guide, if any modifications were made during the study and what form of data was taken (e.g., tape recordings, video material or notes).

6. The analytic approach used should be made explicit and the chosen method should be appropriate to the research question. This should include information on how coding systems/conceptual frameworks evolved and there should be presentation of sufficient data to support the findings.
7. Reflexivity. The study should include a discussion of the researcher’s role and potential bias/influence on participants and data collection.

8. There should be clear evidence that ethical considerations have been taken into account including that ethical committee approval has been granted. There should also be information on how autonomy, consent, confidentiality and anonymity were managed.

9. A clear statement of findings which includes sufficient discussion of the research process so that others can follow how their decisions were made. The findings should also be discussed in relation to the original research questions.

10. A discussion of the relevancy and transferability of the research should be included. The findings should be discussed with regard to how they add to existing knowledge or understanding and should outline future directions for investigation. The limitations and weaknesses of the study should also be clearly outlined.
Appendix 3:

Quality Rating Scoring of Included Studies
Quality Rating Scoring of Included Studies

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6. Analytic approach used made explicit and chosen method should be appropriate to the research question. This should include information on how coding systems/conceptual frameworks evolved and the presentation of sufficient data to support the findings

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7. Reflexivity. The study should include a discussion of the researcher’s role and potential bias/influence on participants and data collection

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<td>A discussion of the relevancy and transferability of the research should be included. The findings should be discussed with regard to how they add to existing knowledge or understanding and should outline future directions for investigation. The limitations and weaknesses of the study should also be clearly outlined</td>
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⁴ Scores in each category were added together to create a total score out of 10 for each study
Appendix 4

Table of Original Themes & Corresponding Sub-Themes for

Purpose of Synthesis
### Table of Original Themes & Corresponding Sub-Themes for Purpose of the Synthesis

<table>
<thead>
<tr>
<th>Study</th>
<th>Themes Reported in Original Study</th>
<th>Sub-theme in Synthesis</th>
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</table>
| Curtis et al 2011 (Study 1) | • Parents’ Food Related Biographies & Intergenerational Relations  
• Children, Young People & Intergenerational Relations | Own Weight History  
Difficulties of Parenting |
| Davis et al 2008 (Study 2)    | • Parents generally think that other people’s overweight children are lazy and do not exercise.  
   However, two contrasting ideas emerge when parents are asked about their children; either they do  
   not exercise enough, watch too much TV, or play too many video games; or that their children are  
   active, but still seem to gain weight (Theme 1)  
• Though most parents believe that unhealthy habits contribute to childhood obesity & their child’s  
   weight problems, some parents believe that obesity has genetic links, that children will “grow into  
   their height” or that even with healthy eating and exercise, some children will be overweight. (Theme 3) | Attribution |
<table>
<thead>
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<th>Uncertainty</th>
<th>Resources</th>
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<tr>
<td>• Parents are concerned about their child’s weight, particularly as it relates to health and future health, and are interested in information about exercise and dietary changes to help their child lose weight. However, some are concerned that telling their children to lose weight will lower their self-esteem. (Theme 2)</td>
<td>• Parents have tried a variety of methods to help their children lose weight, but none have been successful and most are short-lived. (Theme 4)</td>
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<tr>
<td>• Parents are concerned that other children make fun of their overweight children. (Theme 5)</td>
<td>• There are many perceived barriers to their children losing weight, including most importantly, lack of resources in the community, poor school lunches, distance to weight loss programs, time to do healthy activities (eg exercise, prepare a healthy meal), the higher cost of healthy foods, the potential cost of weight loss programs, and a lack of motivation on the part of their children. (Theme 6)</td>
</tr>
<tr>
<td>• Motivation is key to helping their children succeed, but is difficult to provide. Some possibilities for motivation include goal setting, money or other incentives, social support from other children, and</td>
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</table>
| | making the program enjoyable. (Theme 7)  
| | • Parents wanted a free or low-cost comprehensive program that gives the option of life-long participation, with a weight loss facility that is open long hours. (Theme 8)  
| Gronbaek 2008 (Study 3) | • Causal explanations for overweight  
| | • Problem location – assigning responsibility within the family  
| | • Motivating for lifestyle modification  
| Haugstvedt 2011 (Study 4) | • Being worried about stigmatization of their child  
| | • Wanting to protect their child  
| | • Feeling insecure in setting limits for their child  
| | • Showing acceptance of their child while still wanting a change  
| | • Being questioned about their parenthood  
| Hughes | • Mothers believe that nature, genetics, or heredity determine weight (Theme 1)  
| | Attribution  
| | Resources  
| | Uncertainty  
| | Attribution |
| 2010 (Study 5) | • Eating & emotions are connected (Theme 10)  
| | • Parents’ behaviours & family environments also influence a child’s diet & activity patterns (Theme 2)  
| | • Mothers’ control over her child’s diet is challenged by other family members (Theme 9)  
| | • Mothers’ own obesity affects their outlook on children’s weight management (Theme 3)  
| | • Mothers do not define a healthy weight by measurements or standardised growth charts (Theme 4)  
| | • Mothers speak about a child’s size in terms of bone structure, frame & clothing size (Theme 5)  
| | • Children are not considered overweight as long as they are active, playful, happy, & have good appetites (Theme 6)  
| | • Children are considered overweight if they are seen as inactive, lazy, or are teased (Theme 7)  
| | • Mothers trust medical authority (Theme 8)  
| | • Mothers use food to shape behaviour (Theme 11)  
| | • Mothers have trouble controlling their children’s eating habits (Theme 12)  

| Own Weight History

| Recognition

| Parenting
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<th>Study</th>
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<td>Maternal perceptions of causative factors</td>
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<td>Jackson et al 2005 (Study 6)</td>
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<td>Feeling judged &amp; blamed: ‘I think about what other people think of me as a mother’</td>
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<td>Being a reluctant role-model: ‘I’ve got this little nine-year-old watching me’</td>
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<td>Experiencing frustration &amp; uncertainty: ‘I can’t get her through this’</td>
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<td>Despairing for the future: ‘When does he stop being cute?’</td>
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<td>Jain et al 2001 (Study 8)</td>
<td>Mothers do not define a healthy weight by measurements or by standardised growth charts (Theme 1)</td>
<td>Recognition</td>
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<td>Children are considered overweight if they are seen as inactive, lazy, or are being teased about their</td>
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<td>Description</td>
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<td>Children are not considered overweight as long as they are active, playful, happy, and have good appetites (Theme 4)</td>
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<td>Mothers believe that nature, genetics, or heredity determine weight (Theme 5)</td>
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<td>Parents’ behaviours and family environment also influence a child’s diet and activity patterns (Theme 6)</td>
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<td>Mothers have trouble controlling their children’s eating habits (Theme 7)</td>
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Attribution

Parenting

Own Weight History

Lindelof
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<th>Year</th>
<th>Study</th>
<th>Findings</th>
</tr>
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</table>
| 2010 | (Study 9) | - Believe the home is an environment where healthy food is prioritised  
- Blame the child for unhealthy eating habits  
  • Attitudes towards exercise  
- Blame the child for being lazy  
- Perceive the child as having a moderate level of exercise  
- Consider exercise as sport or work out  
  • Responsibility & obesity  
- Believe the child needs to make a bigger effort to reduce his/her weight  
- Cannot support more than already do |
| Lorentzen 2012 | (Study 10) | - Personal support & acceptance  
  • Indulgence & protection  
  • Setting limits  
- Barriers to successful dietary change |

*Attribution*
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<th>Study</th>
<th>Resources</th>
<th>Feeding &amp; Emotion</th>
<th>Parenting</th>
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| Pescud & Pettigrew In Press (Study 11) | • Time scarcity  
• Cost  
• Fear of children experiencing hunger  
• Securing children’s affection  
• Dietary imbalances  
• Laziness | | |
| Southwell & Fox 2011 (Study 12) | • Celebrating weight gain  
• Feeding & emotion  
• Avoiding the issue  
• Physical & mental health  
• Lack of control  
• Emotional drain | | |
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<th>Recognition</th>
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<td>• Recognition</td>
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<td>• Time pressures &amp; time management</td>
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<td>• Knowledge deficiencies</td>
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<td>• Safe places for physical activity</td>
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<td>• Insufficient support &amp; resources for parents</td>
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<td></td>
<td>• Self-esteem</td>
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<td>• Family dynamics &amp; values</td>
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<td>• Providing a good health role model for children</td>
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<td>• Children’s preferences &amp; demands</td>
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Appendix 5

Summary of Author Guidelines for Qualitative Health Research
Length of Manuscript

There is no predetermined word or page limit. Provided they are “tight” and concise, without unnecessary repetition and/or irrelevant data, manuscripts should be as long as they need to be.

The editor might require a reduction in length if the manuscript contains material that does not add anything useful to the topic being discussed. Limits might be imposed on the number/size/length of tables, figures, reference lists, and appendices.

“REVIEW” YOUR MANUSCRIPT

One common reason for “revise” decisions is that authors are sometimes so immersed in their data and findings that they lose track of

- whether the information presented contributes new knowledge
- whether the appropriate method and design have been used
- whether ethical standards have been met
- whether the information is presented in a complete, concise, and logical manner, with attention to writing style, and
- what the reader needs/wants to know (remember that QHR readers have expertise in diverse areas, and therefore many will not be familiar with concepts and terminology common to your research area)

PRIOR TO SUBMISSION
• Make sure your entire manuscript is prepared in accordance with these Guidelines in every respect.

• Have your manuscript professionally edited by an expert in the English language. This is especially important if English is not your first language. Remember to inform your editor of the need to use U.S.-English spelling, and provide him or her with a copy of these Guidelines.

• Proofread your manuscript aloud; doing so will help you identify awkward phrasing, run-on sentences, incomplete sentences, improper punctuation, missing text, and much more. We recommend that the corresponding author and all coauthors proofread the entire manuscript (including abstract and references) from a paper copy rather than a computer screen.

Your keywords are words related to the article topics that readers or researchers could search on to find your published article. They are also used to assist QHR in selecting appropriate reviewers for your manuscript during the review process.

Keywords should follow on the same page as the abstract. Leave a blank, double-spaced line between the abstract and the keywords (see the sample manuscripts beginning on page 35).

Include keywords selected only from the QHR Keyword List, below. List them exactly as they are shown in the keyword list, in lowercase letters (except for proper names), horizontally across the page, in the order in which they appear on the keyword list. Try to select at least five keywords. Use the most specific keywords possible from the list provided.
Individual keywords should be separated by semicolons; note that some keywords are actually two or more words, and might include commas. Do not capitalize the first keyword unless it is a proper name (i.e., Africa), and do not add a period (full stop) at the end of the keywords.

You may request that new keywords be added to the list, but the words should be general in nature, and not specific to a narrow topic. New keywords will be added at the editor’s discretion.

QHR KEYWORD LIST

Note: We recommend reading the entire list to identify the most relevant keywords.

Remember that the keywords might not be listed exactly the way you think of them (the specific words and the order of words might be different).

Aboriginal people, Australia, addiction / substance, adherence / compliance, adolescents / youth, alcohol / alcoholism, altruism.
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160
healing
health and well-being
health behavior
health care
health care administration
health care disparities
health care professionals
health care screening
health care, access to
health care, alternative and complementary
health care, acute / critical
health care, culture of
health care, economics of
health care, international
health care, interprofessional
health care, long-term
health care, managed
health care primary
health care, remote /
rural
health care, teamwork
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health care, work
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health information
seeking
health insurance
health outcomes
health policy / policy
analysis
health promotion
health seeking
health, determinants of
hearing / deafness
heart health
Heidegger
hepatitis C
hereditary diseases
hermeneutics
heuristic techniques
HIV/AID
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holistic care  life-threatening / phenomenological
terminal
homelessness  analysis (IPA)
hope  interpretive description
human resources  interpretive methods
humanistic  intervention programs
perspectives  interviews
social construction  interviews, electronic
humor  interviews,
immigrants / migrants  semistructured
Huntington’s disease  immunization
Husserl  induction
hypertension  interviews,
infection
illness and disease  unstructured
infants  knowledge
illness and disease,  construction
chronic  knowledge transfer
infants, high-risk
illness and disease,  knowledge utilization
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illness and disease, infectious
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| social constructionism | surgery | translation |
| social development | surgical enhancement | transplantation |
| social equality / inequality | surveys / questionnaires | transsexuals |
| social identity | survivorship | trauma |
| social issues | symbolic | triangulation |
| social services | interactionism | trust |
| social support | symptom management | tuberculosis (TB) |
| social work | systematic reviews | uncertainty |
| sociology | teaching / learning strategies | urban issues |
| sorrow | technology | validity |
| spinal cord injury | technology, assistive technology | van Manen |
| statistics | technology, medical | violence |
| stigma | institutional | violence, against |
| stories / storytelling | technology, use in research | women |
| stress / distress | theory development | violence, domestic |
| stroke | | vision |
| suffering | | visual methods |
| | | vulnerable populations |
war, victims of women’s health, wound care
weight management midlife young adults
women’s health women’s issues
workplace

PREPARATION OF MANUSCRIPT ELEMENTS

TITLE PAGE

The title “page” may be longer than one page. To maintain author anonymity during peer review, it is submitted as a separate document. Title page information should not be included in the main manuscript document. Do not format a running header.

The title page should include the following, in this order:

Article title

A title should convey, as clearly and succinctly as possible, the main idea, focus, or content of a manuscript. It should be clear in meaning even when standing alone.

Make your title 10 to 12 words (or fewer) in length; avoid long, “wordy” titles.

Avoid titles with colons or quotations unless they are necessary to convey an important concept or idea in the article.

ABSTRACT AND KEYWORDS

The abstract should be placed at the top of page 1 of the main manuscript document. It should be a single paragraph, no more than 150 words in length, and briefly describe your article. It should not contain headings or citations, and should not be
divided into sections. Place your keywords below the abstract, on the same page (see “Keywords,” above).

Double space the entire abstract page (including the keywords). Briefly state the purpose of your research, the main findings, and your primary conclusions. Make sure the abstract is written in the first-person, active voice.

MAIN MANUSCRIPT

Note that the sample manuscripts beginning on page 35 are abbreviated for illustration purposes, and might not contain all optional elements that could be included in an actual manuscript. The sample articles contain all four heading levels.

The main text of the manuscript begins at the top of page 2 of the document, immediately after the abstract page. Write your article in the first-person, active voice.

The main text of the manuscript should be broken into appropriate sections by the use of section headings. Sections should flow in a logical sequence, and include, at a minimum, Methods, Results, and Discussion (these are all level-1 headings); other level-1 headings and subheadings may be used at the author’s discretion. The author may choose to use different names for the three main sections, but the basic content should be that which would appropriately fall under the headings of Methods, Results, and Discussion.

There are very specific requirements for the preparation of in-text citations; refer to the APA Publication Manual, 6th edition, for details. Every in-text citation should have a corresponding reference in the reference list—no exceptions.
During the review process, author citations should include only the word Author and the year: (Author, 2008). If and when the manuscript is accepted for publication, the missing information can be restored.

Double space the entire manuscript document, except for text contained in figures. Use only U.S.-English spelling (except in the references, as appropriate, and for direct quotations from published written sources). Use U.S.-English translations of non-English quotations or excerpts. Use a minimum of two (2) heading levels.

Attend to copyright regulations and permission requirements (required). Submit, at the time of manuscript submission, written permission for the use of any names, photographs, or copyrighted tables, figures, and/or text; written permission must come from the person(s) depicted in the photographs, or in the case of copyrighted work, from the copyright holder (which is not necessarily the author or the journal in which it is published; see page 7).

REFERENCES

Note: Proper formatting of the reference list is the responsibility of the author, NOT journal personnel.

The reference list (also known as a bibliography) should include complete references for the sources used in the preparation of your manuscript. Every reference must be cited in the text.

The reference list should begin on a separate page (not in a separate document) following the last page of manuscript text (or after the notes, if any). Each type of reference (journal article, book, chapter in edited book, newspaper, online reference,
and so forth) must be formatted in accordance with the precise guidelines contained in APA, 6th edition.

Elements such as listing order, spelling, punctuation, spacing, capitalization, and the use of italics or Roman (regular) font are as important as the content of the reference. Note that if an author has two or more initials, there should be spaces between the initials; incorrect = X.Y.Z.; correct = X. Y. Z.

References should be listed in hanging paragraph format (with indentations at ½ inch or 1.3 cm.), in alphabetical order by the last name of the first author; additional considerations might apply (see APA). The hanging paragraphs should be created by using Word’s Format > Paragraph feature.

During the review process, author references in the reference list should include only the word “Author” and the year: Author. (2008). To prevent author identification during the review process, do not include the article title, journal name, or any other part of the reference. Do not place these references in alphabetical order in the reference list; place them at the very beginning or very end of the list. If and when the manuscript is accepted for publication, the missing information can be restored and properly placed.

Avoid the use of unnecessary references and lengthy reference lists. Extensive bibliographies will not be published; articles should include only the “essential” or key references. If the author wishes to offer a secondary reference list (for example, references used in meta-analysis), it should be so stated in a note, and made available to readers by contacting the author directly. Do not include such a list in the manuscript document, but it may be submitted separately for purposes of review.
Use only the 6th edition of the Publication Manual of the American Psychological Association (APA) as your source of instruction for references (this is critically important). Translate non-English titles into English (see APA for instruction on how to do this). Reference and cite all other studies mentioned in the article. Test all Internet URLs (Web addresses) immediately before submission to ensure that they are accurate, and that the sites are still accessible; do this prior to submission of all revisions and accepted manuscripts, as well.

APPENDICES

Appendices are not encouraged, and are published only at the editor’s discretion. If included, appendices should be placed in the main manuscript document following the reference list, and before any tables (place them before the bios in an accepted manuscript). Appendices must be referred to in the text.
Appendix 6

National Research Ethics Service Approval Letter
NRES Committee North West - Greater Manchester West
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7821
Facsimile: 0161 625 7299

13 March 2012

Miss Tracy Gemmell
Department of Clinical Psychology,
2nd Floor, Zochonis Building
Brunswick Street, Manchester
M13 9PL

Dear Miss Gemmell

Study title: How do Children Accessing Weight Management Services Perceive their Body Size.
REC reference: 12/NW/0158

Thank you for your letter of 12 March 2012, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research site

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

A Research Ethics Committee established by the Health Research Authority
Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

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<tr>
<th>Document</th>
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<td>Evidence of insurance or indemnity</td>
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<td>Interview Schedules/Topic Guides</td>
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<td>Investigator CV</td>
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<td>Dr Anja Wittkowski</td>
<td></td>
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<tr>
<td>Response to Request for Further Information</td>
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Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol

A Research Ethics Committee established by the Health Research Authority
• Progress and safety reports
• Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/NW/0158 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

[Signature]

Dr Lorraine Lighton
Chair

Email: Shehnaz.isahq@northwest.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Ms Lynne Macrae – R&D Department, The University of Manchester

Miss Reagan Blyth – R&D Department, Pennine Care NHS Trust

A Research Ethics Committee established by the Health Research Authority
Appendix 7

National Research Ethics Service Approval of Amendment

Letter
15 March 2013

Miss Tracy Gemmell
Department of Clinical Psychology,
2nd Floor, Zochonis Building
Brunswick Street, Manchester
M13 9PL

Dear Miss Gemmell

Study title: How do Children Accessing Weight Management Services Perceive their Body Size.

REC reference: 12/NW/0158
Amendment number: Substantial Amendment 2
Amendment date: 08 March 2013
IRAS project ID: 97140

- The proposed change is to widen the age group of children included in the study from 8-12 years old to 7-13 years old.

The above amendment was reviewed on 15 March 2013 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

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A Research Ethics Committee established by the Health Research Authority
Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members’ training days – see details at http://www.hra.nhs.uk/hra-training/

12/NW/0158: Please quote this number on all correspondence

Yours sincerely

Signed on behalf of:
Dr Lorraine Lighton
Chair

E-mail: nrescommittee.northwest-qmwest@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Reagan Blyth, Pennine Care NHS Foundation Trust
Lynne MacRae, University of Manchester

A Research Ethics Committee established by the Health Research Authority
### NRES Committee North West - Greater Manchester West

**Attendance at Sub-Committee of the REC meeting on 15 March 2013**

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<tr>
<td>Dr Peter Donnelly</td>
<td>Lay Member</td>
<td>Lay Plus</td>
</tr>
<tr>
<td>Dr Lorraine Lighton (Chair)</td>
<td>Consultant in Communicable Diseases</td>
<td>Expert</td>
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Appendix 8

Research & Development Approval Letter from Pennine Care NHS Trust
Research and Development Department

Miss Tracy Gemmell
Department of Clinical Psychology
2nd Floor Zochonis Building
Brunswick Street
Manchester
M13 9PL

Dear Tracy,

Research and Development approval letter
Re: How do Children accessing weight management services perceive their body size
Pennine Care reference: 12-C-02-A REC reference: 12/NW0158

Thank you for submitting your research project for consideration by the Research and Development (R&D) Department. The project was reviewed by the R&D Panel in line with the ‘Research Governance Framework for Health and Social Care’ and in regards to its impact on resources for the Trust and its suitability within our research portfolio.

We have also verified the relevant documentation and approvals from all necessary regulatory agencies. These may include, but are not limited to, the National Research Ethics Service (NRES), the Medicines and Healthcare products Regulatory Agency (MHRA), and the Administration of Radioactive Substances Advisory Committee (ARSAC).

On this basis, we are now able to grant approval for your project at Pennine Care NHS Foundation Trust, subject to the terms and conditions listed below.

- The currently approved protocol is Version 1 dated 27th January 2012 and the approved documents, including the Participant Information Sheet and Informed Consent Form, are those listed in the Research Ethics Committee’s favourable opinion letter for this project dated 13th March 2012. These must be the only versions in use.
- In the event of any amendment (substantial or minor) to the protocol or documentation, approval must be sought from the necessary regulatory agencies. Approval for the amendment must also be obtained from the Research and Development Department before implementation.
- Any significant deviation from the approved protocol or documentation must be notified to the R&D Department as soon as the issue is discovered.
- The Chief Investigator, local Principal Investigator and all other researchers working on the project must abide by and adhere to their specific responsibilities as detailed in the ‘Research Governance Framework for Health and Social Care’. They must also meet all UK statutory requirements, with particular significance, where applicable, to: the ‘Data Protection Act 1998’, ‘The Medicines for Human Use (Clinical Trials) Regulations 2004’, the ‘Mental Health Act 2007’, the ‘Human Tissue Act 2004’ and all subsequent amendments to these.
- The only researchers approved to perform the research activities for this project at any Pennine Care site or involving any staff, service users or other persons under our duty of care are those listed on the SSI form and/or delegation log for Pennine Care. 

continued on page 2...
Research and Development Department

continued from page 1...

- All personnel listed on the SSI form and/or delegation log for Pennine Care must undertake and provide evidence of Good Clinical Practice (GCP) training at least once every two years.
- Recruitment figures for Pennine Care participants in relation to this project must be sent to the R&D Department on a minimum of a six monthly basis.
- If applicable, the Sponsor or Chief Investigator must notify the R&D Department of any Serious Adverse Events (SAEs) that occur during the conduct of the trial.
- The R&D Department must be notified about any suspension and upon completion of the project, and must be sent a copy of any final report and/or findings.
- Pennine Care reserves the right to suspend or terminate approval for this project with immediate effect if any of these conditions are breached or in any other circumstances it deems necessary.
- Any further project specific conditions as detailed below:

- This letter must be countersigned by the Sponsor’s Representative, Chief Investigator and Principal Investigator or Local Collaborator as proof of their agreement to the terms and conditions described above.

Thank you again for submitting your project to Pennine Care. We wish you good luck with recruitment and with the progress of your project. If you need any further assistance, then please feel free to contact the R&D Department via the contact details at the top of this letter.

Research Approval Granted:
Project: How do Children accessing weight management services perceive their body size
Pennine Care reference: 12-C-02-A  REC reference: 12/NW0158

Name: Reagan Blyth
Role: Associate Director of Quality Assurance and Research, Pennine Care NHS Foundation Trust
Signature: [Signature]

We, the undersigned, hereby agree to all of the terms and conditions as specified by the approval letter above.

Name: 
Role: 
Signature: Sponsor’s Representative

Name: 
Role: 
Signature: Chief Investigator

Name: 
Role: 
Signature: Principal Investigator/Local Collaborator*

*delete as applicable

Please return one original signed copy of this letter to the R&D Department immediately and retain the other copy for your own project file.
Appendix 9

Research & Development Approval Letter from NHS Ayrshire
& Arran
Dear Miss Gemmell

How do Children Accessing Weight Management Services Perceive their Body Size

I confirm that NHS Ayrshire and Arran have reviewed the undernoted documents and grant R&D Management approval for the above study.

Approved documents:

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</tr>
<tr>
<td>Parents Information Sheet</td>
<td>Version 2.0</td>
<td>12/03/12</td>
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</tbody>
</table>

The terms of approval state that the investigator authorised to undertake this study within NHS Ayrshire & Arran is:

- Miss Tracy Gemmell, University of Manchester

With no additional investigators.
The sponsors for this study are University of Manchester.

This approval letter is valid until 7 May 2014.

Regular reports of the study require to be submitted. Your first report should be submitted to Dr K Bell, Research & Development Manager in 12 months time and subsequently at yearly intervals until the work is completed.

Please note that as a requirement of this type of study your name, designation, work address, work telephone number, work e-mail address, work related qualifications and whole time equivalent will be held on the Scottish National Research Database so that NHS R&D staff in Scotland can access this information for purposes related to project management and report monitoring.

In addition approval is granted subject to the following conditions:

- All research activity must comply with the standards detailed in the Research Governance Framework for Health and Community Care www.cso.scot.nhs.uk/publications/ResGov/Framework/rgfedtwo.pdf and appropriate statutory legislation. It is your responsibility to ensure that you are familiar with these, however please do not hesitate to seek further advice if you are unsure.

- You are required to comply with Good Clinical Practice (ICH-GCP guidelines may be found at www.ich.org/LOB/media/media482.pdf), Ethics Guidelines, Health & Safety Act 1999 and Data Protection Act 1998.

- If any amendments are to be made to the study protocol and or the Research Team the Researcher must seek Ethical and Management Approval for the changes before they can be implemented.

- The Researcher and NHS Ayrshire and Arran must permit and assist with any monitoring, auditing or inspection of the project by the relevant authorities.

- The NHS Ayrshire and Arran Complaints Department should be informed if any complaints arise regarding the project and the R&D Department must be copied into this correspondence.

- The outcome and lessons learnt from complaints must be communicated to funders, sponsors and other partners associated with the project.

- As custodian of the information collated during this research project you are responsible for ensuring the security of all personal information collated in line with NHS Scotland IT Security Policies, until the destruction of these data. Under no circumstances should personal data be stored on any unencrypted removable media e.g. laptop, USB or mobile device (for further information and guidance please contact the Information Governance Team based at Ailsa Hospital 01292 513993 or 513954).
If I can be of any further assistance please do not hesitate to contact me. On behalf of the department, I wish you every success with the project.

Yours sincerely

Prof Craig White
Assistant Director (Healthcare Quality) & Caldicott Guardian

c.c.  Professor Alison Wearden, University of Manchester (Academic Supervisor)
     Dr John Fox, University of Manchester (Academic Supervisor)
     Nalin Thakker, University of Manchester (sponsor contact)
     Lesley Douglas, Finance, Ailsa Hospital
     Information Governance, Ailsa Hospital

www.nhsaaa.net
Appendix 10

Information Sheet for Parents
Information Sheet for

Parents

Title of Project: How do Children Accessing Weight Management Services Perceive their Body Size.

We would like to invite your son/daughter to take part in our research study. Before you decide whether you are happy for them to do this we would like you to understand why the research is being done and what it would involve for your child.

What is the study about?
The study is trying to find out how children attending the MEND group feel and think about their body size. It is also trying to find out if their size affects them in their daily lives and if so in what ways. It is hoped that this information will help to improve weight management programmes for children.

Why have I been asked to take part?
Your son/daughter has been asked to take part in the study because they are aged between 7 and 13 years old and are attending the MEND healthy living groups.
What will happen if they do not take part?

Taking part in this research is completely voluntary. Your child does not have to take part and not participating in the study will not alter their treatment in any way.

If we decide to take part, what will my child have to do?

If your child decides to take part in the study and you are happy for them to do this we will ask you both to fill in a consent form. Your son/daughter will then undertake an interview with the researcher. The time and place of this interview will be arranged over the phone between the researcher and you as parent or carer. Depending on which is easier for you this will either take place in the MEND building or in your own home.

If the interview takes place in your own home the researcher will follow the University of Manchester Lone Worker Policy. This means that the researcher will inform a designated person of where they are going and their estimated time of return. They will then contact this person to inform them that they have left the participant’s house. If the researcher does not contact this person then procedures will be followed to locate the researcher and ensure their safety.

Ideally children will be interviewed on their own however they can have a parent or carer with them if they wish.

This interview will be audio recorded.
What will my child be asked about during the interview?

During the interview the researcher will ask your son/daughter questions and encourage them to talk about how they feel about their body size. They will be asked if their weight affects their lives and if so in what ways. Your child will be able to stop the interview at any time. The interview will take around an hour to complete.

The researcher may have to re-contact participants after the interview has taken place in order to ensure the researcher fully understands your son/daughter’s responses to questions. This will be arranged in the same way as the initial interview ie the researcher will contact you and arrange a time to meet with your son/daughter.

Are there any risks involved in taking part?

As the study is asking questions about the potentially sensitive subject of body size there is a risk that participants may become upset during the interview. If your son or daughter does become upset they will be offered the opportunity to take a break and/or asked if they wish to stop the interview. Parents or carers will be informed of this and no pressure will be placed on your son or daughter to continue taking part.

If any risk or child protection issues are disclosed these may have to be shared with the relevant authorities.

It should be noted however that it is unlikely that the questions included in this study will cause any lasting distress to participants.
What if my child changes their mind about taking part?
Your son/daughter is free to change their mind about taking part in the study at any time before, during or after the interview. They do not need to give a reason. Non identifiable data may still be used if they choose to withdraw after their interview data has been anonymised.

What if I or my child loses capacity to consent to taking part in the study?
If you or your child loses capacity to consent to taking part in the study then your son/daughter and all their identifiable data would be withdrawn from the study. Any data which is non-identifiable to the research team may be retained.

What will happen to the information they give?
The interview recordings will be anonymous and no identifying details will be attached to them. However, if the researcher thinks that your child is at risk to themselves or there are any child protection issues then this information may have to be shared with the relevant authorities.

All data, including interview recordings, will be stored in a locked filing cabinet accessed only by the researcher and people authorised to check that the study is being carried out correctly. All will treat the data confidentially. Your son/daughter’s personal contact details will be stored separately from their interviews. These will also be in locked filing cabinet.

What will happen when the study is complete?
You son/daughter will be involved in the study for about 60-90 minutes. Once the interview has been conducted and analysed, the findings will be
summarised in a report. This report will be sent to academic journals to be
published and the findings may be presented at conferences. A summary
report of the findings will also be written for participants which will be given to
those who would like a copy when the study has been completed.

The final report will contain direct quotes from your child’s interview however
these will be anonymous and no identifying details will be included.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to
speak to the researchers who will do their best to answer your questions. If
they are unable to resolve your concern or you wish to make a complaint
about the study, please contact a University Research Practice and
Governance Coordinator on 0161 2757583 or 0161 2758093 or by email to
research-governance@manchester.ac.uk.

Who is involved in the research?
This research is being conducted by Tracy Gemmell in collaboration with Dr
John Fox and Professor Alison Wearden.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people,
called a Research Ethics Committee, to protect your interests. This study has
been reviewed and approved by the NHS Research Ethics Committee on
13/03/2012. The REC reference number is 12/NW/0158.
What do I do now?

If you would like to hear more about the study and speak to the researcher involved please fill in the tear off slip at the bottom of this form. Please return this to one of the MEND group leaders. The researcher, Tracy Gemmell, will then phone you to talk about the study and tell you more about how your son/daughter can take part.

You can also email the researcher at tracy.gemmell@postgrad.manchester.ac.uk to register your interest in taking part in the study.

Thank you for considering taking part in this study.

Tracy Gemmell
Trainee Clinical Psychologist
The University of Manchester,
Division of Clinical Psychology,
2nd Floor Zochonis Building,
Brunswick Street
Manchester M13 9PL
Tel. 0161 3060402
tracy.gemmell@postgrad.manchester.ac.uk
Dr John Fox, Clinical Psychologist
Address as above
john.fox@manchester.ac.uk

Professor Alison Wearden
School of Psychological Sciences
Coupland Building
University of Manchester,
Oxford Road
Manchester, M13 9PL
Tel. 01612752684
alison.wearden@manchester.ac.uk

Consent to Be Contacted Slip
I would like to hear more information about this research and consent to be contacted by the researcher, Tracy Gemmell.

Name………………………………

Telephone Number………………………………

Signature………………………………………..

Date………………………………..
Appendix 11

Information Sheet for Children
Research Project

How Do Children Accessing Weight Management Services Perceive Their Body Size

I would like to invite you to take part in my project. This leaflet will tell you about the project to help you decide if you would like to take part.

What is the project about?

The project is trying to find out how you feel about your weight. It also is trying to find out if your weight affects the things you do and the things you would like to do.

Why have I been asked to take part?

You have been asked to take part because you are aged between 7 and 13 years old and are attending the MEND healthy living groups.
What will happen if I do not take part?

You do not have to take part in the project if you don’t want to. It is your choice. If you don’t want to that’s ok. You will still be able to come along to the MEND groups.

What will I have to do if I take part?

If you decide to take part you will have to fill in a consent form. This is a piece of paper you put your name on to say you understand what the project is about and that you would like to take part in it. Your parent or person who looks after you will also have to fill in a consent form. I will then meet with you either at the MEND building or at your home. I will ask you questions and encourage you to talk about how you feel about your weight. There are no right or wrong answers I just want to find out how you feel. We will talk for about an hour. You can ask me to stop the interview for a break at any time. You do not have to restart the interview after this break if you do not want to.

What if I change my mind about taking part?

You can still change your mind about taking part in the project after we have met up. You can ask for what we talked about not to be used in the final report.
What will happen to what we talk about?

What we talk about will be recorded. Only me and my teachers will get to hear what we talk about. They will not get to know your name. These recordings will be kept in a safe place.

What will happen when the project is finished?

Once the project is finished I will write a report about it. This report will be about how you and other children feel about their weight. It will have things that you have said in it. Your name will not appear in this report so no one else will know you took part.

I will send this report to be printed in a magazine called a journal. You can also have a copy of this report.

What do I do if I would like to take part?

If you would like to take part in the project tell your parent or the person who looks after you. They can fill in a form for me to phone them about the project.

If you have any questions please ask the MEND staff.

Thank you for reading this leaflet.
Appendix 12

Consent Form for Parents
Title of Project: How do Children Accessing Weight Management Services Perceive their Body Size.

Name of Investigator: Miss Tracy Gemmell

Please Initial
Box

1. I confirm that I have read and understood the information sheet dated 12/03/2012 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my child's participation is voluntary and that they are free to withdraw at any time, without giving any reason, without their medical care or legal rights being affected.

3. I understand that if I or my son/daughter should lose capacity to consent during the study both my son/daughter and any identifiable data would be withdrawn from the study and any data which is not identifiable to the research team may be retained.
4. I understand that audio-taping is anonymous and will be destroyed after use. I give my permission for the researcher to audio-record the interview.

5. I agree that direct quotes from the interview can be used in reporting of the research. I understand that my child’s personal details will not be identified in this report.

6. I understand that data collected during the study may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my child’s records.

7. I would like to receive a summary of the findings.

8. I agree to my child taking part in the above study.

Name of participant:..................................

Name of parent/guardian..............................

Signature.............................. Date........

Name of person taking consent:........................

Signature:..........................Date:.......
Appendix 13

Consent Form for Children
Consent Form

How Do Children Accessing Weight Management Services Perceive Their Body Size

Researcher: Tracy Gemmell

Please Initial Box

1. I have read and understood the information sheet dated 12/03/2012 (version 2) for this project. I have had time to think about the information, ask questions and have had these questions answered.

2. I understand that it is my choice to take part in the study and that I can say no. I understand that I can stop taking part at any time and that I don’t need to give a reason.

3. I understand that nobody else will hear my interview and that it will be destroyed after it’s used. It is ok for my interview to be recorded.
4. I agree that things I say in the interview can be used in the finished report. I understand that my name will not be in the finished report.

5. I would like a copy of the finished report.

6. I agree to take part in this project.

Name of participant…………………………….
Signature………………………. Date………

Name of person taking consent:…………………….
Signature:.........................Date:....... 

Name of parent/guardian.........................

Participant No:
Appendix 14

Interview Schedule
Interview Schedule

General Questions

- Likes & Dislikes

- shared activity to do this using pictures with me also doing it.

Q.1 How are you finding the MEND group?

- what do you do?

-what do you like about it?

-what do you not like?

Q.2 Tell me about how you ended up coming to the group?

- who suggested you come along?

- did you go to see your doctor before you came along?

Q.3 How would you describe your weight?

- do you think you are overweight?

Q.4 Does it matter whether you are overweight or not?
Q.5  How do you feel about your weight?

- is there anything good about it?

- is there anything bad about it?

Q.6 Does your weight affect anything you do?

- does it stop you from doing anything?

- does it affect your friendships?

- does it affect life at home?

- does it affect life at school?

Q.7 Why do you think you were overweight? (What do you think has led you to being overweight?)

Q.8 What do you think would help you to lose weight & not put it back on?
Appendix 16

Anonymised Extract from Coded Transcript of Interview with Participant 2
Anonymised Extract from Coded Transcript of Interview with
Participant 2

<table>
<thead>
<tr>
<th>Initial Thoughts</th>
<th>Interview</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size seems really important to her</td>
<td>P: Yea</td>
<td>Heavier=more importance size</td>
</tr>
<tr>
<td></td>
<td>I: When you were heavier so before you went to MEND did it matter then?</td>
<td>Heavier=more concerned</td>
</tr>
<tr>
<td></td>
<td>Was the same or different?</td>
<td>Emphasising physical limitations</td>
</tr>
<tr>
<td></td>
<td>P: It was kinda the same but it was a lot more to matter to me, like I was a lot more concerned.</td>
<td>Emphasising attempts to overcome</td>
</tr>
<tr>
<td></td>
<td>And I couldn’t, as I said I couldn’t run very much but I still pushed myself and pushed myself. An, so now that em, now that I’ve lost some weight I’m like a lot happier with myself than I was before as I was heavy but I’m happier now more cos</td>
<td>Lost weight</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Losing weight= happier</td>
</tr>
<tr>
<td>? Emphasising how bad things were but also how hard tried</td>
<td></td>
<td>Heavier =less happy with self</td>
</tr>
<tr>
<td>control or receives praise for this</td>
<td>I’ve lost the weight so I am.</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>Feelings linked to weight</td>
<td><em>I: It might sound like I’m asking the same question again but</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>P: That’s ok</em></td>
<td></td>
</tr>
<tr>
<td><em>I: Em, how did you feel about your weight before you went to MEND?</em></td>
<td><em>P: Em, I felt, em, felt quite, em angry at myself because I fed myself every night rubbish and I keep doing it repeatedly and I knew I wanted to stop it I just couldn’t. So I was really angry at myself for doing that to myself. But I’ve lost weight now so but I’m not as angry now</em></td>
<td></td>
</tr>
<tr>
<td>Weight affects feelings re:self</td>
<td><em>Angry with self</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Blames self</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Repeating pattern eating</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Wants to stop way eating</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Can’t stop self eating</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Blames self</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Losing weight decreases</em></td>
<td></td>
</tr>
<tr>
<td>Eating linked to how feels about self</td>
<td>but I still get angry now and again because I have a packet of crisps or something but. It’s like more fruit I’m eating now so I’m not as angry at myself.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>“forced” strong language</td>
<td>anger</td>
<td></td>
</tr>
<tr>
<td>? extreme self-blame, punishing self</td>
<td>Anger linked to eating</td>
<td></td>
</tr>
<tr>
<td>Use of “rubbish” again</td>
<td>Eating healthier = less angry</td>
<td></td>
</tr>
<tr>
<td>? why repeatedly doing this -? Sounds like a compulsion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**I:** It's quite interesting that you were saying that you were angry at yourself for your eating.

**P:** Yea it’s because I forced myself to eat rubbish when I knew I wasn’t supposed to, em, but I just repeatedly done it so I was getting angrier at myself so I was.

**I:** Why do you think you kept kinda, like you were saying feeding yourself.
<table>
<thead>
<tr>
<th>Sounds confused but like</th>
<th>repetition of just became a habit - ? as unsure why doing it</th>
</tr>
</thead>
<tbody>
<tr>
<td>thinks is own fault.</td>
<td>Self-blame verging on disgust</td>
</tr>
<tr>
<td>Uncertain why doing it</td>
<td>Repetition to emphasis</td>
</tr>
<tr>
<td>? habit a way to explain things</td>
<td></td>
</tr>
</tbody>
</table>

V angry with self

---

**P:** It was just I think it just became a habit em, when I was, em, I think it just became a habit like eating crisps for snack, the I’d go home and have another two maybe three. I think that just became a habit and I just fed myself and fed myself rubbish. So then I got angrier with myself knowing that I shouldn’t be eating but I still did it repeatedly.

---

**I:** That’s quite difficult if you’re feeling angry at yourself but finding it difficult to stop

---

**Eating became a habit**

**Eating became a habit**

**Recognition volume eating**

**Eating became a habit**

**Fed self “rubbish”**

**Self-blame**

**Angry with self re: eating**

**Awareness unhealthy pattern**

**Repeating pattern eating**