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Connecting Self, Body and World: a Counselling Psychology Perspective

Susannah Grant

**Portfolio for Professional Doctorate
in Counselling Psychology (DPsych)**

**City University
Department of Psychology**

Submitted July 2014



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pp. 285-292: **Part D Appendix.** Manuscript Submission Guidelines for Health
journal.

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“It takes a village to raise a child”

African Proverb

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Throughout the training, the support of my family has been unwavering. I am deeply grateful to my parents, Frinny and Adrian, for their love and steadfast belief in me; and to my husband, Saxon, for his love, patience and so often making me laugh. Last but by no means least, I want to thank our son, Quinten, who has so enriched our lives this last year, and to all our family who have looked after him so that I could finish writing this portfolio.

Dedication

This portfolio is dedicated to my father who is a true source of spirited academic discussion and encouragement, and an unfaltering pillar of strength and compassion.

DECLARATION

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

List of Abbreviations

Abbreviation	Meaning
ACT	Acceptance and Commitment Therapy
APA	American Psychiatric Association
BMI	Body Mass Index
BPS	British Psychological Society
CBT	Cognitive Behavioural Therapy
DBT	Dialectical Behaviour Therapy
DH	Department of Health
FDA	Foucauldian Discourse Analysis
GT	Grounded Theory
HCPC	Health and Care Professions Council
HRT	Habit Reversal Training
HSE	Health Survey for England
IOTF	International Obesity Task Force
IPA	Interpretative Phenomenological Analysis
LAA	Local Area Agreement
NCMP	National Child Measurement Programme
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
PCT	Primary Care Trust
RCPCH	Royal College of Paediatrics and Child Health
SACN	Scientific Advisory Committee on Nutrition
SHA	Special Health Authority
TTM	Trichotillomania
TTSC	Transactional Model of Stress and Coping
WHO	World Health Organization

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PART A
PREFACE

The preface introduces the three pieces of work that comprise this Doctoral Portfolio. I provide a brief overview of the work, the thematic connection between them, my personal motivations for carrying out the work, and lastly, some epistemological considerations.

Overview of Pieces of Work in the Doctoral Portfolio

Part B: The first component of the portfolio is an extended case study entitled ‘A Case Study of Trichotillomania From a Cognitive Behavioural Perspective’. This case study outlines therapeutic work I completed with a client suffering from TTM. TTM is currently found in the DSM-IV-TR under ‘Impulse control disorders not elsewhere classified’ (American Psychiatric Association, 2010), and in the ICD-10 under ‘Habit and impulse disorders’ (World Health Organisation, n.d.). It is described as “hair-pulling, with a rising urge or tension prior to pulling or when attempting to resist, and pleasure, relief or gratification during or after pulling” (Lochner et al., 2011, p. 276). The work was completed within a cognitive behavioural framework, drawing on relevant theory and research developments in relation to TTM. The case study includes an overview of the sessions completed, highlighting key points and progress made during the sessions, within the context of this under-researched clinical presentation.

Part C: The second section of the portfolio is a qualitative research study entitled ‘The Maternal Experience of Being Told Your Child is “Overweight” as part of the National Child Measurement Programme: An Interpretative Phenomenological Analysis’. This research explores the maternal experience of receiving a letter from the National Child Measurement Programme (NCMP) that states that their child is ‘overweight’, or ‘very overweight’ (clinically obese) (National Health Service, 2009). A sample of 8 participants was recruited to take part in the study through a number of different avenues using paper, online, and word-of-mouth. Participants took part in semi-structured interviews, where they talked about their experiences of receiving the letter. The data were analysed using Interpretative Phenomenological Analysis (IPA), a research method focusing on exploring and understanding the lived experience (Smith, Flowers, & Larkin, 2009).

Part D: The third section of the portfolio is a research journal article entitled ‘*‘It’s Like a Horrible tag on you or Something’’: The Maternal Experience of Being Told Your Child is “Overweight”*’. This article is extracted from the research presented in Part C, focusing on one of the three master themes presented in corresponding thesis, ‘the Disempowered Self’. I decided to focus on this theme as I felt that it may provide valuable and actionable insights for future development of BMI surveillance and feedback programmes such as the NCMP. This article has been written ready for submission to the journal *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*.

Evolution of the Thematic Connection of the Portfolio

In the early part of the DPpsych training, I established the loose parameters of the thematic connection of my portfolio as being related to the relationship between psychological and physical health, and the ways that people relate to their bodies. Whilst this still remains, as I reflect on the thematic connection now, I can see my understanding of the self-body connection has developed over the course of the DPpsych training. At the start of the training, I predominantly saw the self and the body as two separate entities that were in some way connected. Now, I see them far more holistically, both necessary aspects of human experience. As such I believe that the pieces of work in this portfolio offer insights into the broader area of ‘embodiment’, and the idea that, as Langdridge (2007) wrote, “consciousness is always embedded in the body” (p. 39). Alongside the shifts in my understanding of the self-body connection, I also became more aware of the importance of considering the unique worlds people live in (for example, the people they are in relationship with, and the meanings they ascribe to aspects of their broader environments) in relation to their lived experiences. As I aim to illustrate through the work in this portfolio, by considering the interconnectedness between these aspects (self, body and world), I believe counselling psychologists are guided towards a more holistic understanding of the people we meet and work with, both in therapeutic relationships and in relationships with our broader communities, and that this understanding may equip us to work more effectively.

Personal Motivations

Whilst I knew what the ‘loose’ parameters of this portfolio would be, I first became interested in the specific topic of the research study during a lecture on obesity. My initial enquiry into the subject highlighted the breadth of related aspects, such as the potential impact on physical health and the economic cost of weight-related care. I was struck by many slogans such as ‘the war on the obesity epidemic’ and, somewhat naively, felt called to join what could be called the ‘battle’. However, I did not have to look much further to find literature on other aspects, such as weight-related stigma, weight bias, and discrimination, and the related psychological impact of these. The more I learnt, the more complex I realised the area was. I questioned my position with regard to the topic, as well as the role that healthcare professionals and researchers may play in adding to stigmatised messages regarding weight.

It was this complexity that ultimately became a personal motivation for conducting the research study. I hoped to conduct a piece of research that offered new insights to aid weight-related interventions, but consciously tried not to do so from a stigmatising position, or further add to stigmatisation. I felt this latter point was ethically important and felt aligned with counselling psychology’s core “ideographic epistemological humanistic and relational value base” (Walsh & Frankland, 2009, p. 41). Indeed, whilst I designed the research study with this in mind, I found that as I conducted the research interviews and heard individual stories, holding this in mind became even more important to me. As I conducted both the research and my clinical work, I was struck by the potential impact of diagnostic labels on the lived experience, whereby words about the body have a direct impact on how people experience themselves in/as their body. Additionally, I found it interesting to see that diagnostic labels about the body could evoke such different reactions in people: whilst the research participants in Part C did not welcome hearing the words ‘overweight’ or ‘obese’ in reference to their child, the client presented in Part B found some comfort in learning about the term ‘TTM’ and feeling as though she was not alone in her struggles.

My personal motivations for presenting this piece of client work are twofold. Firstly, it demonstrates my growth as a practitioner, and my ability to work creatively with clients. The work was rooted in the current understanding of TTM but not limited by

it as an area that is still under researched. It was continually tailored with the aim of suiting the client's needs and disposition. Secondly, it brings TTM into the spotlight. I believe that this is important, given the need for further research to increase effectiveness of treatment, as well as raising awareness of TTM in general, with the hope of helping reduce any taboo or misunderstandings associated with it.

Epistemological Considerations

Given the different epistemological position of cognitive inquiry and phenomenological inquiry, I considered how my case study (conducted within a cognitive behavioural framework) and my thesis (analysed using IPA) could 'sit together' in this portfolio, and how this related to my identity as a counselling psychologist. In relation to the differing epistemological positions, Smith et al. (2009) noted that whilst there are differences between cognitive and phenomenological inquiry, they share an interest in "sense-making and meaning-making" (p. 194). I believe it is this shared interest that unites these pieces of work. Additionally, I suggest that my client study, whilst grounded within a cognitive behavioural framework, demonstrates work completed with a pluralistic approach (Cooper & McLeod, 2010). In this way, the client and I sought to engage in therapy that pulled on differing methods as best suited her aims for therapy at that point in her life. Cooper and McLeod (2010) argued that at the heart of pluralism lies the notion that "there may be many 'right' answers... [and that] there is no one, privileged perspective from which the 'truth' can be known" (Introduction to a pluralistic approach section, para. 3). This fits with the values I hold as a counselling psychologist, both as a therapeutic practitioner, and, more generally, as I engage with the wealth of 'knowledge' that I encounter as a scientist-practitioner. Whilst there may be many different interpretations of the term 'scientist-practitioner', within the context of counselling psychology it emphasizes, as Strawbridge and Woolfe (2003) suggested: "the need to engage in on-going research, and the role of the practitioner as a producer, as well as user, of knowledge and understanding" (p.6). Counselling Psychology programmes equip trainees to be proficient researchers and practitioners, enabling them to bring an understanding of the value evidence-based practice to their clinical work, which is something that is increasingly required in professional settings (Frankland, 2003; Rafalin, 2010). From this perspective,

instead of being problematic, having pieces of work in this portfolio that draw on different epistemological positions highlights an ability to move between positions to best serve the inquiry, client, or specific model of therapy offered by a service, and I believe that is one of the most valuable skills I have learnt as part of the training.

References to Preface

- American Psychiatric Association. (2000). *DSM-IV-TR: desk reference*. Arlington: VA.
- Cooper, M., & McLeod, J. (2010). Pluralism: towards a new paradigm for therapy. *TherapyToday.net*. Retrieved from <http://www.therapytoday.net/article/show/2142/>
- Frankland, A. (2003). Counselling psychology: the next ten years. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.) (2nd edn.), *Handbook of Counselling Psychology* (pp. 656-670). London: Sage.
- Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Harlow, England: Pearson Education Ltd.
- Lochner, C., Stein, J. D., Woods, D., Pauls, D. L., Franklin, M. E., Loeke, E. H., & Keuthen, N. J. (2011). The validity of DSM-IV-TR criteria B and C of hair-pulling disorder (trichotillomania): Evidence from a clinical study. *Psychiatry Research*, 189(2), 276-280.
- National Health Service. (2009, September 1) 'The National Child Measurement Programme'. *NHS choices website*. Retrieved from <http://www.nhs.uk/Livewell/childhealth1-5/Pages/ChildMeasurement.aspx>
- Rafalin, D. (2010). Counselling psychology and research: Revisiting the relationship in the light of our 'mission'. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 41-55). Oxford: Wiley-Blackwell.
- Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, England: Sage.
- Strawbridge, S., & Woolfe, R. (2003). Counselling Psychology in Context. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.) (2nd edn.), *Handbook of Counselling Psychology* (pp. 3-21). London: Sage.

Walsh, Y., & Frankland, A. (2009). The next 10 years: Some reflections on earlier predictions for counselling psychology. *Counselling Psychology Review*, 24(1), 38-43.

World Health Organization. (n.d.). ICD-10 online. Retrieved from <http://apps.who.int/classifications/icd10/browse/2010/en#/F63.3>

PART B
EXTENDED CLIENT STUDY
**A Case Study of Trichotillomania from a Cognitive Behavioural
Perspective**

PART C

DOCTORAL RESEARCH STUDY

The Maternal Experience Of Being Told Your Child Is ‘Overweight’

As Part Of The National Child Measurement Programme: An

Interpretative Phenomenological Analysis

Abstract

Children in England currently take part in a government-funded childhood weight surveillance and feedback initiative - the National Child Measurement Programme (NCMP). Limited research has been undertaken, predominantly using a positivist framework. This study explored the maternal experience of being told one's child is overweight or obese as part of the NCMP. Semi-structured interviews were carried out with the eight participants, and the data were analysed using Interpretative Phenomenological Analysis (IPA). Three master themes emerged: 'the Impacted Self', 'the Disempowered Self' and 'the Mother Self'. 'The Impacted Self' suggests that participants' experiences changed over time: there was initial surprise and shock; subsequent uncertainty and rumination regarding whether or not the weight category ascribed to their child was appropriate and, if so, concern regarding their role in the event; and an evolving experience, where participants either were able to move on and reject the category, or move on and accept the category, or remain stuck within uncertainty. 'The Disempowered Self' suggests that participants felt their power, authority, or confidence was undermined or removed; being judged, blamed and shamed; being branded and reduced to a weight label; and being controlled by numerous others, such as professionals, the letter, and societal meanings. 'The Mother Self' suggests that being a mother was an integral part of the overall experience, specifically: being a nurturer and protector in relation to their child; experiencing a unique bond to their child both emotionally and biologically; and navigating complexity of varying motherhood 'pulls', both logistical and psychological. This research study provides an in-depth exploration of the lived experiences of some of those who are affected by the NCMP, which is absent from current literature. Possible implications for the future development of the NCMP and related programmes, and for future research, are discussed.

CHAPTER 1

INTRODUCTION

1. Overview of the Chapter

In this chapter I provide an overview of the relevant literature and research related to the research question. Firstly, I orientate the reader to the area of being ‘overweight’² in childhood, including: prevalence, consequences, psychosociocultural considerations, and the mother’s role. Secondly, I introduce the use of BMI measurement and reporting, including: controversy regarding classification of weight categories, surveillance and screening uses, and current use of BMI measurement and reporting in childhood. I then introduce the reader to the programme currently used in England, the National Child Measurement Programme (NCMP). Thirdly, I discuss the literature regarding parental feedback of child BMI measurement, including a review of the studies directly related to the NCMP. Lastly, I provide a rationale for the research study, identifying its potential implications for counselling psychology, including clinical practice and broader relevance.

2. Being ‘Overweight’ or ‘Obese’ in Childhood

2.1. Prevalence of being ‘overweight’ or ‘obese’ in childhood

The World Health Organization (WHO) has stated that ‘childhood obesity’ is “one of the most serious [global] public health challenges of the 21st century”, with an estimated 42 million children under the age of five classified as ‘overweight’ in 2010 (“childhood overweight and obesity”, n.d.). The number of children who are ‘overweight’ or ‘obese’ has risen progressively over recent years, and is expected to continue to increase worldwide (Puhl & Latner, 2007).

² Throughout the thesis, I refer to weight terms in apostrophes as shown: ‘healthy’, ‘overweight’, ‘very overweight’, or ‘obese’, to indicate that these are terms ascribed to individuals, rather than an absolute fact.

The Health Survey for England (Bridges & Thompson, 2010) reported that 16% of children (aged 2-15 years old) were classified as ‘obese’ and 30% of children were classified as ‘overweight’ or ‘obese’. In the publication ‘Tackling Obesities: Future Choices’, Butland et al. (2007) predicted that if no preventative measures are taken, 25% of children would be ‘obese’ by 2050.

2.2. Consequences of being ‘overweight’ or ‘obese’ in childhood

The current widespread interest in excess weight and obesity stems from concerns regarding individual, societal, and economic consequences (Department of Health, 2011). Research continues to accumulate that indicates that being ‘overweight’ or ‘obese’ is associated with both physical and psychosocial problems (Theodore, Bray, & Kehle, 2009) affecting individuals and society as a whole, and that for children who are ‘overweight’ or ‘obese’, adverse consequences may track through the full course of their lives (Spruijt-Metz, 2011). Indeed, being ‘overweight’ or ‘obese’ in childhood is strongly linked to obesity in adult life (Jebb, Rennie, & Cole, 2003), with the Chief Medical Officer (Donaldson, 2008) estimating that 79% of children who are ‘obese’ in adolescence remain ‘obese’ into adulthood.

2.2.1. Financial cost

In terms of the financial cost in the UK, it is estimated that the NHS spends more than £5bn each year as a consequence of ‘excess weight’, and that this in turn has an impact on economic development (Department of Health, 2011, p. 5). It is forecast that indirect costs may increase to £10bn by 2050 (Butland et al., 2007). NICE (2013) indicated that most of the financial costs of being ‘overweight’ or ‘obese’ in childhood will appear in adulthood. In order to reduce the number of ‘overweight’ children who remain ‘overweight’ in adulthood, they explored financial investment in childhood weight management programmes in England. After an initial five-year implementation, the estimated annual cost of the programme is approximately £4.8 million.

2.2.2. Physical consequences

There are a number of reported physical health concerns for ‘overweight’ children. These include “increased risk of cardio-vascular problems, metabolic disorders,

pulmonary complications, gastrointestinal disorders, sleep apnoea, orthopaedic problems, and certain types of cancers” (Theodore et al. 2009, p. 693). Obesity has been linked to “high cholesterol and triglycerides, hypertension, insulin resistance, type 2 diabetes, the metabolic syndrome, polycystic ovarian syndrome, non-alcoholic fatty liver disease, as well as breast, colorectal, and some other cancers” (Spruijt-Metz, 2011, p.129). As noted above, children who are ‘overweight’ or ‘obese’ in childhood are more likely to be overweight or ‘obese’ in adulthood when many of these problems commonly first become apparent.

2.2.3. Psychological consequences

In addition to physical consequences, whilst research in the area is certainly not conclusive, it highlights a number of psychosocial concerns. These include experiencing low self-esteem, depression, body dissatisfaction, difficulties with interpersonal relationships, and suicidal behaviour (Puhl & Latner, 2007), as well as anxiety and hopelessness (Spruijt-Metz, 2001).

2.3. Psycho-sociocultural considerations of being overweight or obese in childhood

2.3.1. Stigmatisation, weight bias and peer victimisation

Research suggests that children who are overweight or ‘obese’ are at increased risk of experiencing weight-related stigmatisation (Gray et al., 2009). Weight-related stigma can be defined simply as the “social sign that is carried by a person who is a victim of prejudice and weight bias” (Washington, 2011, p.1). Puhl and Latner (2007) offered an alternative definition as “negative weight related attitudes and beliefs that are manifested through stereotypes, bias, rejection and prejudice towards children and adolescence because they are overweight or obese” (p. 558). For example, stigmatised messages in Western society about overweight people are that they are ‘lazy’, ‘stupid’, and ‘worthless’ (Schwartz & Puhl, 2003).

Weight bias, defined as “the inclination to form unreasonable judgements based on a person’s weight”, is thought to be caused by the belief that overweight people fail to lose weight due to inadequate willpower or that they will be motivated to lose weight through experiencing shame and stigma (Washington, 2011, p.1). Weight bias is

expressed as teasing, discrimination, employment disadvantages, educational and healthcare discrimination, and harsh media representations (Washington, 2011). There is evidence that interpersonal sources of weight bias and stereotyping of overweight and ‘obese’ children are present in peers, educators, and parents, and that such experiences can negatively affect social, emotional, and academic development (Puhl & Latner, 2007).

In terms of how overweight children are treated by their peers, research suggests that ‘obese’ children are viewed negatively (Gray, Kahhan, and Janicke, 2009) and are more likely to be socially marginalised than their peers (Strauss & Pollack, 2003). Although it might be expected that an increased prevalence of being overweight or ‘obese’ in childhood might lead to it becoming more socially acceptable, trends in prevalence suggest that the opposite is true, and that stigmatisation has, in fact, also increased (Latner & Stunkard, 2003).

In respect to educators, research suggests that teachers may also be affected by societal messages regarding weight or hold stigmatised views of children who are ‘overweight’. Hence, they may contribute to weight bias either unintentionally or by actively treating ‘overweight’ students differently to non-‘overweight’ students (Puhl & Latner, 2007). A concern is that formally identifying pupils as ‘overweight’ might accentuate such attitudes.

Puhl and Latner (2007) wrote that “perhaps the most surprising source of stigma towards youths is parents” (p. 564), and summarised their review of the area by reporting that the evidence available suggests that “parents endorse and may transmit weight-based stereotypes to their children, [that] sons and daughters experience weight-related teasing [and] daughters financial discrimination, by their parents’ (p. 573). In a similar vein, Pierce and Wardle (1997) reported that some parents expressed anger that their child did not live up to their expectations in terms of their weight; and Kinston, Loader, and Miller (1988) reported that families with an ‘obese’ child experienced the condition as “intense, pervasive, and negative” (p. 261).

Stigma, bias, and stereotyping arising from negative beliefs and attitudes about being ‘overweight’ can be expressed in many forms, such as verbal and physical bullying and relational victimisation (Bromfield, 2009). Gray et al. (2009) reviewed existing research relating to peer victimisation and obesity in children. They noted that peer

victimisation, defined as “the experience of overt (e.g., pushing, hitting, kicking) or relational (e.g., gossiping, teasing, ignoring, excluding) forms of aggression as perpetrated by an individual or a group of peers” (p. 721), is a widespread concern, particularly in ‘obese’ children who are more likely than non ‘obese’ children to be “victims and perpetrators of peer aggression” (p. 721). Whilst acknowledging the need for caution in attributing cause and effect, the authors highlighted a number of studies showing that the peer victimisation of ‘obese’ children can have negative consequences on psychosocial functioning, emotional wellbeing, and health behaviours. Specifically, they noted an association between peer victimisation and lower quality of life, lower self-esteem, higher levels of depression, loneliness, suicidal ideation, and suicide attempts. They highlighted research suggesting ‘obese’ children are less likely to spend time with friends, more likely to be dissatisfied with romantic relationships, and less likely to marry when adults. Additionally, they noted that ‘obese’ children also experience increased body dissatisfaction and weight concerns, dieting, binge eating, unhealthy weight control and bulimic behaviours; with increased isolated sedentary activities, negative attitudes towards sport, and reported barriers to engaging in physical activities.

2.3.2. Sociocultural messages about weight: Morality, and medicalising weight

There are a number of sociocultural factors that may lead to stigmatised views of individuals who are ‘overweight’ or ‘obese’. Ogden (2004) noted that the focus on thinness in contemporary culture may play a role in low self-esteem and body image in individuals who do not fit the “stereotypical attractive thin image” (p. 355), and Orbach (1988) explored the impact of messages about weight through the fashion industry and being part of a culture where to be thin is ‘good’. This last point is echoed by Gard and Wright (2000), who suggested that weight has become a moral issue, where to be ‘overweight’ or ‘obese’ is seen to be an “individual failing or weakness” (p. 7).

The biomedical ‘facts’ presented are challenged by some, arguing that these medicalised discourses in society lead to stigma. Indeed, Warin, Turner, Moore, and Davies (2008) suggested that the discourse about obesity is “loaded with ideology and cultural beliefs about how we view ‘fatness’” (p. 98). Gard and Wright (2000) suggested that the current knowledge of obesity is “confused and replete with flawed

and misleading assumptions” (p. 3), leading to speculation becoming ‘fact’ (p. 5) in academic literature and popular media. They further highlighted the use of emotive language such as the obesity ‘epidemic’ and the ‘war’ on obesity (p. 8), which they argued raises concerns about the impact of the dissemination of information passed into the public domain through the media, which are subsequently incorporated “into their existing beliefs about the world”, affecting the attitudes of the wider society (Gard & Wright, 2000, p. 9).

2.4. The mother’s role

2.4.1. The mother’s early role in feeding

Recognition of the mother’s role in feeding and nurturing children is well established; Warin et al. (2008) suggested that the very role of being a ‘mother’ is central to determining food provision. Indeed, Keenan and Stapleton (2010) suggested that the mother’s role in her child’s weight begins even prior to birth, where the relationship between food, nutrition, and motherhood can begin from the planning stages of pregnancy. Whilst acknowledging the variety of people directly and indirectly involved in children’s healthcare, such as fathers, family members, healthcare professionals, community members, and educators, Luman et al. (2003) pointed out the crucial role of the mother in caring for the health of her child from preconception onwards. They highlighted ways in which the mother’s influence and role in her child’s health can be seen from early stages through behaviours such as taking prenatal supplements or stopping smoking – and note the two-way effect of such changes: what is beneficial for the health of the child is also beneficial for the health of the mother. Similarly, whilst it is certainly true that feeding children can be carried out by people other than the mother, many feminist writers have claimed that responsibility for early infant nurture and nutrition lies predominantly with mothers (Keenan & Stapleton, 2010).

2.4.2. Being ‘overweight’ or ‘obese’ in childhood: The mother’s responsibility

Zivkovic et al. (2010) examined discursive relations between childhood obesity, mothering, and child neglect, and argued that children are portrayed as “innocent victims of poor parenting” (p. 375). In addition, they suggested that parenting is “code” for mothers, who hold “gendered responsibility for food and families”

(p.375). Similarly, Maher et al. (2010) argued that media coverage focuses on the provision of meals by women. In addition, as the shift towards personalised care and self-care within the NHS continues, more pressure is placed on mothers to take responsibility for the positive health of their children.

2.4.3. Stigmatisation of mothers of 'overweight' or 'obese' children

Although research on stigma, parenting, and being 'overweight' or 'obese' in childhood has mainly focused on the role of parents as being involved as vehicles of stigma, bias, and discrimination, a small body of research has suggested that parents themselves feel affected by stigma (Purl & Latner, 2007). Some mothers are reported to feel 'blamed' by healthcare providers and held responsible for their child being 'overweight' (Edmunds, 2005). Pierce and Wardle (1997) suggested that parents feel guilty that their child is 'overweight', and experience self-doubt at not being able to respond to another's accusation that they have the power to change their child's weight. Related discourses have been explored by Kokkonen (2009), through collection of data from a Finnish Internet discussion site. The findings suggested that parents were largely viewed as the cause of their child being 'overweight': They were negatively constructed in terms of character traits, having an inadequate ability to bond with their child, and using 'faulty' child-rearing practices. It is noteworthy that Kokkonen (2009) found that all the parental constructs applied to the mother as opposed to the father.

3. BMI weight classification in children and related uses

3.1. The energy equation and weight change

Individual weight change depends on the balance between the energy taken in and the energy expended; in individuals who are 'overweight', the energy taken in has consistently exceeded that expended (Ahearne-Smith, 2008). Imbalance is thought to result from a variety of genetic, biological, psychological, sociocultural, and environmental factors, affecting both sides of the energy equation and the interrelationships amongst these factors (Ahearne-Smith, 2008). In simple terms, if energy consumed as food exceeds expenditure, the excess energy is stored in the

form of body fat. Hence, being ‘overweight’ is an indirect reference to the amount of excess fat.

3.2. Defining and measuring ‘overweight’, and the BMI

Due to the cost and complexity of measuring fat per se, weight is used as a surrogate: A person with a weight above a predefined level is considered to be ‘overweight’ (and assumed to have excess fat). Weight clearly depends on more than just body fat and adjustments are made in an attempt to take this into account – the commonest factors adjusted for are height, age, and sex. The most widely used measure is the Body Mass Index (BMI): this is calculated by dividing the weight (in kg) by the square of the height (in m). In adults, the BMI calculated in this way is used without any further adjustment. ‘Normal values’ have been derived from population surveys of weight and height and defined statistically – those with BMIs beyond a particular percentile value being classified as abnormal. (A cut-off set at the 85th percentile, for example, will mean that 15% would be expected to lie above this, by definition.) Depending on the BMI classification system used, scores fall within specific weight categories, such as ‘underweight’, ‘normal weight’, ‘overweight’, and ‘obese’. There is no uniform international BMI scale and classification. The various BMI systems vary principally in respect of the population used to derive the normal range, and the percentiles chosen for the cut-offs between categories.

It is harder to determine what constitutes being ‘overweight’ in children due to changes in the body as children grow (Spruijt-Metz, 2011), and BMI scores must be interpreted accordingly. Hence, children’s BMI scores are additionally adjusted for age and gender to take account of different developmental growth patterns.

As with adult BMI measurements, there is currently no uniform BMI classification system used with children, and the debate regarding the suitability of which BMI cut-offs should be used continues (NICE guidelines CG43, 2006; SACN & RCPCH, 2012). Neovius et al. (2004) discussed discrepancies between classification systems used with children, and argue that this lack of uniformity raises questions about inefficiencies in healthcare delivery and prevention programmes. In the UK, three BMI classification systems are currently used: the 1990 UK Nationals BMI percentile charts, which classifies the cut-off for ‘overweight’ at the 85th percentile

and for obesity at the 95th percentile; the International Obesity Task Force (IOTF) classification based on reference data pooled from 6 countries, allowing common standard for international comparisons; and in clinical practice where the 91st and 98th percentiles of the UK 1990 National BMI percentile charts are used (Ahearne-Smith, 2008; National Obesity Observatory, 2011).

Drawing attention to the underlying assumption discussed above and potential for misleading measurement errors, the National Institute for Health and Clinical Excellence (NICE) in England (2006) cautions that BMI thresholds are used as an estimate only. Additionally, in a recent collaboration between the Scientific Advisory Committee on Nutrition (SACN) and the Royal College of Paediatrics and Child Health (RCPCH) (2012) regarding the issues related to the use of BMI figures to define weight classification of children, attention was drawn to the lack of scientific evidence linking specific BMI values with short- and long-term health risks of obesity (arguably a better basis for defining abnormality than a simple statistical approach as currently used). They suggested that current BMI classification systems to define being ‘overweight’ or ‘obese’ in childhood are a “historical precedent” (p. 4), originally put in place to address clinical management and surveillance needs; and they further recommend that the descriptors ‘overweight’ and ‘obesity’ are changed to “at risk of overweight” and ‘at risk of obesity” (p. 6).

3.3. Different uses of BMI scores and classifications: Surveillance and screening

Initially, BMI measurements in the general population were used solely for surveillance purposes – to provide data to describe a specific group of people (rather than individuals) at a particular point in time or for monitoring weight-related trends over time in a population. Surveillance involves analysis of aggregated anonymised data with no feedback to individuals. More recently, because of the growing concerns about escalating rates of obesity, this use has been extended to ‘screening’ of individuals to identify those ‘overweight’ in the belief that this will lead to changes in eating or exercise behaviours that improve health. Individuals are now identified with subsequent notification of their ‘results’. Arguably, this extension to screening represents a fundamental change in weight and height measurement programmes. This, in turn, carries significant new responsibilities for those responsible due to the ethical and psychosocial implications of feeding back

potentially sensitive information to individuals or to their carers (Nihiser et al., 2007a).

Stewart-Brown and Farmer (1997) argued that, prior to making decisions to implement any screening activity, social and psychological costs must be explored. In particular, they noted examples where (a) receiving false positive results has led to increased levels of anxiety, which have not decreased immediately after subsequent reassurance of 'normality' following further testing, and where (b) classifying people as 'positive' had led to increased anxiety, sickness leave, and a reduction in self-perceived health status even where the classification warranted no further medical intervention. They further suggested that it is possible that there may also be psychological impact on the friends and family of the person who has been screened, and questioned the impact of public misconception as to the nature of the screening and the possibility of reduction in the sense of personal control. In concluding, they argued for careful exploration of the risks as well as benefits before implementing individual screening programmes. More specifically, Govea (2011) highlighted the importance of considering the ethical implications of any interventions related to childhood obesity, and Washington (2011) argued that any intervention that leads to further negative psychosocial consequences, such as weight bias or low self-esteem, is considered "a serious ethical problem" (p. 1).

3.4. School-based BMI screening initiatives

Recently, measuring children's BMI in schools has become more common (Kubik, Fulkerson, Story, & Rieland, 2006), with parts of the USA, Australia, and England implementing broadly similar initiatives (see: Nihiser et al. 2007a; Lazarus et al., 1996; Grimmett, Croker, Carnell, & Wardle, 2008). Soto and White (2010) discussed the addition of screening to surveillance as part of school health initiatives related to childhood obesity. They suggested that alongside limited evidence of the success of BMI screening and reporting in schools leading to changes in weight, there are also significant concerns regarding the potential adverse impact on children and their emotional wellbeing, such as being subject to teasing, experiencing body sensitivity, or engaging in unhealthy dieting. Whilst in broad terms screening aims to inform public, professional, and parental understanding, questions are raised in terms of the individuals measured (and their carers) regarding classification accuracy,

privacy, stigma, parental, and children's response to the screening and overall effectiveness. When considering the potential impact on children taking part in BMI screening, Nihiser et al. (2007a) suggested that care should be taken to minimise potential harm to those participating by creating a safe and supportive environment for children of all sizes. Grimmer et al. (2008) also highlighted the possibility that children may be distressed to hear of their weight category, with consequences for their self-esteem and own weight-control behaviours.

3.5. School-based BMI screening in England: The National Child Measurement Programme (NCMP)

As part of the government's initiative aimed at reducing childhood obesity, the NCMP was set up in 2005 (Grimmett, Croker, Carnell, & Wardle, 2008). By basing measurement in schools, the NCMP provides comprehensive data on children's weight and height; it is funded jointly by the Department of Health and the Department of Education. The Programme's website describes its aims as "to help local areas to understand the prevalence of child obesity in their area, and help inform local planning and delivery of services for children; gather population-level surveillance data to allow analysis of trends in growth patterns and obesity; and enable primary care trusts and local authorities to use the data from the NCMP to set local goals as part of the NHS Operating Framework vital signs and their LAA [Local Area Agreements] National Indicator Set, agree them with SHAs [Special Health Authorities] and government offices, and then monitor performance" (Department of Health, 2011). Additional aims are to increase public and professional insight on the topic and engage with families through providing their child's results.

Children are weighed and their heights measured in Reception Year (age 4-5 years old) and Year 6 (age 10-11 years old). Parents are informed that they can 'opt-out' of the scheme, and are provided with information about how they will receive their child's results prior to the measurements being taken (NHS, Livewell, NCMP website). The BMI of the child is included in the feedback letter along with the child's weight classification: 'underweight', 'healthy weight', 'overweight', or 'very overweight'. In addition, the DH recommends including the leaflet "Top Tips For

Top Kids” and provides a number of locally developed resources including leaflets and flyers (Department of Health, 2011).

There is some variation in the way in which the NCMP is implemented locally. For example, Hull PCT worked with school nursing teams to provide proactive follow-up calls before routine letters were sent to parents of children who were ‘overweight’ or ‘very overweight’. During this call, additional advice was given as well as sign posting to services and offering further interventions (such as reweighing the child in 3 months, referral to an ‘Eat Well Do Well’ weight management programme for children and young people, or a home visit from the school nurse) (Ipsos MORI social research institute, 2010).

4. Parental Involvement With Childhood BMI Screening

4.1. Possible effects of feedback to parents

In a review of the literature, Dunsmuir and de Suasmarez (2011) noted that parents play a key role in the weight of their children, as discussed above. They argued that parent’s modelling of eating and exercise behaviours, as well as the psycho-social home environment for eating, can all influence children’s behaviours and attitudes. Indeed, Golan and Crow (2004) advocated that parents are viewed as “key players and central agents of change” (p. 46) with regard to treatment and prevention of weight-related problems. When this is coupled with research showing that many parents do not accurately know the weight of their child (Myers & Vargas, 2000) and do not always recognise that their child is ‘overweight’ (Jansen & Brug, 2006), the potential benefits of screening and feeding back results to parents, such as raising awareness and potentially instigating changes in diet and activity patterns where this is thought to be beneficial (Kubik et al., 2006), seem clear. Indeed, in reviewing the literature regarding parental influence, Howard (2007) suggested that interventions directed towards parents rather than children are the most effective, highlighting the importance of the family meal in terms of both emotional and nutritional wellbeing, and the parents’ role in promoting ‘health’, positive actions, and role-modelling has been advocated.

However, there remain questions as to what parents' views of BMI reporting are, whether they want to be told their child's BMI (Soto & White, 2010), and how best to feed back this information to them (Deitz, Story, & Leviton, 2009). Soto and White (2010) highlighted a number of studies which point towards positive parental perceptions of BMI screening and notification; however, they also pointed out some exceptions to this, such as increased parental concern for the psychological impact on their children.

4.2. Psychological impacts on mothers and their families

The psychological impact on parents of school-based childhood measurement programmes and parental reporting has been examined in three studies, two based in England and one in the USA. For the purposes of this introduction, rather than a critique of the full studies, the relevant parts are outlined and discussed below.

4.2.1. Grimmert, Croker, Carnell, and Wardle (2008)

Grimmett et al. (2008) undertook a predominantly quantitative descriptive study, the primary aim of which was to research the possible distress participating in the NCMP might cause children. The six schools chosen to participate were all in London. Both parents and children were invited to take part in the study, which involved completion of questionnaires six weeks prior to and four weeks post-BMI feedback. The questionnaires included a bespoke question on parental perception of their child's weight together with validated measures covering the following parameters: parental feeding practices, child body self-esteem, child eating behaviour, and weight-related teasing. A follow-up was completed providing some qualitative data on parents' and children's views of both participating in BMI measurement and the feedback process. The parental questionnaires were sent for completion at home, and children's questionnaires completed by children with a researcher, either in class (Year 6) or one-to-one (Year 3). Of those asked, 51% (n= 398) of parents volunteered to take part in this round of the NCMP, 46% (362) did not respond, and 3% (26) actively declined taking part, stating their concerns as: "disquiet about weighing children, reluctance to raise the child's awareness of weight issues, and concern about the involvement of schools in the process" (p. 686). Of the parents who agreed to their child being measured, 90% (357) completed the baseline

questionnaire and 72% (287) completed both baseline and follow-up questionnaires. The majority of the children (79%) were white and 99% of their parents had an educational qualification (GCSE or higher); these socio-demographic characteristics need to be considered when interpreting the findings.

Of the children taking part in the study, 13% (n=45) were classified as ‘overweight’ and 4% (n=16) as ‘very overweight’. 21% of parents commented on the measurement process and feedback of results, reporting mixed reactions. Seven parents stated that the experience caused an upset to either their child or themselves. In addition, two parents of ‘overweight’ children called in to state their concerns about their child seeing the feedback, and their own upset at seeing the weight classification in writing.

The percentage of children who were classified as either ‘overweight’ or ‘very overweight’ (17%) is lower than would be expected based on the prevalence suggested by the Health Survey for England (HSE) that reports that 30% of children are ‘overweight’ or ‘obese’ (Bridges & Thompson, 2010). As the authors of the report of this study suggested, it is possible that the low percentage of ‘overweight’ children in the sample may be due to ‘overweight’ parents not volunteering to take part in the study. Although the results suggest that such school-based interventions can be implemented without causing significant harm to the large majority of children and their parents, questions arise regarding the 49% who chose not to participate in the study, those who did return completed questionnaires but then did not participate in the qualitative follow-up part of the study, as well as those parents who did raise concerns. Perhaps, as the authors suggested, it is the case that parents who chose to feed back comments were more likely to be distressed, but one could also argue that the opposite might be true, and that a lack of response does not mean the experience was positive and non-harmful. Indeed, it might be the case that those who did not choose to take part in the study, or not to comment on the measuring and feedback, did not feel – for whatever reason – able or motivated to do so. In addition, although the proportion of respondents who expressed concerns are reported to be low, the numbers in this category nationally could be significant, given the scale of the NCMP and the many children and parents taking part across England. In other words, if representative of the wider population, the figures could raise more concern than they first appear to. The details provided in the appendix of the responses from

three parents who actively chose not to take part in the study (appendix 1) and seven parents who provided feedback after their child had been weighed also appear rich, and indicate that qualitative research could provide further insight into the phenomena. Similarly, the responses from children following participation in weighing highlight areas such as emotional upset, teasing, and privacy, raises questions regarding ethical consideration in relation to the intervention. Whilst this study's main aim was to research the potential for distress to children participating in the NCMP, it also raises questions about the psychological reaction of parents who stated that they felt some degree of upset, and about how the experience was for them and their families, and what might be gained from more in-depth exploration.

4.2.2. Mooney, Statham, Broddy, and Smith (2010)

Mooney et al. (2010) undertook research examining early experiences of the NCMP in a study funded by the English Department of Health. They stated that the two aims of the study were “to explore the impact on parents of receiving routine feedback about their child’s height/weight, and their views on how this information was presented to them; and to learn from the experiences of Primary Care Trusts (PCTs) which had chosen to implement routine feedback procedures in 2008/09” (p. 3). The samples were taken from four geographically dispersed PCTs, which were implementing the programme within the pre-determined timescale of the project.

The study of parents consisted of two principal parts: firstly, a largely quantitative postal survey was undertaken of parents who had recently received the feedback letter including the results of their child’s measurements and weight category; and secondly, a telephone-interview-based qualitative study of a sub-sample of those parents who had completed the postal survey. The first part, the postal survey, consisted of 12 predominantly closed questions within the following sections: ‘your child’, ‘your child’s weight’, ‘information that came with the letter’, and ‘...questions about yourself and your family’ (p. 54-55). More specifically, for example, the questions within the section entitled ‘your child’s weight’ included: what was your child’s weight category?; do you agree with that description of your child?; and do you think it was helpful to get your child’s results? The second part, the interview, included sections on ‘demographic and family structure’, ‘reaction to receiving the letter’, ‘agreement with results’, ‘before you got the letter’, ‘after the

letter – making changes’, ‘speaking to people’, ‘the letter itself’, and ‘additional information that came with the letter’. For the majority of questions, the interviewer had a list of pre-specified responses, with an open text box for additional detail. (For example, the question on ‘feelings on getting letter’ listed 11 possible responses: pleased/proud; worried/upset; angry; not bothered; mixed feelings; what I expected; can’t remember; shocked/surprised; not known; other1; other2.)

Of those sent the postal survey, 31% (n=616) responded. The results showed that there was relatively little disagreement about the classification given amongst parents of children who were classified as ‘healthy’ (1%), whereas parents of children who were classified as ‘overweight’ or ‘very overweight’ showed a much higher percentage who disagree/strongly disagree (59%, and 39% respectively). Similarly, more parents of children classified as ‘overweight’ or ‘very overweight’ stated that receiving the results was unhelpful/very unhelpful (26%, and 18% respectively) compared to parents of children classified as ‘healthy’ (3%). In terms of parental views on receiving the feedback letter, only 1% of parents of children classified as ‘healthy’ were not satisfied, contrasting with 31% and 25% parents of children classified as ‘overweight’ and ‘very overweight’ respectively.

Of the postal survey respondents, 53% agreed to further contact. Interviewees were chosen from this pool using a purposive approach aimed at securing a balanced sample on a range of characteristics (sex, age, socioeconomic status, and ethnicity). 49 interviews were completed; each interview lasted between 20-60 minutes. All weight categories were represented: ‘underweight’, ‘healthy weight’, ‘overweight’, and ‘very overweight’, with parents of children in the ‘overweight’ or ‘very overweight’ category oversampled. Interviews were carried out with 45 mothers and four fathers, and the researchers noted that interviews with parents of children classified as ‘overweight’ tended to last longer than those children classified as ‘healthy’. This seems to indicate that parents of children who have been classified as ‘overweight’ had more that they wanted to talk about, and may mean that they found the opportunity to discuss their experiences valuable. In addition, they commented that seven participants had insufficient understanding of the English language for the interview to proceed. 39% of parents of ‘very overweight’ and 54% of parents of ‘overweight’ children disagreed with the results. More than half of the parents who responded were surprised by the results, and some went on to describe their reasons,

for example: this contradicted what they had been previously told by other medical professionals, or they saw their child as “solid”, “big boned”, or having a “big frame” (p. 22) rather than ‘overweight’. With regard to finding the feedback helpful, the results showed that whilst 90% of survey respondents found the feedback helpful, nearly 20% of parents with ‘very overweight’ children stated the feedback was either unhelpful or very unhelpful, rising to just over 25% of parents with ‘overweight’ children.

Initial feelings of parents were reported as shock/surprise, pleased/proud, angry, worried, and upset. In addition, findings from the interviews showed that some parents felt guilty, ashamed, or at fault and questioned their parenting: “really bad, disappointed, not doing my job properly as a mother” (p. 24). Other points raised by respondents were the impersonal nature of the letter, and feeling that the child was a “statistic” or “put into a category” (p. 24). Three parents stated that they found the letter “harsh or patronizing... ‘too blunt’ or ‘not sensitive enough’” (p. 25). Some parents were concerned about the negative effect the letter could have on their child, for example: poor body image, and anxiety about potential health risks such as diabetes.

Addressing their second aim, 11 interviews were carried out with NCMP staff across the PCTs, and with staff in each of the 11 participating schools. These were analysed using thematic analysis. The school staff interviews highlighted that of four parents who contacted the school post feedback, three parents of ‘overweight’ children contacted the school to state their disagreement or to complain. The NCMP staff reported a variety of parental reactions to receipt of the letter across the 4 PCTs, from seeking advice to calling to complain. Three of the four PCTs reported calls from parents who were angry or complaining about the letter. One PCT reported that three out of ten calls from parents of ‘overweight’ children were “pure complete ‘How dare you?’” (p. 39); another PCT stated that parents who were angry “tended to be parents whose children just fell into the overweight category” (p. 39). One PCT noted that all calls from parents were to complain. Interviewees felt that the weight categorisation might be the origin of complaints and reported parents challenging the descriptor ‘overweight’ as related to their child.

The researchers acknowledged study limitations: the small scale of the study does not offer a full representation of the national picture; the threat to generalisability from the low response rate, citing in particular under-representation of participants with limited knowledge of English; and opportunistic selection of PCTs to fit in with timescale required. Although different members of the research team completed the thematic analysis, the analysis was subject to input from the whole team, including checking, discussion, and agreement of themes. The number of telephone interviews (n=49) is high for a qualitative study. The use of descriptors is also of interest, as the category of ‘healthy’ weight may be indicative of the authors’ attitude regarding different weight categories and what constitutes being ‘healthy’. In addition, the use of pre-constructed categories raises questions regarding the possibility of looking for or placing more meaning on specific categories within the interview, which might not allow for participant experience to be captured in its fullest. The groupings reported correspond with the pre-constructed categories outlined on the interview schedule and raise questions about whether a more open approach using alternative qualitative methods would have led to similar results.

4.2.3. Kubik, Fulkerson, Story, and Rieland (2006)

Kubik et al (2006) conducted what they called a pilot study to explore parental “opinions and beliefs regarding school-based BMI screening and parent notification programmes” (p. 496). The study was based on a postal survey and the sample was taken from four schools in Minnesota, USA. All four schools were participating in BMI measurement programmes; however, only two schools fed back results to parents with the other two acting as study controls. Letters were sent out in English, Spanish, and Somali. 22% of students in the intervention school and 21% of the control school were from ethnic minorities. Due to research budget constraints, parents participating in the postal survey had to have a sufficient level of English to take part in the study. Of 1133 invited to participate, 70% returned completed questionnaires. The survey instrument used was content-validated, and was made up of 33 predominantly closed questions about receiving the letter and school weight measurement programmes (e.g. What parts of the letter did you discuss with your child?; How important do you think it is for schools to include height and weight as part of the yearly student health screening?; Are you concerned about your child’s weight?); family lifestyle (e.g. Does your child have a TV in his/her room?); their

child's physical activity (e.g. How much physical activity do you think your child gets most days?); eating (e.g. How often does your family eat the evening meal together?; In the next 30 days, how many servings of fruits and vegetables do you intend for your child to get on most days?); and demographic details about the parent/guardian. Most specifically related to this study, one question asked: 'How did the information in the letter make you feel?'. Four check boxes were available: very uncomfortable, somewhat uncomfortable, slightly uncomfortable, not at all uncomfortable; and in response to the question 'How?' (supplementary material gained from Kubik, p. 2). The majority of respondents were female, educated beyond high school level, and currently in work. A minority of respondents (20%) reported feeling discomfort with the feedback, with parents of 'overweight' children more likely to feel this way. In addition, of the 45% of parents who stated that they shared the results with their child, 17% stated that their child was uncomfortable with the feedback, and this 17% were more likely to be parents of 'overweight' children. Interestingly, the parents of older female children were less likely to want future yearly BMI screening and feedback, and the authors conjectured that this may be due to increased concerns regarding eating disorders in adolescence, especially amongst girls. The authors acknowledged that, whilst this study is one of the first to address BMI screening and parental feedback and has a strong survey response rate, it is limited in the generalisability of the study due to the population sample. In addition, the participants were mainly women, Caucasian, educated, and had a level of English that allowed them to take part in the study, and the authors acknowledged this as a source of response-bias. The fact that it was undertaken in the USA makes it less relevant than the two other studies reviewed here. Nevertheless, this study does provide some limited insights into the parental views of BMI screening and feedback in a situation that appears comparable to the NCMP in England. However, the data are predominantly quantitative and do not provide the depth that would be needed to fully understand the reported feelings of discomfort felt by the 20% of parents or the 17% of children. As the authors noted, whilst the proportion of parents who have an 'overweight' child may be relatively small, further research is needed to provide insight into this important group.

4.2.4. *Falconer et al. (2014)*

In response to the concern that providing BMI feedback to parents of ‘overweight’ children might have harmful effects (as well as other additional possible benefits and harms of the NCMP), Falconer et al (2014) conducted a ‘pre-post survey’ of 1844 parents of children taking part in the 2010-2011 NCMP from five PCTs. Questionnaires were administered three times: before BMI feedback, one month after feedback and six months after feedback. In all cases the following outcomes were assessed: ‘parental knowledge of childhood obesity’ (e.g. ‘do you think that being overweight increases a child’s future risk of any of the following: diabetes, cancers, heart disease, high blood pressure, and arthritis?’), ‘child’s diet’ (e.g. ‘do you think your child’s current weight is a health risk?’), ‘child’s physical activity’ (e.g. ‘on average, how many minutes of physical activity does your child do?’), and ‘child’s daily screen time’ (responses were categorized against the recommended two hours per day). Additional outcomes assessed in parents of ‘overweight’ children were: ‘parental recognition of their child’s overweight status’ (e.g. ‘how would you describe your child’s weight at the moment?’), ‘parental perception of associated health risks’ (e.g. ‘do you think your child’s current weight is a health risk?’), ‘weight-related teasing’ (assessed using a teasing/marginalisation subscale of an obesity-specific quality of life scale), and ‘child’s self esteem’ (assessed using an educational functioning subscale of an obesity-specific quality of life scale). Additionally, at follow-up, all parents were asked about whether they had sought further information, and what emotional response they had had to the feedback. The authors provided a list of the possible responses: “surprised, guilty, proud, pleased, upset, angry, ashamed, judged, or indifferent” (p. 7). They found that 21% of parents of ‘overweight’ children, and 24.1% of parents of ‘obese’ children reported feeling “upset” (compared to 0.5% of parents of ‘healthy’ weight). Additionally, they found that 15.4% of parents of ‘overweight’ or ‘obese’ children noted that they felt “guilt”, and 14.8% “anger” (compared to less than 1% of parents of ‘healthy’ and ‘underweight’ children) (p. 13). The authors noted that, given the “sensitive nature of weight” (p.15), care should be taken when considering how to provide feedback to parents.

4.2.5. *Syrad et al. (2014)*

Syrad et al. (2014) conducted 52 semi-structured interviews with parents (83% of these were with mothers) of children who had been labelled ‘overweight’ or ‘very overweight’ as part of the NCMP 2010-2011. From a sample of 285 parents who had been told that their child was ‘overweight’ or ‘very overweight’ (this sample was recruited by Falconer et al (2014); study outlined above), Syrad et al (2014) selected and contacted 108 potential participants from different ethnic and socio-economic backgrounds. The interviews took place in the participants’ homes, or over the telephone, and aimed to cover parental perceptions of their child’s weight and health risk after receiving BMI feedback. Specifically, the areas covered in the interviews were: background (e.g. ‘can you tell me a little about your family?’); feedback (e.g. ‘do you agree/disagree with the feedback?’); actions/behaviour changes (e.g. ‘what did you do when you got the feedback?’); service use (e.g. ‘have you contacted any services about your child’s weight?’); risk perception (e.g. ‘how do you think being overweight might affect children now/in the future?’); and overall experience (e.g. ‘are there any changes you would like made to the NCMP?’) (p. 9). The data were analysed using interpretative thematic analysis. Findings of the study indicated that parents disregarded feedback as they believed that “health and happiness as being more important than weight” (p. 1), that they felt the feedback did not take into account the individual child’s lifestyle, and that being ‘healthy’ was based on more than weight alone (such as emotional wellbeing, and diet). Additionally, the findings suggested that parents did not view appearance as reflecting weight (e.g. when they compared their child visually to other children, they did not believe their child looked overweight), that weight was attributed to inherited or acquired factors (e.g. weight attributed to genetics or ‘puppy fat’, rather than being a health risk), and that different cultural influences lead parents to view being overweight more or less negatively. The authors noted that whilst the sample size is reasonably large, one plausible limitation of the study is the possibility of response-bias in the study by Falconer et al (2014) from where the sample was drawn. Additionally, response-bias may have been present in their sample: for example, the authors noted that in response to their initial invitation to participate in the study 17 parents did not want to take part due to being “too busy or upset” in regards to the feedback (p. 3), and that 73% of these parents had children who were “obese” (p.3-4).

4.2.6. *Further insights, from media and online presence*

Alongside academic research and professional discussion, the NCMP has also received media attention, and has online presence. For example, this presence can be seen in UK-based newspapers, UK-based television and radio shows, and the NHS NCMP webpage.

Published newspaper articles include: “Youngster, 5, Branded Overweight by Health Chiefs” (Daily Mail Reporter, 2011), and “Why are Hundreds of Healthy and Happy Children Like These Being Branded OBESE by the NHS?” (Ley, 2012). The choice of words in these article titles may be particularly emotive in order to evoke a reaction in their readers and the general public. Indeed, Mooney et al. (2010) reported that a parent in their study had sent photographs to their local BBC radio station “defying them to describe him as overweight” (p. 40). The radio station and local television station ran stories, prompting the Director of Public Health to make media appearances regarding the NCMP.

The National Health Service has a ‘NHS Choices’ topic-specific webpage dedicated to the NCMP. The webpage provides an overview and rationale for the programme and also contains a section for the general public to post comments. Between May 2008 and June 2014, there were 28 comments posted on the website from 26 individuals. Of these 26, 21 could be described as critical of the programme or disagreed with the category assigned to their child, one could be described as supportive of the programme, and two could be described as general observation about the website video. A further two comments consisted of a teacher suggesting that parents should consider the food they provide to their children in packed lunches, and a response to this that could be described as critical. The comments of 19 of those who could be described as critical related to children who had been classified as ‘overweight’ or ‘obese’. Recent examples of this latter group include:

“...In response to the letter, while attending an appointment with my child's consultant in hospital, I spoke with him about this and was reassured that the possibility of her being overweight was completely out of the question and that I was to carry on as normal! So you see these findings are inaccurate.” (March, 2014);
“...I'm livid. I had expected to get a letter stating that my son is a healthy weight, not a letter suggesting he is overweight. He isn't overweight and I had expected to be

able to show him this letter to reinforce that fact. Utterly pointless exercise, not just pointless but actually worse than pointless - it's dangerous and damaging" (April, 2013); "Have just received a letter from [sic] the National Child Measurement Programme. Apparently my son is clinically obese...WHAT....???!!!!!! The letter included a Change For Life leaflet. How dare you presume to know my child's [sic] lifestyle and what he eats..!!..." (January, 2012); "When my 4 1/2 boy came home from school with a letter saying he had been weighed at school and that he was obese I was really upset..." (December, 2011).

These examples of media and online presence indicate that this subject is of current interest and that some of people who are affected by the programme want platforms to share their experiences. The latter point may be particularly true for parents who have a critical reaction to hearing that their child has been assigned the label 'overweight' or 'very overweight'/'obese'.

5. Rationale for the Research

5.1. Rationale for research study

The area of childhood obesity is clearly complex and multifaceted. As shown above, whilst current research has gone a long way to developing an understanding of the different factors at play, there are still many unanswered questions, with particular controversy about the interventions used in an attempt to tackle a number of different aspects of being 'overweight' in childhood. As my review of the literature led me to learn more about the NCMP, and its current use and stage of development in England, I became further interested in how the programme affects those involved and what their experiences are. Although a small body of research has looked at this to some degree, as outlined above (Kubik, Fulkerson, Story, & Rieland, 2006; Grimmett, Croker, Carnell, & Wardle, 2008; Mooney, Statham, Broddy, & Smith, 2010), Soto and White (2010) acknowledged that the impact of providing parents with BMI feedback is still largely unknown. Specifically, there is a gap in the literature that focuses on in-depth understanding of the impact on parents of taking part in such initiatives who have children who are classified as 'overweight' or 'very overweight (obese)'. This seems particularly important, given that research that has

been undertaken indicates that it is this group of parents who have found involvement in the programme most difficult (Grimmett et al., 2008). Experience from other screening programmes illustrates how the impact of any screening intervention must be carefully considered at individual and societal levels (Stewart-Brown & Farmer, 1997). Such consideration is also an important part of deciding whether interventions are ethical, and how further developments could enable them to be both more acceptable and more effective. For example, Grimmett et al. (2008) raised the possibility of excessive parental concern following BMI feedback, and the implementation of restrictive diets. Similarly, Purl and Latner (2007) suggested that it is possible parents may become critical towards their child if they feel negatively evaluated for having an ‘overweight’ child. These concerns further highlight the importance of considering the impact on parents who have been told that their child is ‘overweight’. Additionally, it is important to consider the wellbeing of the parents themselves, and how they may be personally psychologically affected by such news.

As shown in the literature, research indicates that mothers play the pivotal role in nurturing and feeding children (Warin et al., 2008; Keenan & Stapleton, 2010) and that within the context of childhood obesity, the position of parent is more commonly constructed as ‘female’ (Kokkonen, 2009). Whilst this does not discount the experiences of fathers, given the likelihood that mothers are involved in the process of the NCMP, this study focuses on the maternal experience only.

5.2. Rationale and implications for Counselling Psychology

5.2.1. Clinical practice

Historically, the identity of the counselling psychologist was based on the scientist-practitioner model, where the relationship between research and clinical practice was central to the profession (Rafalin, 2010). At first glance, research on screening for ‘overweight’ amongst school children does not seem to address an area that is directly related to clinical practice. However, on closer inspection, there are a number of reasons why the research is of importance to the practice of counselling psychology. In terms of the area of ‘childhood obesity’, the increased prevalence of this and related physical and psychological consequences means that it is likely to be seen in the clinic room in increasing frequency. In terms of working clinically with

weight concerns in children, there is a growing body of research that suggests that systemic interventions that include family therapy and family-based training are effective (Carr, 2009). As challenges faced by those with obesity in childhood may span into adulthood, increasing the effectiveness of early intervention in childhood seems highly important. Further research into the ways in which mothers (and their families) react to being told that a child is ‘overweight’ could provide increased understanding to practitioners working with mothers, their children, and their families more generally. Additionally, counselling psychologists work with women experiencing a variety of challenges throughout their lives, including clients facing challenges with stigma, weight, and parenting – the specific scenario of mothering a child reported to be ‘overweight’ could provide insights into these more general issues.

In addition to considering what relevance this study may hold in regards to specific clinical areas, the very nature of the research undertaken, with its ideographic focus and grounding in phenomenology, dovetails with counselling psychology’s values and focus on clients’ complex and nuanced subjective experience. Similarly, continually being sensitive to the relationship between the client and the therapeutic practitioner is seen as a vital part of clinical practice, which could be described as being mirrored in some ways by IPA’s reflexive practice. Woolfe (2001) highlighted the tensions that counselling psychologists may find themselves confronting as they shift between “being-in-relation and technical expertise” in clinical practice, and that such tensions may be eased by returning to, and acting from, the profession’s values that emphasize “being, not doing” (p. 19, Strawbridge & Woolfe, 2003). This seems to echo the experience of the IPA researcher who is required to be ‘in relation’ with the participants and their data, to co-create, to be attentive to what is said and unsaid, and to try to represent both descriptive and interpretative layers of analysis. Additionally, in their clinical work, counselling psychologists focus on their client’s wellbeing, as opposed to just seeking a ‘cure’ (Rafalin, 2010), which mirrors the motivation of this study. Instead of focusing, for example, directly on the effectiveness of BMI feedback in reducing weight, this research aims to provide insights that consider the lived experience of those who are affected by these weight related interventions.

5.2.2. *Broader role of Counselling Psychology*

Rafalin (2010) explored counselling psychology's relationship to research, highlighting the profession's hope to "engage with people in ways that attend to each individual's unique experiences" (p. 42) and to its "commitment to research as a vehicle for change" (p. 42). She suggested that the profession is "challenged by considerable social, political and professional tensions" embedded in ongoing societal changes, and that it has a "pivotal contribution to make in facilitating social action and instigating transformative change" (p. 49). She further suggested that as scientist-practitioners, counselling psychologists have the opportunity to make change through both research and clinical practice, and that through working at the "edge of our profession" (p. 51), collaborating with different professionals, and working at community level rather than at the level of the clinic room, counselling psychology research could offer something broader, where there is the potential for "significantly impacting on society".

Furthermore, since its inception, the profession of counselling psychology has been interested in social and political changes "questioning the underlying assumptions of the status quo within society" and in working "in ways that empower rather than control" (BPS, n.d.). As such, it seems appropriate that counselling psychologists engage with and use their skills to contribute to understanding ways in which the public's wellbeing may be affected by changes in society, in this case, school-based BMI measurement and parental feedback, and act in a way that fosters empowerment as opposed to control. Indeed, Milton (2005) suggested the value of undertaking research that can contribute to an understanding of how the world affects an individual's wellbeing. He highlighted the importance of engaging in research with social and political dimensions that are relevant to the profession, and considering the relationship between these and clinical work.

This research study is a response to a perceived phenomenon occurring at individual and societal levels, and one which is indeed affected by social and political changes over the last few years since school-based BMI measurement and parental feedback was instigated. It does not claim to be conclusive (as I discuss in the last chapter), but to shine light on another highly relevant aspect of 'childhood obesity'. I hope that the findings will be relevant to, and further research may evolve through collaboration with, other professions, such as teachers, allied healthcare professionals,

doctors, health and community psychologists, and local government. In such a way, the locus of the research can be considered to be working at the ‘edge’, responding to community needs, and utilising counselling psychology’s skills in a way that may be useful to a range of other professionals – for example, when considering whether or not further developments of initiatives such as the NCMP should be undertaken.

I hope that the research undertaken is not only ‘empowering’ for those who took part but also to other mothers affected by school-based BMI measurement and parental feedback, and does indeed provide some insight into the individual experience of a phenomenon that occurs now due to societal and governmental change. Whilst holding this in mind, the research aims to return to counselling psychology’s commitment to honour the individual’s subjective experience: “We see people... Not problems, not cases, not patients, we relate with people” (Walsh & Frankland, n.d.). In this way, phenomenological research is used to enable insight into the subjective experience of people directly affected by the intervention, looking beyond the ‘problem’ of childhood obesity, beyond the classification of children based on their BMI, and focusing on individual psychological experiences.

In the next chapter, I describe the research methods that I used to explore these issues.

CHAPTER 2

METHODOLOGY

1. Overview of the Chapter

In this chapter I outline my rationale for adopting a qualitative methodology, and, in particular, IPA. I outline my epistemological position and the use of reflexivity in this study. Following this, I describe how the research was conducted, including recruitment and sampling, setting up and conducting interviews, and ethical considerations. Then, I provide details of my analytic strategy. Lastly, I discuss and reflect upon the process of carrying out the research.

2. Rationale for Adopting a Qualitative Research Paradigm

As shown in the Introduction chapter, much of the research that has been carried out relating to childhood BMI measurement and parental feedback suggests that there is a subsection of parents, within those of overweight children, who find the process distressing. To my knowledge, most of the research carried out thus far has focused on larger scale samples, and used quantitative or mixed methods designs, and whilst the qualitative findings do offer insights into the views of these parents, no in-depth study has been carried out to date. In-depth qualitative research has the potential to offer new insights and further understandings about those who have experienced the phenomenon in question.

Langdridge (2007) summarised qualitative research methods as “naturalistic description or interpretation of phenomena in terms of the meanings these have for the people experiencing them” (p. 7). Willig (2008) noted that, as opposed to quantitative researchers, qualitative researchers are interested in the “quality and texture of experience, rather than with the identification of cause-effect relationships” (p. 8). A qualitative approach was chosen because of the purpose of the study: to explore the lived experience of a group of mothers in particular circumstances; it was not the intention to describe statistically how often pre-identified events occurred.

As a counselling psychology student, I was invited to consider my professional

identity and values, and the ways in which my choice of research methodology and my clinical work fit together. Whilst I have discussed this more in the Reflexivity section of the Discussion chapter, it is important to note here that such reflection formed part of my rationale to undertake qualitative research. McLeod (2003) noted that qualitative research fits well with counselling psychology values, and suggested that counselling psychologists possess qualities needed to do both qualitative research and therapy: “empathy, genuineness and acceptance” (p. 89). Further, as stated by Wertz (2005), I was keen to engage in research that “emphasizes the importance of returning to psychological subject matter with an open attitude and evoking fresh, detailed descriptions that capture the richness and complexity of psychological life as it is concretely lived” (Wertz, 2005, p. 167).

3. Interpretative Phenomenological Analysis (IPA)

3.1. Rationale for adopting IPA

Ultimately, as Smith et al. (2009) suggested, I chose a research methodology that I felt was most consistent with the epistemology of the research question. I felt that IPA was the most appropriate methodology to employ to address the research aims due to its ideographic nature and its focus on understanding how individuals make sense of their experiences. Prior to this, however, and given the number of qualitative methodologies available, I spent some time considering which would be best suited to the research. Most specifically, I considered IPA, Foucauldian Discourse Analysis (FDA), and Grounded Theory (GT), which seemed to most closely relate to the research question.

Although there are similarities between these three methodologies, there are distinct differences in their methodological aims. Willig (2008) discussed similarities and differences between IPA and Grounded Theory. Whilst she noted that they share many features in common, she outlined fundamental differences in their purposes: Grounded Theory aims to “identity and explicate contextualized social processes that account for phenomena”, whereas IPA aims to gain an “understanding of the quality and texture of individual experiences... the nature or essence of the phenomena” (p. 73). Like IPA, FDA is interested in “psychological life” (p. 112, Willig, 2008);

however, like Grounded Theory, its purpose differs from IPA. Instead, FDA's focus lies with language and the ways in which discursive constructs "make available certain ways-of-seeing the world and certain ways-of-being in the world" (p. 113). This is not to say that IPA does not consider the role of language and the role language plays. Langdrige (2007) noted that from a phenomenological perspective, language is seen as a means by which we "reveal the world and our relationship to it... [and make] our shared experience of the world more explicit" (p.161). Furthermore, Eatough and Smith (2006) explained that "IPA gives a central place to experience while acknowledging the multiple influences on it; its historical and cultural situatedness including language and social norms and practices" (Eatough & Smith, 2006, p. 119). By contrast, from an FDA perspective, language and discourse "facilitate and limit, enable and constrain what can be said, by whom, where and when" (Willig, 2008, p. 112).

3.2. Overview of IPA: methodology and epistemological considerations

IPA is a relatively young qualitative research method, first used during the mid-1990s. This research method was first designed by Jonathan Smith who sought to develop a research methodology that could fit within mainstream psychology, as well as tend to the qualitative and experiential.

IPA focuses on what a particular experience means to an individual and on their 'lifeworld' (Langdrige, 2007). Smith et al. (2009) outlined three theoretical underpinnings which inform IPA: phenomenology, the focus on "exploring experience in its own terms" (p. 1); hermeneutics, the "theory of interpretation" (p. 3); and idiography, "the detailed examination of a particular case" (p. 3).

Larkin, Watts, and Clifton (2006) outlined the two main commitments of IPA as "the phenomenological requirement to understand and 'give voice' to concerns of participants; and the interpretative requirement to contextualize and "make sense" of these claims and concerns from a psychological perspective" (p. 102). As noted above, IPA is 'idiographic' in nature. Researchers work with individual cases of a relatively small homogenous sample, before looking across cases and reflecting on participants' shared experiences (Smith et al., 2009). Instead of making broader claims, Eatough and Smith (2008) explained that IPA is interested in "diversity and variability of human experience" and focuses on "textures and nuances within related

personal accounts” within small samples (p. 182).

Whilst IPA aims to understand the participant’s view of particular phenomena, it also surmises that it is impossible to gain direct access to their lifeworlds (Willig, 2008). Instead, knowledge is arrived upon through a process of ‘double hermeneutics’, whereby the researcher interprets or tries to understand and make sense of the participant, who is also trying to make sense of the phenomenon in question (Langdridge, 2007). Smith and Osborn (2008) suggested that the researcher engages in both empathic and questioning hermeneutics whereby they explicitly try to take the insider perspective as well as questioning what else might be going on, reflecting on the implicit or that which the participant is less aware of. In this way, IPA could be said to take both an insider ‘emic’ and an outsider ‘etic’ position. They further explain that IPA adheres to the belief that people are “cognitive, linguistic, affective and physical beings”, and that whilst it holds that there is a “chain of connection” between these, participants may not always be explicit in their accounts of their experience, meaning the IPA researcher must utilise their interpretative skills to see beyond what is said.

The interpretative nature of IPA allows the researcher to “transcend or exceed the participants’ own terminology and conceptualization” (Smith, 2004 as cited in Larkin, Watts, & Clifton, 2006, p.114). IPA acknowledges that the researcher’s interpretations will be influenced by their own assumptions and views about the world (Willig, 2008). Due to this, and given that this second level of interpretation moves beyond the participant’s account and is therefore subjective and reflexive, it is essential that care is taken not to manipulate a participant’s meaning, and that insights are offered tentatively within a context of flexibility (Willig, 2008). IPA also acknowledges other ways in which the role of the researcher is integral to the knowledge that is created, such as the ways in which they communicate with, interview, and relate to the participant.

In terms of IPA’s ontological position, Willig (2008) explained that IPA subscribes to a relativist ontology, where IPA does not aim to arrive at a singular ‘truth’ about the external world, but aims instead to understanding how individual people experience and make sense of phenomena. IPA also takes a symbolic interactionist perspective. Eatough and Smith (2008) explained that, from this perspective, people are seen as to be “creatively involved in the development of a sense of self through

the interpretative action which takes place between people” (p. 184).

IPA is both grounded in a realist approach aiming to represent the participant’s phenomenological world, and reflexive acknowledging the interpretative role the researcher plays (Willig, 2008). IPA takes a relativist approach to ‘reality’ and argues that there are as many versions of reality as there are individuals experiencing it. However, it also takes a realist approach in relation to the individual’s experience in that it is ‘real’ to the individual. IPA assumes that these versions of reality can be captured, more or less accurately, by the researcher. IPA does not adhere to one theoretical line of thinking, in terms of how an individual perspective can be interpreted, but instead offers an ‘epistemological openness’, allowing the researcher to engage in a variety of “analytic strategies” guided by the research questions (Larkin, Watts, & Clifton, 2006, p. 116). Smith and Osborn (2008) also noted that whilst IPA and cognitive theory choose to undertake research from different paradigms, the former qualitative and the latter quantitative, they remain similar in their interest in “mental processes” (p. 54). In addition, Eatough and Smith (2008) noted that IPA and cognitive theory conceptualise cognition differently, where IPA sees cognition as “an aspect of being-in-the-world” rather than “isolated separate functions” (p. 183).

4. Reflexivity

‘Reflexivity’ is a process of continual inquiry by the researcher which allows the researcher to acknowledge and consider ways in which they as a person – with beliefs, thoughts, biases, assumptions – affect the research process both at a theoretical level (epistemological reflexivity) and at a personal level (personal reflexivity) (Willig, 2008). Ponterotto (2005) further suggested that researchers reflect upon the impact of the research process on their ‘emotional and intellectual life’ (p. 132). I explore my epistemological and personal reflexivity in the section following. The Reflexivity section of the Discussion chapter contains an exploration of the impact of the research on my emotional and intellectual life.

4.1. Epistemological reflexivity

Willig (2008) noted that there are a number of different epistemological

classification systems, with varying labels and meanings offered by different researchers. Hence, knowing what label to espouse is not straightforward. This having been said, in qualitative research, it is important for researchers to engage with epistemological reflexivity, and Ponterotto (2005) suggested that researchers consider a number of 'paradigmatic schema' and work from the one that most resonates with them. Having entered into this exploration, I currently feel that my epistemological position and ontological beliefs lie most closely with those of contextual constructionism and critical realism, and I outline my reflections below.

I found Madill et al. (2000) particularly helpful in guiding my epistemological reflections. Madill et al. offered three epistemological categories: realist, contextual constructionism, and radical constructionism. I identify most with the meaning Mahill et al. gave to the label 'contextual constructionism'. Specifically, I consider both the participant and the researcher to be "conscious beings interpreting and acting on the world around them within networks of cultural meaning... where all meaning is local, provisional, and situation dependent" (Madill et al., p. 9). Reflecting on this, as suggested by Pidgeon and Henwood (1997), I acknowledge that the research is subjective and affected by a number of factors such as researcher interpretations, participant understandings, and the view of the world that both I and the participants bring to the research (Mahill et al., 2000). Mahill et al. (2000) explained that contextual constructionists do aim to 'ground' their results; one way that this can be done is through returning repeatedly to the participant text as done in this study. They noted that some contextualists adhere to a critical realist ontological position. Willig (2008) described a 'critical realist' position as that which "combines the realist ambitions to gain a better understanding of what is 'really' going on in the world with acknowledging that the data the research gathers may not provide direct access to this reality" (p. 13). Fade (2004) further explored the meaning of a critical realist perspective: "critical realism accepts that there are stable and enduring features of reality that exist independent of human conceptualization. Difference in the meanings individuals attach to experiences are considered possible because they experience different parts of reality" (p. 647). My view of the world and what knowledge can be created through this research aligns with this. Participants offer different experiences of the same phenomena. The 'real' and stable element is the participant receiving the letter that informs them their child is 'overweight' or 'very

overweight'. How a participant will experience this is unique and individual.

4.2. Personal reflexivity

From the outset of the study, I engaged in a number of reflexive activities in the hope of uncovering more about my personal beliefs, opinions, and biases in relation to the research topic. These have ranged from discussions with different members of the City University counselling psychology faculty and my peers, keeping a reflexive diary, answering a set of questions outlined by Langdridge (2007, p. 59) that aim to foster reflexive engagement with the research, and recording myself answering the questions posed in the interview schedule. I will now discuss pertinent areas that arose through this exploration.

I am an English Caucasian married woman in my early thirties. I did not have children when I started the research or undertook the research interviews, but during the course of writing up the research had my first child. I am of 'average build', and I have not been told that I am 'overweight' at any BMI measurements that I have experienced. I am aware of times when I have felt societal pressures to have a body that looks 'healthy' with regard to my weight. Through my clinical work, I have gained some experience of working with women who struggle with their body image, related low self-esteem, and eating practices. This includes women who are 'overweight'. I do not have specific clinical experience working with either children who are 'overweight' or mothers of children who are 'overweight'.

As part of my reflexive practice, I considered how these personal and professional experiences may have impacted on and shaped the research. Indeed, I was asked by three of the participants whether I was a mother, and upon telling them that I was not, this prompted them to further explain their experiences. There may also have been assumptions made about me that were not voiced by the participants. I have reflected upon my size, and how this might have enabled or limited what the participants felt comfortable to share about their views and experiences, especially in relation to what 'overweight' means to them.

The early stages of arriving at a research question saw many of my assumptions and views of the research topic come to light. The way which I initially viewed the topic of 'childhood obesity' lay more within the realms of a biomedical model, prompted

by my limited understanding of the topic area and my clinical work in an eating disorder service. Through the process of initial literature review, I became aware of the role of stigma and bias and saw, to my discomfort, the ways in which I, too, had fallen into that camp without always consciously realising it. As my understanding of the physical and psychological aspects grew, so did my felt connection to those who were affected physically or psychologically by the experience of being 'overweight'. I noticed more about societal and medical discourses that I live 'within' and about my own values of what it means to be 'healthy'. As a scientist-practitioner, I questioned my core values, and reconnected to the humanistic values that had attracted me initially to the profession of counselling psychology. This depth of empathic reflection led me to consider those involved in the research area in new ways, and upon reading about childhood BMI measurement and parental feedback, I wondered about what the experience was for those involved. Not only did there seem to be a gap in the research literature from an academic perspective, but I was also affected by the number of Internet forum posts that saw mothers describe reactions to the initiative, which suggested they were angry, upset, or distressed. This personal and 'felt' motivation for engaging in the research question led me to become involved in a topic that I saw as somewhat 'political', which was not something that I had originally intended to do. I was aware, and not initially comfortable with the idea, that my research could be seen by some as taking a political position, arising through critiquing an initiative that was put in place by 'an entity' I held as having more power and knowledge than me. As the process continued and I neared the final stages of writing up the study, I noticed that my increased confidence in value of the findings shifted my feelings. I no longer felt nervous that the contribution of the study was controversial, but that it held value to all who were interested in this area. Put another way, I felt that there had been a shift from me-them, to us, where the possibility of collaborating and sharing useful knowledge came to the foreground.

Finally, I have no doubt that my personal interest in motherhood at this time in my life was in part guided by my and my husband's hope to start a family, and as discussed in the Reflexivity section of the Discussion chapter, as I became a mother part of the way through writing up the research, I found participants' accounts became meaningful to me in new ways.

5. Sampling and Recruitment

5.1. Purposive sampling

In line with IPA's idiographic approach, this study employed a purposive sampling recruitment strategy (Smith, Flowers, & Larkin, 2009). Purposive sampling allowed participants to be recruited who fell within a specific 'core' criterion, ensuring the sample was homogenous to this extent (Langdridge, 2007).

Initially, the core criterion was that participants were mothers living in England who had received a letter stating that their child was 'overweight' or 'very overweight' after their child had been weighed in school as part of the NCMP. As recruitment efforts continued, and further participants were needed, as suggested by Smith et al. (2009), the core criterion was extended to include the category of 'borderline overweight'.

5.2. Recruitment

This study employed a three-tier recruitment strategy: on-line advertising, paper advertising, and word-of-mouth. On-line advertising was conducted through a number of avenues. Firstly, a website was constructed which gave information about the study, my role, recruitment criteria, and offered a place for people to add their own comments about the research area (Appendix A). Secondly, an advertisement suitable for on-line publishing was designed (Appendix B). Contact was made with a number of websites, forums, and blog-writers specialising in motherhood or parenthood, requesting their assistance in advertising the study through their social media. In addition, after being recommended as a good recruitment source by a peer, the study was advertised on one non-motherhood specific website. Of 25 on-line sources contacted, nine either posted the advertisement, gave a link to the website, or wrote their own caption regarding the study providing additional information to their viewers.

Paper advertising was conducted in three ways. A number of paper recruitment materials were designed (Appendix C) and these were distributed as flyers, adding posters to London public notice boards, and sending a recruitment pack and letter to 100 London primary schools.

Word-of-mouth recruitment was conducted through requesting friends and family to pass on information regarding the study to people in their social circles. In addition, some of the participants expressed a wish to tell their friends about the study. All participants were offered a £15 voucher for taking part in the study as a gesture of thanks.

Ultimately, five participants responded to advertising on motherhood-related on-line websites, two participants responded to advertising on non-motherhood-related on-line websites, and one participant responded after hearing about the study from a friend.

5.3. Sample size

There is no concrete recommendation for the number of participants used in IPA studies; the emphasis lies on prioritising the quality of the data rather than the quantity (Smith et al., 2009; Langdridge, 2007). Langdridge (2007) suggested researchers consider ‘the norms in the discipline’ and Smith et al. (2009) suggested that at professional doctorate level, an appropriate sample size is between four and ten participants. Ultimately, eight participants took part in the study reported here, with the final choice of sample size based on continual review of the depth of data gained at each interview, and study limitations such as time and cost.

5.4. Initial contact

Prospective participants contacted me via email, either directly or through the advertising website. Where an email address was provided, initial contact was made via email by sending a follow-up invitation to participate, participant information sheet, and consent form for the participant to look through at their convenience (Appendix D). Where phone contact was requested, initial contact was made via telephone, an email address obtained, and the follow-up invitation, consent form, and information leaflet sent. Participants confirmed their intended participation via email, and either in-person or Skype face-to-face interviews were scheduled for a convenient time and location for the participant. Of the 17 women who initially expressed an interest in taking part, engagement with four was lost after initial contact was made and five actively withdrew from the study: three participants stated

that their child had requested they did not take part; one stated that she had given birth to another child since she first responded and did not have the same availability as previously; and one withdrew due to childcare difficulties.

6. Data Collection

6.1. Venue

Of the seven interviews conducted in person, five were held in reserved private rooms in libraries local to the participant, one was conducted in a reserved private room at a university, and one was conducted in a reserved private room at the workplace of the participant. Each venue offered a level of privacy that the participant stated they felt comfortable with, and was at a convenient location for the participant. The decision was made not to offer interviews at participants' own homes as a precautionary safeguard. This is now accepted good practice, particularly when participants are recruited over the Internet. The eighth interview was conducted over video Skype, where both the researcher and the participant remained at their own homes.

6.2. Pre-interview

Each participant who took part in a face-to-face interview was greeted at the building reception area and taken to the meeting room previously set up with two audio-recorders, refreshments, and a copy of the participant information sheet and consent form. Participants were thanked for their time and for their willingness to participate in the interview. Care was taken to foster a relaxed friendly rapport with participants, inviting them to clarifying any outstanding queries they had. They were reminded that care would be taken to ensure their data remained anonymous, that they could withdraw or stop at any time during the interview without giving a reason, and that, should they wish, their data would be deleted at any point in the research process up until publication. Participants were also reminded that the interview would be audio-recorded and that it would last approximately 60-90 minutes. Participants were asked to re-read, complete, and sign and date two consent forms, after which I also signed and dated them. One copy was given to the participant and I retained the other copy.

In the case of the audio/video Skype interview, the consent form was electronically signed and sent via email between participant and researcher as part of the Skype call.

After reflection with my supervisor, I decided not to ask participants to complete a demographic data form prior to the interview, on the basis that to do so could place categories and meaning onto the participants. I thought that to do so might be suggestive, where the researcher might guide the participant rather than be guided by what was important to them. In addition, Morse (2008) suggested that qualitative researchers too often provide demographic details that are better suited to quantitative research needs, and that provision of such details with small sample sizes can lead to a threat to anonymity. Morse (2008) suggested that instead of focusing on description of the participant, description of the context is more important. Indeed, description of the context does provide demographic data to some extent. This information emerged during the interviews and is summarised at the beginning of the Results chapter.

6.3. Interview

The interviews were semi-structured. Semi-structured interviews are distinct from structured interviews in that they are guided by the interview schedule rather than dictated by it. Thus, semi-structured interviews offer a flexible approach, allowing the researcher to follow the participant's lead rather than being pulled back to a schedule. This, in turn, allows for increased rapport – the interviewer can gently probe further into interesting issues and novel and unexpected topics that arise during the course of an interview (Smith & Osborn, 2003). Although the use of semi-structured interviews is the most commonly used method for data collection in IPA, they are not always most appropriate (Smith & Osborne, 2003). I did, therefore, consider other means, such as postal questionnaires, electronic e-mail dialogue, and diary entries (Smith et al., 2009), but concluded that semi-structured interviews would best provide the quality and type of data that I sought in this study. Alongside balancing the input of researcher/participant through researcher awareness, a number of interview skills were also employed to aid this process: asking open questions; 'funnelling' questions whereby both the participants' "general views and their response to more specific concerns" are accessed (Smith & Osborn, 2008, p. 62); reflecting on the impact of researcher interventions during and after each interview;

and further improving interview skills.

A provisional interview schedule was piloted with three mothers who were not part of the main study. Following feedback, questions and prompts were amended and the schedule below was drawn up. The interview schedule was used to guide the process only up to a point, and although I had the schedule to hand during the interview, I knew the questions well prior to beginning so that I did not need to keep referring to the paper but could be present to the participant and follow their lead. I held in mind that each participant was the ‘expert’ in their own experience, and used questions/prompts most appropriate to the individual account. I aimed to find a balance enabling both parties to ‘co-create’ the dialogue, and was mindful of allowing participants time to answer in full before asking another question.

Table 1. Flexible Interview schedule and prompts

Please can you tell me what comes to mind when you consider how this experience was for you?
Emotions, thoughts, physical sensations, behaviours...
What, where, who with, what did you do...
Can you tell me more about...
Please tell me what it means to you to be a mother who has received a letter saying their child is overweight?
Can you tell me more about...
the letter / being a mum / receiving the letter
Please can you tell me what happened when you first read the letter?
Emotions, thoughts, physical sensations, behaviours...
What, where, who with, what did you do...
How was this for you....
How has the experienced changed over time...
How would you describe your relationship to receiving the letter?
What did it mean to you...
What was the impact on you...
Emotions, thoughts, physical sensations, action...

What, where, who with, what did you do...

Can you tell me about others who were involved?

.... Friends, children, partners, professionals....

Emotions, thoughts, physical sensations, behaviours...

Are there any specific parts of the experience that stand out?

Is there anything more you want to say?

Is there anything that you feel we haven't covered?

6.4. Closing the interview

Table 2. Participant interview duration

Participant	Length of Interview (to nearest minute)
Anne	77
Jemma	82
Lucy	54
Jessica	71
Nula	65
Marie	30
Kate	48
Val	78

The seven interviews lasting 45-90 minutes were mutually drawn to a close at a time that felt appropriate to each interview, with care taken to tell participants when the time taken was approaching 90 minutes. This was done out of respect for the participant's time, as 90 minutes had been the maximum time agreed with participants, and although they were invited to continue if they wished, all felt they had said everything they had wanted to. The interview lasting 30 minutes was ended after this time had elapsed as requested by the participant and agreed prior to the interview.

All participants were given the debrief form (Appendix E) to read, and time was spent answering any further queries they had about the study to address whether they felt they wanted further support post-interview and where this was the case, how this support might be sought. All participants were again thanked for their time and participation in the study.

7. Ethical Considerations

7.1. Ethical practice

A number of safeguards were followed to ensure that the research study was ethically sound. Prior to engaging in the research, ethical approval was granted by City University Ethics Committee and throughout the process the BPS Division of Counselling Psychology 'Professional Practice Guidelines' (particularly section 2.5 'The practitioner as researcher', n.d., p.6), the BPS 'Code of Human Research Ethics' (2010) and HCPC Standards of Proficiency for 'Practitioner Psychologist' (2012) were followed.

Informed consent was gained from each participant taking part. Each participant was initially sent an electronic copy of the form along with the information sheet before agreeing to take part. Interviews were not scheduled until at least 48 hours after a participant agreed to take part. At interview, the consent form was discussed verbally with participants as well as providing them with additional copies for both the participant and myself to sign.

Smith et al. (2009) suggested that alongside these safeguards, qualitative researchers should engage in ongoing reflection, considering, for example, how interviews may impact the participant and potentially leave them feeling distressed. When such situations occurred in two of the interviews, the participant was verbally reminded that we could take a break or stop the interview. Although after pausing they chose to continue, during the debrief, they were verbally reminded that if they did decide that they wanted their data removed from the study, this was possible at any point in the research process. Alongside this, they were reminded that the thesis would be published in the doctoral portfolio, that research papers might be published, and that after this point it would not be possible to remove their (anonymised) data from the publications.

Alongside providing participants with a comprehensive debrief form, the debrief section of the interview was not time-limited, allowing any queries or concerns participants raised to be handled sensitively, respectfully, and in a supportive manner. Care was taken to maintain participant anonymity throughout the whole process, particularly at the point of compiling quotes for the written version of the analysis. Some quotes were not used as exemplar statements in the Analysis chapter due to the concern that they might threaten the participant's anonymity.

7.2. Adding to stigma and imposing meaning

As discussed in the Introduction chapter, there is concern that through the ways in which healthcare professionals and others engage in discussion around the topic of being overweight, they may inadvertently add to related stigma. Whilst I hoped to conduct research that was empowering and offered participants the opportunity to have their voice heard, I continually reflected on the ways in which I engaged with participants and my use of language at each point of communication. In particular, I found keeping a reflexive diary of great use in order to monitor my concerns and reflections regarding this. I describe these reflections later in this chapter.

Similarly, when drawing up the interview schedule, wording was carefully considered, and questions were deliberately aimed to be neutral and open (Smith et al., 2009). At all times, every attempt was made not to impose meaning onto participants (Willig & Stainton Rogers, 2008). During the analysis stage, where interpretation of data was required, care was taken to keep returning to the participants' texts, their own words, and to remain true to their meaning and experience as much as possible.

7.3. Paying participants to participate

Paying participants to engage in research has raised ethical questions, especially in relation to motivation for their engagement (Head, 2009; Beckford & Broome, 2007; Draper, Wilson, Flanagan, & Ives, 2009). In reviewing researcher rationale for participant payment, Head (2009) cited the following examples: helping to avoid bias; attracting participants who did not feel they had something of use to offer but were attracted to the project and monetary incentive; offering a gesture of thanks for

participation; going some way to ‘equalise’ the power imbalance between researcher and participant; and compensation for time lost.

My motivation to give participants a voucher for participation was twofold. Firstly, I hoped to offer a gesture of thanks for their participation. Secondly, I hoped to ‘equalise the power imbalance’ to some degree, and that by both parties leaving the interview with something tangible to use, the exchange would be more balanced. Deciding the monetary value of the voucher rested on a number of factors: my own experiences of being paid for research interviews; discussion with my supervisor and peers; and the budget set aside for the research.

7.4. The researcher–participant relationship

Whilst being aware that my clinical skills might be beneficial in terms of my ability to be sensitive to the researcher-participant relationship, and they might also benefit my interviewing skills, I was continually reminded of my ethical responsibility to remain in the role of researcher and not as therapist within this setting. Indeed, Kvale and Brinkmann (2008) highlighted the ‘uncertainty’ of how participants will be affected by research, and whether the researcher should engage with or steer clear of interventions that are in some way therapeutic (p. 268). Similarly, Kvale and Brinkmann (2008) remind researchers of the ‘ethical transgression’ that can occur when the researcher’s empathy can lead participants to disclosing more than they would have liked to (p. 268).

8. Analytic Procedure

8.1. Transcription

Smith et al. (2009) suggested that IPA transcriptions include all words spoken by the researcher and participant, and include hesitations, false starts, and breaks in sentences. Langdridge (2009) noted that although the level of transcription is seen to be relatively simple compared to that required by other qualitative methods, there are still questions about the level of accuracy of the transcription required, such as whether it is vital to phenomenological research to include all utterances (such as ‘mmm’,) or whether the research tries to improve the comprehensibility of the data

by amending grammatical errors. Whilst acknowledge that there is still debate around this area, he returns to the purpose of phenomenological research – that of exploring the participant’s experience – and suggests that whilst the details of language used may provide insights into the participant’s experience, such details are not the focus of phenomenological research.

Taking the above into consideration, interviews were transcribed to the level of detail suggested by Smith et al. (2009) by the researcher. The audio-recordings were stored electronically and the files password-protected.

8.2. Analytic strategy

Larkin, Watts, and Clifton (2006) suggested that IPA be viewed as “a ‘stance’ or perspective from which to approach the task of qualitative data analysis, rather than a distinct ‘method’” (p. 104). Smith et al. (2009) offered a set of IPA analysis guidelines; however, they noted that this is not ‘definitive’ and encourage ‘healthy flexibility’ of analytic strategies undertaken by IPA researchers (p. 79).

I used both the IPA analysis guidelines set out by Smith et al. (2009), and my own ways of working with the data to aid my analysis. An exert of Jemma’s transcript with analysis notes and emergent themes is shown in Appendix F. This process evolved as the analysis continued, and required both the consideration of a logical analytical strategy and embracing flexibility in order to see past ‘strategy’ and fully engage with the data.

Transcripts were worked with one at a time, as suggested by Smith et al. (2009). Firstly, each transcript was read a few times whilst listening to the audio-recording simultaneously. At this point, words or sections of text were marked at times when I felt it highlighted something about the participant’s experience. Secondly, comments were written in the right-hand margin of the page. Although these were not categorised as linguistic, descriptive, or conceptual as set out in the guidelines by Smith et al. (2009), I held these categories loosely in mind, and often found my comments did indeed fit these categories. In this way, the coding emerged from the data, with a degree of fluidity, rather than by looking for data to fit a specific set of categories. Thirdly, emergent themes were identified and recorded in a right-hand column. The related text was read through a number of times and the theme

descriptors amended as appropriate. Fourthly, similar emergent themes were clustered together using ‘MindNode Pro’, an electronic mindmapping programme. An example (Lucy) is shown in Appendix G. This allowed themes to be moved around the page and added to or removed from a particular cluster. Each cluster was then given an appointed initial theme name. At each stage of analysis, care was taken to engage with the data both as distinct parts (for example, individual words, sentences, themes) and holistically (for example, the transcript as a whole, the overall feeling of the participant’s experience as a whole). This activity of working with the whole, the parts, and then finding a new whole is consistent with hermeneutic enquiry (Smith et al., 2009).

This strategy was used with all individual transcripts, following which analysis across cases was undertaken. Here, patterns were identified, constituent theme names that I felt were a ‘fit’ across participants were adopted from an existing names or ascribed. Lastly, through a similar process of looking for patterns, master themes emerged. Again, at times words or phrases that had previously emerged through analysis were ascribed to master theme names, and at times I felt new names that encapsulated an overarching theme was used. Appendix H provides an overview of the three master themes and their constituent themes, with an example quote illustrating each constituent theme. As noted by Smith et al. (2009), bringing all the cases together, looking for patterns, and engaging with the variety of themes across all cases involved a to-ing and fro-ing between cases, and balancing the “convergence and divergence, commonality and individuality” between them (p. 107). In order to arrive at the master themes, the degree to which the themes were recurrent across all cases was considered. Whilst there is no set rule on what constitutes a recurrent theme in IPA, obtaining a certain level of recurrence does increase validity of the findings (Smith et al 2009). Although participants differed in the degree to which they were represented in the three master themes, as I moved into the latter stages of analysis, I continually shifted my focus back to participants’ emergent themes to ensure that they were represented. Again, this process was embedded in the consideration of the individual parts and the whole, balancing IPA’s “idiographic focus on the individual voice at the same time as making claims for the larger group” (Smith et al., 2009, p. 107).

9. Validity

Yardley (2000) proposed a set of criteria for assessing validity in qualitative research. Firstly, the researcher must demonstrate ‘sensitivity to context’, showing that they are sensitive to the theoretical context of the study, related research, the relationship between researcher and participant, the sociocultural context of the study, and ‘the ways in which “normative, ideological, historical, linguistic and socio-economic influences” interplay with beliefs and behaviours of both related researcher and participant (Langdridge, 2007, p.1 56). Secondly, the researcher must demonstrate ‘commitment and rigor’, showing that they have adequate skill, competence, have engaged fully with the data, and have demonstrated ‘thoroughness’ in terms of sample selection, data collection, and analysis (Smith et al., 2009; Langdridge, 2007). Thirdly, the researcher must demonstrate ‘transparency and coherence’, showing step-by-step detailed accounts of the research process, writing up the process in a clear and logical way, and ensuring that the study conducted is consistent with the theoretical underpinnings of the methodology used (Smith et al., 2009). Fourthly, the researcher must demonstrate ‘impact and importance’, showing that they have something of value to offer the wider world (Smith et al., 2009; Langdridge, 2007).

Smith et al. (2009) noted that whilst these criteria are of great use to the IPA researcher, IPA is in itself a ‘creative process’, and, as such, researchers are encouraged to take a flexible approach to ensuring validity, as well as finding that balance between striving for “very high quality” and knowing what is “good enough”(p.184). Parker (1994) also noted that whilst it is important to consider the validity of qualitative research, given the subjective, co-creative, and unfolding nature of phenomenological research, it is also important to stress that findings are “as fragile and mutable as real life is” (p. 11).

In order to address the issues of quality and validity, the following procedures were put in place.

9.1. Sensitivity to context

In terms of ‘sensitivity to context’, careful consideration of the literature was undertaken. This related to IPA and its theoretical underpinning, considering contributions and limitations of the research to date, author biases, quantitative and

qualitative offerings, questioning the socio-cultural factors at play with regard to the topic, ethical questions, and counselling psychology's role in relation to the subject area. In addition, a reflexive diary was kept throughout the research process in order to consider my interactions with participants, my interventions during interviews, and my own assumptions about the research as it continued. I tried to remain sensitive to the participant and their individual needs, not inviting them to disclose more than they would feel comfortable with after the interview and monitoring the "tension between a professional distance and a personal friendship" throughout the process (p. 268, Kvale & Brinkmann, 2008). I also discussed particular concerns with my supervisor and peers, such as my interventions during interviews and how these might better be adapted, or how offering vouchers to participants affected our relationship and issues of power in the relationship. Lastly, as suggested by Smith et al. (2009), I remained tentative in my interpretations and the analysis stages of the research, aiming to continually return to the participants' accounts, being sensitive, as far as possible, to their voice.

9.2. Commitment and rigour

When addressing 'commitment and rigour', I gave considerable thought to the degree to which my sample was homogeneous, especially when balancing obtaining an adequate sample size with extending the recruitment criteria. Alongside reflecting on and recording my reflections in relation to my ability and skill at interviewing, I again addressed concerns that I had with my supervisor and peers. Whilst completing analysis, I paid close attention to each transcript, working idiographically, paying attention to the various layers of meaning that unfolded through this process. As suggested by Larkin et al. (2006), I strove to step beyond descriptive phenomenological analysis, and remain true to the interpretative nature and requirements of 'good' IPA research. In doing this, I tried to remain close to Willig's (2012) guidance regarding carrying out interpretation: "the process of developing an interpretation involves a cyclical process of critical reflection that involves systematic questioning of the researcher's own emerging interpretations; it is not a product of his or her unmediated associations and reactions to the data" (p. 24). Guided by Morse et al. (2002), I considered and rejected the idea of seeking

participants' evaluation of the analysis due to the possibility that this might threaten validity rather than increase it. Morse et al. (2002) explained that:

Investigators who want to be responsive to the particular concerns of their participants may be forced to restrain their results to a more descriptive level in order to address participants' individual concerns" and that participant evaluations may "invalidate the work of the researcher and keep the level of analysis inappropriately close to the data. (Morse et al., p.16)

I felt that this was particularly relevant to IPA, which requires the researcher to move from the descriptive to the interpretative. In terms of writing up the analysis of the study, I tried to represent each participant appropriately and, as well as considering what shared themes were present, remain true to participants' individual experiences.

9.3. Transparency and coherence

In terms of demonstrating 'transparency and coherence', I have endeavoured to write up the study in a clear and logical manner, considering whether the way in which I conducted the research and authored the thesis is consistent with the theoretical underpinnings of IPA: phenomenological inquiry, hermeneutic tradition, and idiographic in nature. Alongside discussing arising concerns and queries with my supervisor and peers throughout the process of conducting the research, I also engaged in this at the writing stage, and at both points found this invaluable in helping me more accurately address this criterion.

9.4 Impact and importance

In terms of meeting the criterion for 'impact and importance', I considered a number of potential avenues. Having arrived at the rationale for the study through review of relevant literature, I considered the offering the research could make to the NCMP and, more generally, to the field of BMI classification and feedback, and an understanding of motherhood. I considered the impact of the research area for counselling psychology and the role of the counselling psychologist in conducting research that holds relevance both clinically and for society as a whole. I speculated on the value of the research for the participants and other mothers who had gone

through a similar experience, the potential opportunity of the research to ‘give a voice’ to those who had not yet been given the opportunity to ‘speak out’. I considered the impact of doing this in an academic framework, utilising an in-depth qualitative methodology that demonstrated the importance and value of their individual experience, as well as being able to offer tentative insights into shared experience. Lastly, I thought about the way the research held ‘impact and importance’ for me, and, most specifically, how it lined up with my own personal and professional values in terms of how I view people and the world, and how I work with clients.

10. Discussion and Reflexivity on Research Procedures

10.1. Recruitment

The recruitment methods used had strengths and weaknesses. I hoped that by using paper, online, and verbal means, I was addressing some weaknesses in each strategy. Online recruitment had the potential to reach participants nationally; however, only those who were users of Internet forums, networks, and blogs would have come across the advertisements. Paper recruitment had the potential to reach those who were not Internet users, but it was restricted to central London. Word-of-mouth recruitment had the potential to reach people at a national level and who were not Internet users but was limited in how far it would reach by the number of people that were in my network, snowballing outwards. I considered other ways to recruit, such as using paper recruitment in other areas of England, either by personally flyering or by placing advertisements in local papers; however, the costs of these were beyond the research budget available.

10.2. Sampling

I had not anticipated the amount of time and effort that would be required to recruit participants. As noted previously, I expanded my eligibility criterion to participants who identified with the term ‘borderline overweight’ being ascribed to their child. As far as I am aware this is not a term that would have been ascribed by the NCMP. The NCMP Operational Guidance (2014) indicates the four terms used are “underweight (children may be healthy at this BMI centile)”, “healthy weight”, “overweight” and “very overweight (doctors call this clinically obese)” (p.26).

However, I chose to view the term ascribed to the participant's child as 'borderline overweight' as this was how she perceived the term, and is therefore part of her subjective experience. I questioned the impact that this had on the study, especially in terms of the degree to which the sample remained homogeneous, and how this fitted within theoretical positioning of IPA. In particular, I was aware that if her daughter's BMI was on the borderline between overweight and healthy weight, it is possible that if the measurement had been taken using a different BMI classification system, her daughter might have fallen in the 'healthy weight' category. However, I justified inclusion of 'borderline overweight' on the basis that the message received by the mother was still that her child was considered overweight and, hence, homogeneity was retained.

Given the recruitment criterion, mothers of children weighed in either Reception Year (age 4-5 years old) or Year 6 (age 10-11 years old) were eligible to take part. It is noteworthy, however, that recruitment of mothers whose children were in the older age group proved problematic: As the recruitment continued, three of the participants initially indicating their willingness to take part pulled out of the study after being requested to do so by their child who had been weighed in Year 6. I reflected on the potential differences of the two age groups and past research that suggested that weighing older children could require particular care (Grimmett, Crocker, Carnell, & Wardle, 2008). The final sample had one mother who had a child who was weighed in Year 6, and as analysis continued, further differences between the two age groups became apparent. This point is returned to in the Discussion chapter, particularly within the context of further research inquiries.

All participants who took part in the study initiated contact with me in some form, which suggests that they wanted to share their experiences, and it is important to consider the possibility of bias within the context of this sample. It is possible that other potential participants did not choose to contact me for any number of reasons; for example, they felt too ashamed, they were not affected by receiving the letter, or they wanted to forget the experience. Whilst this could indicate potentially valuable narratives are not represented in this study, it does not lessen the value of the experiences that make up the data of this study.

10.3. Vouchers

As outlined above, I was aware of my motivations for giving a £15 voucher for participation, which were in line with my own values. However, I had not given ample consideration to how this gesture might be experienced by individual participants. One participant felt that her time was worth more than the monetary value of the voucher, and on this basis agreed to meet for 30 minutes only. Although, from my perspective, the monetary value had no relation to the participant's worth in terms of financial value, this interaction highlighted the complexity of offering something of monetary value to potential participants in research. Three participants stated that the gift of the voucher was not necessary and, although they accepted it, wanted me to know that they were participating due to their wish to be involved in the study as opposed to any other motivation. Four participants did not refer to the voucher other than in passing or to express their thanks, with one of these stating that she was looking forward to using it. Whilst my own motivations for giving the voucher still remain, this experience seemed to mirror the theoretical underpinnings of the research, and I reflected on the varying experiences of individual participants being offered the same voucher – in the same way that mothers may be sent the same letter regarding their child but experience it in unique ways. In the same way that my intentions were 'good', so may those be of the NCMP, and yet individual experience of the phenomenon and what it means to the individual differs greatly. As such, this process became an unexpected area of professional and theoretical learning.

10.4. Interviewing

Initially, I found using semi-structured interviews challenging, and was concerned that I would not cover everything I 'needed' to. This affected the ways in which I interacted with the participants, and shifted as the interviews progressed. I noticed that in the earlier interviews I stayed closer to the interview schedule than necessary, which may have meant that the participants' experience was not fully explored. As my experience grew, I became more 'trusting' of the co-creative process, and better skilled in my style of questioning, using less probes and less specific interventions. I also became more accustomed to the length of time of the interviews and more skilled at pacing the interview. I reflected on the phenomena of co-creating during

interviews, for example, where participants offered less and I returned more frequently to the schedule, or the different ‘feel’ and pace of different interviews.

The importance of sensitivity to participant needs occurred for a number of reasons, for example, at points where participants became tearful or were surprised at the ‘depth’ of feeling they described. Similarly, one participant did not speak English as a first language and negotiating our understanding of one another was, a few times, challenging. As noted by Willig (2008), participants taking part in IPA studies need to have access to language that is ‘sophisticated’ enough to convey the depth and intricacies of their experiences. I reflected on whether I would be able to capture her experience ‘well enough’, and was concerned that meaning may have been lost in translation. I noticed that, during this interview, I checked that I had understood the participant’s meaning far more frequently than other interviews. This also raised questions about whether I was being interpretative, which, as Smith et al. (2009) noted, is more appropriate in analysis stages of the research. In addition, one participant attended the interview with her children, which required another shift in being sensitive to her needs and the needs of her children. Here, reassuring her that she could take time out of the interview to care for her children, and being flexible with the pace of the interview at times was important. I also noticed that due to breaks in the interviews and the number of voices in the room, I summarised sections more frequently, helping us both refocus on where we were in the interview. Although I am aware that offering fewer interventions during interviews is usually more appropriate, and decreases the chance of the researcher imposing meaning on the participant, I felt that adapting this for specific cases (such as the above), using the participant’s language where possible, was beneficial.

I also reflected on my interventions and use of language with my supervisor, especially with the participant who became tearful. Through this inquiry, I noticed that I had guided the dialogue to a focus on ‘feelings’ through my use of language: ‘can you tell me more about how that made you feel’ rather than ‘can you tell me more about that...?’ In subsequent interviews, I was more careful to use neutral language, and more aware of the potential impact of subtle changes in the process due to my choice of words. My ability to be more sensitive to the process was evident when, during one of the last interviews, the participant stated that she was pleased with how ‘safe’ the interview had felt, and explained that she had previously

taken part in another study and been surprised by how upset she had felt during and after the interview had occurred.

As the number of interviews conducted increased, I became more aware of the unique position I held in participants' overall experience of receiving the letter. The number of participants who wanted to show me a photograph of their child particularly struck me. Five participants expressed a wish to show me a photo of their child, either within the interview or afterwards, with three mothers showing me photos they had on them. For example, one participant explained she felt anxious to show me her daughter so that I could see how 'ridiculous' the label was, and as with other participants, I reflected on the impact my response to this image could have on her. I noticed that I felt compelled to comment on or positively appraise participants' children, and that my role was meaningful in more ways than I was prepared for initially.

The shift I experienced in terms of my ability to conduct IPA interviews demonstrates an increased 'trust' in myself as a qualitative researcher and the process of IPA research, and an increased ability to practice sensitively and respond to ethical nuances as they arise.

10.5. Skype

I reflected on the differences between interviewing in person and over Skype. Although the latter was less straightforward, and I cannot know how the interview would have differed had we met in person, it seemed to work 'well enough'. It also had the advantage of bringing the time and financial cost of the research down, and this experience gave me insight into the potential of using this means of communication within a professional context. Whilst the decision was made beforehand to 'complete' the consent form electronically via email, and was completed as part of the recorded interview, this did have the disadvantage that the consent form was 'signed' by the participant and researcher by typing, not by adding handwritten signatures.

10.6. Right to withdraw

Initially, I offered participants the right to withdraw from the study at any time, as I did not believe it sat with my ethical values to give them a time limit and I did not want participants to feel ‘trapped’ at any point. However, Smith et al. (2009) pointed out the potential problem with stating that participants can withdraw at any point during the research process, and that, once published, the data cannot be withdrawn in the same way that it can before publishing. Although I addressed this with all the participants verbally, and explained approximately how long they had until the findings would be published, if I was revising the study, I would be more explicit about this in the participant information and consent forms.

10.7. The scientist-practitioner

Care was taken to balance my role as a researcher with the clinical skills acquired through clinical training, and whilst I do not believe that I stepped too far over into a clinical role, it was important to remember that I held the role of ‘researcher’ and ensure I did not slide into practitioner ‘mode’ whilst conducting the debrief. I do believe, however, that my clinical skills were invaluable in giving me confidence to be sensitive to and deal with participant distress effectively.

10.8. Analysis

As the analysis continued and I moved further away from the transcripts to higher order themes, I felt some uneasiness at moving beyond the flow and unique texture of participants’ whole narratives. I believe this is indicative of the transition required to move from the position of data gathering to that of analyst. At various points throughout the research, I was aware of my concerns about ‘getting it right’ and I feel this highlights the felt shift from working quantitatively to qualitatively. For example, choosing labels for themes did not feel straightforward, and I realised that I might never find the ‘absolute answer’, and instead sought to find relevant and ‘best fit’ labels for themes. The role of ‘researcher’ took on new meaning whilst working qualitatively, where my ‘voice’ was required to be an integral part of the research in more ways than when working quantitatively. This was particularly true when moving into more interpretative stages of analysis, and was something that I found challenging initially.

10.9. Writing

I noticed that I felt a certain discomfort when writing the words ‘obese’ and ‘overweight’ as I wrote up the study. I reflected on the meanings I projected onto these terms, and noticed a felt difference between seeing them as neutral diagnostic terms, and emotive stigmatised terms. I continually tried to hold this in mind as I wrote up the study, with the hope that the study would not serve to perpetuate weight-related bias and stigma. As I considered which quotes to use in the Analysis chapter, I initially intended to ensure participants were represented equally. I noticed, however, that the number of pertinent quotes seemed to be related to the length of the interview. For example, the number of quotes from Val (whose interview lasted 78 minutes) is higher than those from Marie (whose interview lasted 30 minutes). Therefore, participants were represented equally, not in relation to the number of quotes presented, but relative to the length of their interview.

The next chapter presents my findings based on the methods described above.

CHAPTER 3

ANALYSIS

1. Overview of Chapter

In this chapter, I provide brief thumbnail sketches of the participants, followed by an overview and a written account of the findings of the study. The thumbnail sketches are intended to contextualise participants' experience. As a way of introducing the findings, prior to the main written account, a summary table of all the themes is provided, along with a diagrammatical representation of the relationship between the master themes and notes pertinent to the written account. The written account aims to illustrate the development of the themes through participant quotations and analytic commentary.

2. Thumbnail Sketches of Participants

Each thumbnail sketch provides details of: the school year that the participant's child was in when they were weighed; the approximate length of time between receipt of the letter and the research interview; and the weight category that was assigned to the participant's child. Additional demographic information that participants raised during the interview is also included. As mentioned in the Methodology chapter, the following profiles contain information foregrounded by participants, and are not on the basis of a questionnaire. Given this, where information has not been mentioned, for example, employment, it does not mean that the participant was unemployed but that their employment status was not raised during their interview. (Note: Reception Year ages are 4-5 years old; Year 6 ages are 10-11.)

Anne

Anne's son was weighed in Reception Year. She received the letter approximately 6 months before our interview. Her son was placed in the 'overweight' category. Anne

is married, is employed, and has 2 children, both under 6 years old. She lives in Central England.

Jemma

Jemma's daughter was weighed in Year 6. She received the letter approximately 2 years before our interview. Her daughter was placed in the 'obese' category. Jemma is divorced from her daughter's father, and is remarried. She has 4 children, aged approximately between fourteen years old and 6 months old. She lives in North England.

Lucy

Lucy's son was weighed in Reception Year. She received the letter approximately 6 months before our interview. Her son was placed in the 'obese' category. Lucy is married and has 2 children, both under 6 years old. She lives in Central England.

Jessica

Jessica's daughter was weighed in Reception Year. She received the letter approximately 2 years before our interview. Her daughter was placed in the 'overweight' category. Jessica is married. She lives in North England.

Nula

Nula's daughter was weighed in Reception Year. She received the letter approximately 8 months before our interview. Her daughter was placed in the 'overweight' category. Nula is married. She has lived in the UK for approximately 5 years and English is a second language. She lives in South England.

Marie

Marie's daughter was weighed in Reception Year. She received the letter approximately 1 year before our interview. Her daughter was placed in the 'overweight' category. Marie is married and has 2 children under 6 years old. She lives in South England.

Kate

Kate's daughter was weighed in Reception Year. She received the letter approximately 2 years before our interview. She identified daughter as being placed in a 'borderline overweight' category. Kate is married, is employed, and has three children under 13 years old. She lives in South England.

Val

Val's daughter was weighed in Reception Year. She received the letter approximately 3 months before our interview. Her daughter was placed in the 'overweight' category. Val is employed and is a single parent. She lives in South England.

3. Themes

3.1. Introduction to themes

Three master themes emerged from the data through analysis: the Impacted Self, the Disempowered Self and the Mother Self. Each master theme comprised three constituent themes:

The Impacted Self

- Being shocked and surprised: experiencing the unexpected
- Uncertainty and fragility: questioning, ruminating, and worrying
- Evolving and emerging: rejecting, accepting, moving on, and remaining stuck

The Disempowered Self

- Being judged: experiencing blame and shame
- Branded child, branded self: Being reduced to a label
- Being controlled by 'them': being deprived of personal power and authority

The Mother Self

- Protecting and nurturing: being responsible for the care of your child
- Connected to your child: being biologically bonded and a role model in their development

- Navigating the complexities of motherhood: Juggling multiple ‘pulls’ and demands

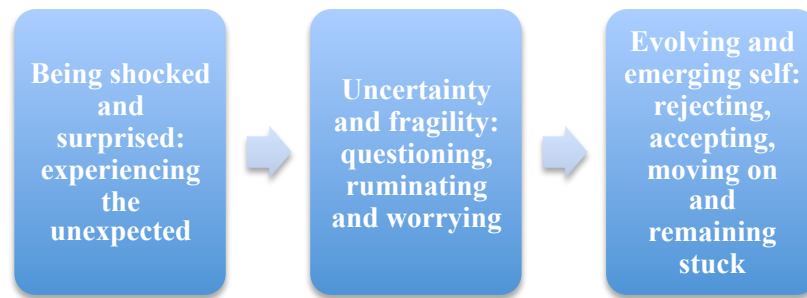
3.2. Additional notes regarding the written account of the findings

To show the development of the themes, the written account comprises of both quotations (which were chosen to best illustrate shared and individual experience) and related analytic commentary. Shorter quotations, words, and phrases are embedded within the written analytic commentary and longer quotations are presented discretely following and followed by written analytic commentary. Whilst themes are presented as discrete for the purposes of the written account, as illustrated in the diagram above, please note that there was overlap between them. Speech is presented in italics, with quotation marks indicating the start and end of each quotation. At the end of each quotation, the participant’s pseudonym and the line number where the quotation can be found on the transcript is marked: i.e. (Marie, 222). Where less relevant text has been deliberately omitted, it is shown as: [...]. Where words have been added to the quotation to contextualise the meaning, they are shown within squared brackets: “*it [the letter] arrived.*” Other observations, such as laughter, is shown within rounded brackets: (*laughs*). Where quotes contain both myself and the participant speaking, changes in speaker are indicated by either SG (my initials), or P (participant). I use phrases such as ‘receiving the letter’ and ‘seeing the weight category ascribed to their child’ to refer to the phenomenon explored in this study – the maternal experience of being told, by letter, that your child is ‘overweight’, as part of the NCMP. The themes are presented in the order outlined in section 3.1.

4. Master Theme 1: The Impacted Self

This master theme describes a shared experience of being impacted by receipt of the letter, initially and over time. The word ‘impact’ both evokes an image of an initial collision with the phenomenon and suggests subsequent legacy of receipt of the letter that participants are left with as they move forward with their lives. As indicated in the diagrammatical representation (Figure 1) through analysis, the Impacted Self emerged as a process that occurred over time:

Figure 2. Progression of the Impacted Self over time



4.1. Being shocked and surprised: experiencing the unexpected

Although the time lapse between receipt of the letter and the interview varied across participants, all participants were able to recall some aspects of the first time they read the letter from the NCMP. This highlighted the initial impact of receiving the letter as particularly striking. Every participant described ways in which some part of receiving the letter was unexpected, particularly the weight category that their child had been placed in. By nature of receiving something unexpected, many participants identified with feeling “*shocked*”. For example, Lucy described being “*taken aback*” and feeling “*disbelief*” (Lucy, 421). Alongside this, participants also described feeling a variety of other emotions such as “*anger*” and “*upset*”. Jessica, for example, described the experience as “*traumatic*” (Jessica, 847). Participants also described ways in which they interacted with the letter itself, for example, re-reading it a number of times. This was indicative of an inability to take in what they were reading initially, which mirrors emotions of shock and disbelief.

This is illustrated by Lucy, who had received the letter approximately 6 months before her interview:

I remember first reading it and being quite, erm, upset and almost not quite believing what I was reading, yeah... [...] I remember reading it and being quite - I s'pose - also I was maybe shocked also by the content of the letter and, and disbelief, and then the emotion came after - when you start reading it again... (Lucy, 544-549)

As she recalls and reflects on the experience, her pauses and broken phrases suggest that whilst she can remember reading the letter, she has not yet fully conceptualised her experience. Instead, the words “*I s'pose*” and “*maybe*” seem to mirror the

experience of being shocked, and suggest that she is unable to fully comprehend what her experience was in that moment. She also identifies a distinct moment in time of “*not quite believing*” before she goes on to experience further emotion. It appears that it is through re-reading the letter, moving beyond the initial moment of shock, that she becomes aware of, or is able to feel, other emotion. Similarly, Val explained that her initial response was: “...*automatically my back has sort of gone up....*” (Val, 268-269), suggesting she responded instinctually (like a mammal when threatened) rather than in a premeditated way. She further summarised the moment of impact by offering more detail of her initial experience in the following two short quotations:

...It's just like wow. What do you say reading something like that? Then you get your head together and think, did I just read what I think I read there?...

(Val, 31-33)

So you are seeing bullet points really. You are not really taking in the story.

(Val, 267-268)

She describes a fragmented experience, where she is unable to process the letter in its entirety. This is emphasised by her description of getting her “*head together*”. Her phrase “*did I just read what I think I read there?*” suggests that she moved from initial experience of being in shock to one of reflecting back, now aware of her own thoughts. This phrase also suggests that the shock and disbelief she felt regarding what was written on the letter was so great she doubted her own ability to read it correctly. Alongside the sense of fragmentation, the phrase “*seeing bullet points*” provides an emotive visual image. Taken literally, the phrase “*bullet points*” suggests that the words seem threatening or attacking, and may appear unexpected leading to shock. Jemma, who received the letter approximately 2 years before her interview, further describes this visual and fragmented experience when the word ‘obese’ “*swam in front of my eyes*”:

P: ...Just that word stood out and swam in front of my eyes and that's what I focused on. And I just had to read it, and read it again, and I was like, totally gobsmacked.

SG: Gobsmacked?

P: Of the word - and I just couldn't believe it. I put it down and I picked it up again, just in sheer disbelief of what I was reading and seeing. (Jemma, 672-677)

Although participants shared an experience of ‘shock’, they differed in the nuances of what impacted them the most. For example, Jemma and Lucy described seeing the weight category ‘obese’ as particularly shocking. Jemma stated that whilst she was “*expecting*” (Jemma, 10) the letter to class her daughter as ‘overweight’, the term ‘obese’ was unexpected, leaving her feeling “*upset and annoyed and angry*” (Jemma, 34). For other participants, however, the term ‘overweight’ was not expected. For example, Anne described her “*disbelief*” (Anne, 33), reading the letter “*a few times*” (Anne, 32) over, and her view of her son being at odds with the category ‘overweight’: “*you can see all his bones and his ribs and he is not fat*” (Anne, 35-36). In a slightly different vein, Jessica explained that whilst she was shocked by the weight category, she was also surprised that her daughter had been weighed at all:

... *I thought, to get this letter out of the blue, I just thought (intake of breath) ‘okay’ (brief laugh) – with no warning [SG: Mm] that the child was going to be weighed...*
(Jessica, 42-44)

The phrase “*out of the blue*” conveys the unexpected nature of the letter. The word “*warning*” may imply a view of the process as dangerous, unpleasant, or threatening. She uses the phrase “*the child*” when referring to her daughter, creating a degree of depersonalisation which may also indicate feeling shocked.

In summary, this theme has explored the consistent experience of surprise, disbelief, and shock at receiving the letter. This was illustrated through participants’ recollection of the moment they read the letter and their subsequent thoughts, feelings, and behaviours. Participants experienced different emotions alongside their initial shock and they differed regarding the specific aspects of what they were most shocked by. However, as a result of this experience, participants shared the experience of feeling uncertain and vulnerable, as described within the next subtheme.

4.2. Uncertainty and fragility: Questioning, ruminating and worrying

Once the initial shock had passed, participants described feeling uncertain and doubtful. They questioned themselves, typically about their child’s weight, their own behaviour, and what their child’s weight category meant about them personally.

The act of questioning themselves highlighted a lack of trust in their beliefs and feeling vulnerable within the context of their own ‘truth’. Their previous ‘truths’ (in terms of their child’s weight and associated meanings) were no longer certain, and their lived experience seemed fragile and vulnerable.

The continual rumination and intrusive nature of questioning and worry was illustrated by Marie, particularly in the phrases “*all day*” and “*you can’t help it*”:

It had been on my mind all day, I mean I wouldn’t say it upset me for the whole day, but certainly it upset me at first, and then I tried to not think about it, but you can’t help it, help but think about it, and then you start to question yourself – is she overweight?
(Marie, 46-49)

Lucy echoes this, and described how questioning herself and worry invaded her busy daily life as she cared for her children:

...just playing on my mind – going over in my mind and questioning in my mind... just the emotion of every time you – I’m very busy with two young children – but it keeps everything that you do - keeps bringing up in your mind and questioning...
(Lucy, 245-248)

Val described being able to bypass any rumination during the day, but was confronted by thoughts and self-doubt at night:

P: You wouldn’t think about it and then you would go to bed and think ‘I can’t believe you are saying that. What have I done wrong? Have I just given her, spoilt her? She doesn’t have McDonalds all the time, she has it as a treat. So what have I done wrong? Is she big boned? Is there anything such a thing as big boned?’ I said, ‘oh no it’s puppy fat, I was chubby’.

SG: What was it like to have all these questions?

P: It’s hard work, it is hard work. And I would probably say more stressful. It could be stressful because you are lying there and these thoughts are just going through your head. You have got other things to worry about, but then that’s at the front of it...
(Val, 370-380)

Her description of the experience as “*hard work*” and “*stressful*” (which was echoed by other participants) suggests that her uncertainty, continuous self-questioning, and

internal dialogue demands extra effort and energy – even when, as her last sentence indicates, she has other demands on these resources.

Some of the participants' self-questioning related specifically to weight-related behaviours, such as *"am I feeding her the wrong types of food, have I been not giving her enough exercise?"* (Jemma, 69-70). Other questions concerned general lifestyle and shared parenting style, such as *"I felt like it questioned me and, and my husband about how, how we bring up our children and it put that into some doubt"* (Lucy, 121-122). These quotes illustrate the extent of concern and worry that was experienced by participants – from specific detailed choices (*"am I feeding her the wrong types of food?..."* Jemma, 69) to global meanings about oneself and one's life (*"I felt like it questioned me and, and my husband about how, how we bring up our children..."* Lucy, 121-122). Participants provided insight into how such meanings and interpretations were experienced, and how their internal world and self-construct were affected. This highlighted a fragile, vulnerable self. For example, in her previous quote above, Val highlighted her felt responsibility by the emphasis on the word "I": *"what have I done wrong? Have I just given in, spoilt her?"* (Val, 372). Her questions imply a perceived personal moral failing.

The uncertainty and fragility felt was sometimes expressed as a struggle between participants' individual 'truth' and another's 'truth' (in this case, the 'truth' as constructed by the letter), and they often reflected on their beliefs about themselves in this context. For example, Jessica described experiencing an internal struggle:

It's a sense of 'I haven't done enough for her', but I knew that I had [SG: Mm] – if that makes sense, I know that I am a good mum and I feed her well, but when someone else is saying that your daughter is overweight, it like 'well obviously I'm not then', you know, I think it's that sense of... 'you're a bad mum'...
(Jessica, 99-103)

Later Jessica described this struggle as two opposing sides of internal dialogue. She likens her experience to having a mental health diagnosis, schizophrenia, and suggests she experiences her thoughts as two people having a debate:

Like a struggling in your own head isn't it... like you are having a conversation with like, it's like I'm a schizophrenic or something (laughs)... it's like the two people, talking to you in your head, and one person saying no actually perhaps she is fat and

I do need to do this, that and the other... on the other hand, it's like, well she's 4 / 4 and a half, don't worry about it, she'll, she'll exercise more at school, she'll do, start doing things, she'll be running around, she'll be fine anyway... It's like that push pull thing isn't it. (Jessica, 781-787)

Participants also described ways in which they sought answers to their self-questioning and reassurance from external visual cues. For example, Lucy remembered reflecting on her son's body shape as she looked at him:

...yeah, I found myself – and I do remember this – looking at him, looking at what he was like, and looking at when he got undressed for bed (laughs) and things. 'Does he look overweight? Does he, is he large?' (Lucy 488- 490)

Her phrase “*I do remember this*” suggests that this behaviour was significant to her. Additionally, she laughed, which might be a way of trying to make light of behaviour that she feels uncomfortable about to some degree.

Similarly, Val explained that she compared her daughter's weight to other children:

I have actually looked at other children – like when we have been in – since having this letter. And I have just stopped and I am kind of looking at other children and thinking: 'where is she in the scale of them? Where would I put her? Would it be down that end or that end like size wise?' (Val, 120-123)

Participants' feelings of uncertainty and lack of trust in their own beliefs about their child's weight and associated meanings was further shown through their interaction with others as they sought reassurance from friends, professionals, and family members. For example, Marie sought reassurance that she wasn't “*just seeing things in my own way [...] living in my own world*” (Marie, 147-149), and Anne wanted to check she was not in “*denial*” (Anne, 126) with regard to her son's weight. Jessica described being with other mothers where they engaged in “*questioning each other*” (Jessica, 75) about the letter and weight categories ascribed to their children.

In summary, this theme illustrated the uncertainty experienced by participants following the initial shock of receiving the letter. This was shown by continual questioning, ruminating, and worrying about the letter and associated meanings. Participants appeared to reevaluate and question their assumptions, unable to take their own ‘truth’ for granted anymore. This fragility was illustrated by seemingly

intrusive self-doubt and blame and indicates the degree of authority that the letter held (discussed further in *The Disempowered Self*). This sense of uncertainty and fragility was also highlighted through participants' reassurance-seeking from the world around them and other people.

Interaction with others did not always lead participants to feel more secure and certain within themselves and lifeworlds. Whilst some participants reported long-term or short-term reassurance, others found that such interaction left them with uncertainty, doubt, and upset. These, and other aspects of the next part of the phenomenological process, are discussed in the following theme.

4.3. Evolving and emerging self: Rejecting, accepting, moving on, and remaining stuck

Although the amount of time that had passed between receipt of the letter and the research interview varied across participants from 3 months to 2 years, they all shared an experience of being in some way changed over time. This subtheme therefore speaks to the longer term impact of receipt of the letter, in contrast to the initial impact or subsequent experience of uncertainty in the earlier subthemes. Indeed, the length of time participants described experiencing their initial reaction, their uncertainty, and the later 'emerging self' varied from moments to hours, days, and years. As time passed, participants had an ever-longer time to process what they had experienced; however, having more time did not mean participants were more able to 'move on' from the experience. Generally speaking, participants' current experience of the letter at the time of interview could be loosely separated into three ways of relating to the letter, encapsulating the emergence of an 'evolving self', or the self at the time of interview. These three ways of relating to the letter were: accepting of the contents of the letter and moving on, rejecting of the contents of the letter and moving on, and remaining in an experience of uncertainty, questioning, and fragility. Progression from the previous theme to the 'evolving self' described in this theme appeared to be catalysed through participants' interaction with 'facts', other people, and their own reflections. Below, the three ways of related to the letter are outlined individually, followed by a description of the manners in which they merged and overlapped in individual ways.

The first way of relating to the letter that emerged was ‘accepting the contents of the letter and moving on’. This was illustrated by Nula and Val. For example, Val describes a dramatic change over the course of a few months since she initially received the letter. Her initial desire to reject the letter is described in her evocative quotation below:

I looked at it and I thought I am going to burn this and then I went to screw it up and then I thought, no I don't even want it in my hands. (Val, 822-823)

Whilst she craves destroying the letter until it no longer exists, her repulsion is so strong she forfeits this desire to get it out of her hands. Later, however, she stresses the importance of time: “*I had to just sit down and wait it out really*” (Val, 362), and she offers a softer, mellower tone as she reflects on her experience: “*So it was a bit heart wrenching, but I said ‘ok, we can just be positive about it’*” (Val, 18). Her phrase indicates a personal decision to move forward, a choice of how to interpret what has happened, and what meaning she can give her experience. Indeed, she later states “*You think, I suppose, they are doing it for a reason, they are trying to help. It depends how you take that response, if you take it as a negative or a positive*” (Val, 320-322). Finally, she describes feeling ready to engage with the school, marking an affirmative shift, embracing the contents of the letter and moving forward: “*I am now willing to speak to you about it and to work with you*” (Val, 367-368).

The second way of relating to the letter that emerged was ‘rejecting the contents of the letter and moving on’. This was illustrated, for example, by Lucy, and Kate. Participants continued to actively reject the weight categorisation and any meanings associated with it. For Lucy, the following quotation suggests an arrival at a new experience, one that shifted from anxiety to a clear, direct, and encouraging stance:

P: I just thought ‘what you are doing is, is ok’ and ‘just continue with where you are, don’t let anything change’ [...]

SG: so that feeling of being able to tell yourself those things...you know, that you’re doing ok, how was that?

P: That was just, it felt so much better, and it felt almost like, er, a weight lifting off your shoulders in terms of not having this worry and this anxiousness about what you are doing was wrong, and, and what I was feeding him was wrong, and his

lifestyle, and actually being able to say 'no, I think we are ok, I'm sure we are, let's just continue with how we are and with what we are doing'... (Lucy, 321-331)

While her choice of words is affirmative, “*just continue*”, “*don't let anything change*”, and she later states “*you just continue as normal like nothing ever happened*” (Lucy, 627-628), it is clear she has not reached this place instantly. Instead, this is a process that has taken time and engagement with the world that she is part of. She describes “*a weight lifting off your shoulders*”, where she is now free from “*worry and anxiousness*”. Although this is not stated explicitly, her quote suggests that she is left feeling more peaceful, more content regarding her choices, and able to move forward. Her path to this new experience involved interacting with the world around her. For example, Lucy describes having a “*lightbulb moment*” (Lucy, 270), realising she could check her son's position on his weight/age curve record: “*it was a breakthrough moment of actually, I have got something here that will give me some answers*” (Lucy, 282-283). In addition, her description of her meeting with her GP, who laughed at the suggestion that her son was obese, highlighted the impact of others' reactions to the letter in shifting uncertainty and questioning. These experiences led her through uncertainty and anxiety, emerging as more self-assured, where she was able to “*genuinely believe*” (Lucy, 574) her own opinions about her son's weight. From this new place, she described being able to make purposeful choices about how she would interact with the letter and move forward:

I'd found out the answer that I wanted and I thought, that's the end, and in my own mind that was how it was going to be. (Lucy, 266-267)

I put the letter to the back of my mind, and – I think I just forgot about it and thought 'move on with life'. (Lucy, 75-76)

Regardless of whether they rejected or accepted the weight category ascribed to their child, participants found new ways of relating to, and making sense of, their experience through personal reflection, talking to others, and seeking out data and visual cues in their worlds. For example, Kate described a process of feeling “*backed up [in] what I knew was right*” through talking to others (Kate, 39-40); and

Val states that through speaking to others she felt she “*got it off my chest*”(Val, 899), allowing her to “*see a clearer route of where I want to go now*” (Val, 899-900). Anne highlighted a felt change that occurred through talking to other mothers who shared the experience: “*...it all seems a bit better when you are not the only one*” (Anne, 770-1). Similarly, Lucy explained that, for her, the support of other mothers meant avoiding the potential of feeling “*isolated*” (Lucy, 405). Instead, her words suggest a sense of camaraderie and shared growth and support as she describes learning “*how [other mothers] felt about it and how they’ve moved on*” (Lucy, 407-8).

In contrast, the third way of relating to the letter that emerged did not illustrate an experience where participants had moved on. Participants described remaining uncertain, questioning themselves and their choices, and their self-concept appeared fragile. They seemed unable to fully move on from the experience. This was illustrated by Anne and Jemma, who had received the letter 6 months and 2 years ago respectively.

Although Jemma described a reduction in the amount of time she found herself thinking about the letter in the quotation below, and feeling “*less angry*” (Jemma, 615), she explained that she “*still*” thought about it:

When I first got the letter it was quite often, it would be like every ten minutes it would just come back into my head. I would be cooking and it would float into my head and I would shake my head and think I’m so annoyed. Later on it would be every day, at least a couple of times a day, you know. I still think about it.

(Jemma, 445-448)

This corresponds with her earlier statement: “*it still makes me angry, and it still makes me cross and it still makes me annoyed*” (Jemma, 229), where her repetition of the word ‘still’ emphasises this sense of remaining in these emotions, and perhaps not feeling able to move past them. In addition, she describes how the letter had been kept hidden in a book, which metaphorically illustrates a sense of being stuck, and her phrase “*it was just that word obese that just sticks in my head. It is all I can think about*” switches from past tense to present, suggesting its current existence in her lived experience.

Anne stated that she still talks about the letter and weight categorisation, identifying herself as “*still torn*” about whether her son is overweight or not. She further explores the lasting impact on her daily experience:

I mean since we have had the letter, I think virtually every day when he has a bath and that, I look at him and I think ‘are you getting fat? Are you fat? Have you got any bigger?’ (Anne, 269-270)

Yes I think you have got to worry about it on a daily basis with your vision of some big roly poly kid in the future, which you just don’t want. (Anne, 504-505)

Her quote suggests that she is not only uncertain about her son’s current weight category but also that she fears he might become overweight in the future, which increases her concern and worry.

Analysis showed that the lines of demarcation of the three ways of relating to the letter were not clear-cut. Those who had predominantly rejected the letter and had moved on with their lives also highlighted ways that the impact of the experience was still raw, or parts of their experience were still evolving. For example, Jessica clearly described rejecting the weight categorisation following discussion with a paediatrician, yet became tearful in our interview: “*there is only so much a person can, you know, take*” (170-171), showing the toll the experience as a whole had taken on her. Similarly, Kate clearly described rejecting the letter through her interview; however, she indicated that she might still feel some vulnerability in relation to the experience. For example, she, like other participants, expressed her desire to show me a picture of her children during the interview:

I’m quite, there is something, this is probably quite psychological, I’m quite anxious to show you my children, in case you - well not in case of anything, but just so you see... how they are. Let me find a picture, is that ok? (Kate, 447-449)

Her quote suggests she experiences a residual vulnerability as a lasting impact of the phenomenon. It also emphasises the continual process of unfolding and evolving of experience, and the part that our interview and I have in her wider experience of receiving the letter. This ‘evolving’ was also evident as she explored action she

wished to take as a result of our interview. Whilst she did not discuss the letter with the school at the time, she stated that as a result of our interview she felt differently:

I possibly want to have a confrontation with someone. (Kate, 202-203)

I am feeling that I want to go and question someone. (Kate, 207-208)

...talking about it now makes me feel able to, um, to express it and verbalize it so it would make me more confident to express it and verbalize it... (Kate, 236-238)

In summary, this theme illustrates how participant experiences changed over time, with an ‘evolving self’ emerging. Three ways of relating to the letter were identified as accepting the contents of the letter and moving on, rejecting the contents of the letter and moving on, and remaining uncertain, vulnerable, and questioning. At a more detailed level, this theme shows how the wider experience is ever-evolving, and the complex and lasting impact of the phenomenon on participants.

This master theme, the Impacted Self, has described a phenomenological process experienced by participants. It outlines participants’ initial reactions to receiving the letter, their subsequent uncertainty, and their later integration of the impact of the letter into their evolving self.

The Impacted Self also provides insight into the following master theme, the Disempowered Self. Participants’ perception of the letter as an ‘authority’ is shown, most specifically, as they describe being uncertain of their previously assumed ‘truths’, and highlight the vulnerability that they feel as a consequence of what ‘truth’ the letter has offered. This highlights the power that the letter holds, and, in turn, the experience of being disempowered that was shared by participants.

5. Master Theme 2: The Disempowered Self

This master theme describes participants’ shared experience of disempowerment. As a consequence of receiving the letter, participants described ways in which they felt that their power, authority, and confidence was undermined or removed. Participants’ experiences appeared to be shaped, at least in part, through their perception of how ‘the letter’, and, in turn, those who were part of the programme, perceived them. The Disempowered Self highlights the ways in which participants’ view of themselves

emerged through their perception of how they were perceived and objectified others. Participants did not describe their lived experience as free and empowered, but from an undermined, disempowered position, where they were at the mercy of the perceptions of others. The following themes illustrate this within the context of feeling blamed and shamed, judged, and controlled.

5.1. Being judged: Experiencing blame and shame

Participants described ways in which they felt judged by sources such as the government, other mothers, the school, and other interpersonal relationships. To participants, this meant, for example, that they had “*failed*”, were “*bad*”, or had done something “*wrong*”; and led to feelings such as sadness, disappointment, guilt, and anger. As an overarching shared experience, participants experienced being blamed (at fault) and shamed (disgraced).

One way in which this experience evolved was within a lifeworld where absolute ‘right’ and ‘wrong’ exists. Within this context, receipt of the letter was experienced as a direct commentary on the ‘rightness’ or ‘wrongness’ of participants’ parenting:

*...You are not doing it all right and you want to do everything right by your kids.
And yeah, that's hard, to be told that actually you are not doing it right.
(Anne, 223-5)*

Furthermore, as shown in the following quotation, this was often experienced as a personal failing, where it was not a behaviour that was right or wrong, or good or bad, but the participant herself: Jessica said that the phenomenon symbolised “*the culmination that ‘well actually I’m a bad mum’*” (Jessica, 191-192). Believing that she is “*bad*”, her quote suggests that Jessica (like other participants) experienced feelings of inadequacy, inferiority, and shame in terms of the ‘mother self’ as a consequence of the phenomenon.

External judgement was experienced from a number of sources, both explicitly and implicitly. For example, whilst participants generally suggested that they felt supported by their partners and family members, Jemma described a different experience with her ex-partner:

P: ...sharing it with Molly's [her daughter] dad, obviously, and him just going out

to town about it all...[...]

SG: And how did that make you feel?

P: Angry, annoyed, fed up, erm, so made to feel like I've done something wrong,

[SG: yeah] you know, that she shouldn't have got the letter if I was looking after her properly and like a big vicious circle come back to me again. That's how I was made to feel from him and from the health service... (Jemma, 190-198)

Her words “made to” suggest she feels that her ex-partner and the health service have the power to make her feel a certain way about herself, and that it is because of them that she feels she may have done something “wrong”.

Additionally, participants described being disempowered within the context of potential judgment. For example, Marie describes thinking that she is continually judged by her peers. In the following quotation, she describes this in relation to food-giving:

Yeah they do, do, they, they, they, they do, they judge you I think - parents judge other parents particularly[...] I think you are constantly being judged as a parent – all the time you feel – you know, like, if you gave your child a packet of sweets you sometimes feel like you might be getting a dirty look from somebody...

(Marie, 162-167)

Her phrase “you feel like you might” suggests that she may fear a potential event rather than one that has actually occurred. However, this does not seem to lessen the ‘felt experience’ for Marie, and provides insight into the felt moral nature of food choices. The word “dirty” is particularly emotive, suggesting that she experiences being disapproved of, reinforcing a view of the world as a place of right or wrong, or good or bad. Val, who works with children herself, acknowledged that she had been judgemental of other mothers:

...I have done it; you look at a mum and you think, that mum's big, that child's big, she is over feeding. In the children's setting, in the Children's Centre, they would probably turn around and say that's abusive because you have over fed them, you are abusing the child. (Val, 779-782)

Coupled with other parts of her interview where she described feeling judged, this quote highlights the two-way nature of judgement and blame, where one can feel

both judged and judging. The word “*abusive*” is particularly emotive. It suggests maltreatment and behaving in a way that is undeniably ‘wrong’ and should not occur.

Participants also mentioned that they saw professionals as another potential source of judgement:

...you wonder, you know, what other, what professionals are thinking about you and are they, are they judging you... (Lucy, 128-129)

Lucy’s comment suggests that she feels she may be under scrutiny. Whilst Lucy questioned the views of professionals from afar, Jemma described her in-person experience with a dietician:

...it’s like they’re looking at you, like... you know, you’ve, you’re doing something wrong [SG: Mm], it’s like, reflected in you, as a parent, I think... (Jemma, 64-65)

Similar to her previous quotation, her phrase describes a process of marrying external judgment with her own self-concept. The words “*they’re looking at you*” suggest she feels critically appraised by the ‘all-powerful professional’. The word “*wrong*” suggest that she internalises her perception of what they may be thinking, and that she may experience feelings of shame. The phrase “*reflected in you*” suggests that it is her awareness of being seen by the other, in this case, the dietician, that leads to humiliation and shame.

Participants highlighted protective measures they took to avoid experiencing judgement from others, and related emotions. Specifically, participants described sharing the receipt of the letter and their experiences carefully: actively choosing to keep their experiences within certain parameters, such as immediate family members, close friends, medical professionals, and other mothers. Nula described ways in which she prepared herself and her internal world prior to engaging with her external world. She noted that “*you have to be prepared*” (Nula, 640) and described adjusting her “*mind setting*” (Nula, 636) so that, when engaging with others, she avoided feelings of “*shame*” (Nula, 638) and feeling “*embarrassed*” (Nula, 638). Lucy explained that she had a condition that must be met in order to share her experiences with others:

If I was, if I was convinced that they, that they wouldn’t judge me for, for having the child – if they would support me... (Lucy, 180-118)

Her phrase indicates that she sought a high-level certainty, suggesting a personal need to protect herself from any unwanted interactions, judgement, and feelings such as shame.

Whilst deciding with whom to share one's experience could be seen as an empowering action, it might have also maintained participants' fears of being judged by others, and fed secrecy and feelings of shame. Secrets, by their nature, create separation between people: those who know and those who do not. Participants differed in the groups and numbers of people with whom they felt 'safe' enough to share their experiences. At one end of a continuum, Lucy, for example, described the support of the mothers in her local community, where, collectively, they discuss lots of topics together on the playground – the letter and their related experiences included. Other mothers, such as Val, explained that she believed that having an 'overweight' child meant that you were "*a failure*" (Val, 722), and shared her experiences with selected people. At the far end of the continuum, Jemma experienced silence amongst her fellow mothers, as outlined below:

Yes, it's like a taboo subject. No-one will say I have got a letter and my daughter was so and so. They won't ... Nobody speaks about it.... [...] You wouldn't get another parent come up to you and say 'oh guess what my letter said'. No-one spoke about it, so you had no idea what anybody else had you know. So just, as I said, it was just between me and Molly [her daughter] at first and she shoved it in a book and didn't want anyone to know...
(Jemma, 312-317)

Jemma highlights the perpetuating cycle of silence and secrecy. She kept quiet and experienced other mothers doing the same, which she later notes is very different to other topics usually discussed in the playground. With regard to her fellow mothers, she remained isolated. Her emphasis on this lack of communication suggests that the silence itself felt all-powerful, and later she notes: "*Obviously you feel like you can't talk to anybody else because no-one has mentioned it, so therefore you don't say anything*" (Jemma, 325-326). She did not explore why she felt unable to be the first person to raise the topic; however, her earlier word "*taboo*" suggests that, for Jemma, the topic felt forbidden, and that speaking out would go against the 'powerful' societal norm. Her description of keeping the letter "*just between*" herself and her

daughter, and that her daughter “*shoved it in a book*”, offers an evocative illustration of shame.

In summary, this theme illustrates participants’ experience of feeling judged, blamed, and shamed – which were acutely disempowering. In relation to this, the following constituent theme explores further the emotive nature of the terms ‘overweight’ and ‘obese’, and participants’ experiences in relation to feeling that they and their child were being negatively labelled.

5.2. Branded child, branded self: Being reduced to a label

From the outset of our interviews, participants identified their struggle to accept the particular weight categories, ‘overweight’ and ‘obese’, assigned to their child. Personal meanings of the words ‘overweight’ or ‘obese’ did not correspond with how they saw their child. Generally speaking, participants felt the words were negative and some saw them as a gateway to discrimination and suffering. Participants expressed their concern about what their child might experience should they be labelled ‘overweight’ or ‘obese’. Some participants also found the term directly “*insulting*” at a parental level, and others noted that the experience led them to feel a decreased sense of “*self-esteem*”.

None of the participants volunteered their child’s factual weight and height during the interviews. Although some participants noted that children’s weight does tend to go up and down, no one disputed the weight figure or height figure written in the letter. In fact, as the quotation from Lucy below illustrates, participants specifically identify the weight category as the source of their surprise, as opposed to the weight or height figure:

I accept that, the weight that he is – I accept the height he is – what I don’t accept is the categorisation if you like, and the fact of the um, the, I am not sure how to say... how they label it...
(Lucy, 204-206)

This quotation clearly marks contrasting experiences of acceptance and rejection in relation to weight and height figures, and the terms associated with different BMI scores. Even if they didn’t remember the exact wording of the letter, the majority of participants remembered what category their child had been placed in. Indeed, for

the majority of participants, it was the term ‘weight’, and how this was experienced, that held most meaning for them overall.

Participants commonly used words such as “*label*”, “*tag*”, and “*branded*” to describe how they saw the process of weight categorisation. Words such as “*label*” and “*tag*” suggest that the person to whom it is applied is now a classified entity. When associated with the literal meaning, the use of the word “*branded*” suggests that to be placed in an ‘overweight’ or ‘obese’ category is experienced by participants as a permanent, painful, and potentially torturous act. Branding also holds historical associations with criminals, animals, and disgrace. In all cases, branding is unwanted, or unasked for (in contrast to tattooing, in which a similar process is voluntarily chosen), which suggests disempowerment of the individual. Not only did participants highlight their struggle with their child being ‘tagged’, but they also highlighted their own feelings of powerlessness in relation to the process. For example, Jemma described the effect on her self-esteem:

P: It's horrible. I don't think you should be labelled as something like that. It's like a horrible tag on you or something.

SG: It's like having a tag?

P: Yes, aha

SG: OK. And what do you feel the impact of this is?

P: Just self-esteem and how she feels about herself and how I feel about myself, you know, as a parent. (Jemma, 700-706)

The weight category was also seen as objectifying: reducing the person from human to category. For example, Anne noted:

He has become a Government statistic now, when it comes on the news that seventy percent of children under five are overweight. You are like, that's him now, he is one of those statistics. (Anne, 45-47)

...he is probably on someone's computer somewhere with a big red flag on it. (Anne, 167-168)

Similarly, participants used phrases which illustrate their view that weight categories contain and single out a person: “*on that pedestal*” (Val, 582)”, “*pigeon holed*” (Anne, 173), “*put in this little box*” (Anne, 173).

Certain images and behaviours associated with these categories were seen as at odds with how participants saw their child. For example, Jemma described the images that came to her with regard to her daughter being categorised as ‘obese’:

I think, it just comes across as, you know, you’re like a big, a marshmallow man, it makes it sound like she’s massive, [...] she’s not [SG: Mm], she’s not a big huge massive girl, and I just hate, hate the word [SG: Mm] it’s a horrible word.

(Jemma, 118-120)

It just implied that she was; to me it would imply that she was about fifty stone and took up about four chairs when she sat down. Do you know what I mean? Like a huge monster, that’s what it felt like to me.

(Jemma, 435-437)

Jemma provides evocative images of the “*marshmallow man*” and “*monster*”, which convey the association between the term ‘obese’ and being grotesque. The marshmallow (a fictional character from the film *Ghostbusters*), is described as “a giant, lumbering paranormal monster” (“Stay Puft Marshmallow Man”, n.d.). Similarly, a monster is a “large, ugly, and frightening imaginary creature; a thing of extraordinary or daunting size” (“Monster”, n.d.). Additionally, she uses other words which provide an image of someone at an extreme or unrealistic weight: “*big huge massive*”; “*four chairs*”; and “*fifty stone*”.

For Lucy, her difficulty associating the term ‘obese’ with her child had more to do with associated behaviour than visual size:

It conjures up an image from the media, erm, of a very, very overweight child who does nothing. Especially in childhood obesity - a child who does nothing, who sits and plays video games, or... and eats junk food – that was my perception of an obese child, um, and I didn’t feel any of those stereotypes we fitted into. (Lucy, 229-233)

This quotation also highlights the significance of exposure to media sources and stereotypes on participants’ experience of receiving the letter. Aligning themselves with perceived weight stereotypes was difficult for the majority of participants:

When people say overweight, it's sometimes, it's said as an insult because it means it, you know, if someone was saying that I was overweight it would mean that I don't take care of myself. Particularly, if you are saying a child is, its ultimately down to the parent, erm because the, the children eat what they are given and they do, do what their parents encourage them to do, or bring them places to do. So erm, it's an insult because it says, like, almost you don't care about your child enough to make sure that they are not overweight, erm and that they are well looked after, or that you care enough to, you know, cook them proper meals that are, you know, healthy.

(Marie, 94-102)

The quotation illustrates the felt knock-on effect of having a child categorised as 'overweight' or 'obese'. It suggests that as participants felt that their child was branded, they felt that they, as parents, were branded too.

Others explored a personal struggle with stereotypical meanings of weight. Jessica illustrated the challenge of not wanting to adopt a stigmatised view of weight personally, but also not wanting, and fearing, her child being labelled 'overweight' due to stigmatised views:

...again, it's that box thing, to be in that... [pause] erm, box of you're one thing or you're not, [SG: Mm] I think... and if you fit in the one box you're not going to succeed in life and if you are fit in the other then you are, that's what I think, you know... and I want my daughter to be in the box that she does. (Jessica, 805-809)
...I just thought oh god, if I'd been a person or a parent who, you know, who was like me and took every little thing on board, or thinks things about things too much, and didn't have the person there to, you know, to answer the phone or, where would I be? (laughs) What situation would I be in now, and would I think that my child's fat, and they're gonna be a loser in life (laughs)... you know, I don't think all fat people are losers in life, but that's just, that's society's view isn't it. It's not particularly my view... I think that person's probably quite sad and needs help actually... (pause) I don't want you to think I think people who are fat are all losers cause they're not, [laughs] but it's just that's what society thinks isn't it, that box... (Jessica, 865-873)

Whilst Jessica holds her own views of what it means to be overweight, her quote shows that when related to her daughter, these are overshadowed by her interpretation of the strength of society's views. Her quote suggests that she feels

her views hold less power than society's views, even though, as the last few lines suggest, her own views are important to her sense of who she is.

In summary, this theme illustrates the ways that weight terms were experienced as unwanted, reductionist, dehumanising and upsetting, and left participants feeling disempowered. Participants described being heavily affected by the weight categories ascribed to their children rather than 'factual' weight or BMI figures. Terms used to classify children were not interpreted as statistical descriptors, but rather as pejorative and stigmatising labels with negative connotations. Also illustrated were the strength of interpreted unwanted stereotypical meanings associated with the terms 'overweight' and 'obese', and desired meanings such as 'healthy' and 'normal', and the ways these interwove with participants' experiences of receiving the letter. Overall, this theme highlights the importance of weight terms, and suggests that they were experienced as emotive and powerful. Reaching beyond weight descriptors, the following theme explores the experience of being controlled and rendered powerless by the 'other' in more depth.

5.3. Controlled by the 'other'

Participants described feeling controlled by an, often faceless, 'other'. This 'other' took the form of the letter itself, the message contained within the letter, professionals, and their interpretation of wider societal meanings. Often, the 'other' did not allow collaborative communication, and was experienced as disempowering.

The anonymous nature of the phenomenon was illustrated by participants' description of their experience of the programme: none of the participants volunteered that the programme was run by the NCMP; some mentioned the involvement of 'the government' and 'child-related programmes', but most commonly, they used generic words to describe a faceless entity: "*someone*", "*these people*" (Kate, 208).

One powerful 'other' was the letter itself. For example, Val explained that receiving the information by letter affected her experience, even prior to opening it:

*Then I thought, oh God yeah, I've got those letters. I never want to open them.
Because they look so official, I don't want to open them.* (Val, 91-93)

Even the appearance of the letter holds significance for Val. The use of the word "official" suggests that she may associate a degree of 'authority' with the letters, or a powerful 'them'. She does open the letter, but there is a sense of doing something because she feels she should, or needs to, rather than because she wants to or does so entirely willingly.

None of the participants were expecting the weight category ascribed to their child, and for some participants, the letter itself came as a surprise. From the outset, the letter held power: it only allowed one-way communication, meaning that participants did not have the opportunity to engage in dialogue, speak back, or ask questions. This suggests that instead of being a collaborative encounter, the letter was experienced as distant and all-powerful. Marie describes this experience in the following two quotations:

In a letter you don't, you don't get the chance to say anything. You are being told something and that's the end of it, accept it. And you know, they've just made it, very much, that's it. (Marie, 205-207)

You want to get that out, you want to get your er, point across and you haven't got the opportunity to. (Marie, 220-222)

Her quotations illustrate the power imbalance felt by participants, and a sense of separation between the individual, 'I', and those who sent the letter, 'them'.

While some participants (Kate and Val) actively chose to avoid formally responding to the letter, suggesting that they might have felt disempowered to some degree, others sought to be in contact with someone involved in the programme. Jessica said that she tried to call but "nobody [was] available" (Jessica, 330). Jemma was in contact with someone as a result of calling the number on the letter, but her quotation below shows that this was not an empowered proactive action:

P: There was a number on the sheet, and I phoned it up straight away and er, I immediately got an appointment for the dietician thing as I felt that's what was asked of me, and then I cried afterwards cause I was so angry with, with the letter.

SG: So you felt that was what was being asked...

P: And then emotions come second and then I just cried with anger and annoyance, you know, I thought this was horrible.

SG: What was the feeling like to feel something was asked of you?

P: Just how it was put across really, it's like 'advised to' in other words you 'need to' [SG: Need to] sort of thing you know, it'd be like if you didn't do it, it would be looked upon as wrong sort of thing. (Jemma, 275-283)

Jemma's quote, especially the phrase "need to", suggests that she felt she had no choice but to make the call. She explains that she made the call before having a chance to experience, and communicate, her upset and anger, suggesting that the perceived demands of the 'other' felt immediate and authoritative. This suggests that she felt both controlled and disempowered.

Participants also described feeling controlled by society in a more general context of one's relationship to the body. For example, Jessica explored the controlling nature of society through body type:

I just think it's a society thing isn't it, it's like you see, you have images of models in magazines, that this is how we should look and be, but life isn't like that is it. (Jessica, 241-242)

...I think there's the pressure to be almost, somebody you are not I think. And I think its understanding yourself and knowing the boundaries of what you can and can't be. (Jessica, 255-257)

This quotation suggests Jessica actively tries to protect herself against the pressure she feels to look differently than she does. She later explores the impact of feeling that 'someone' is dictating how she 'should' live in relation to receiving the letter:

P: ... then someone's kind of almost telling you, you are not doing what you should be doing, that's what I think...

SG: What does the word 'should' mean to you?

P: It's like an unwritten rule isn't it [...] you've got someone telling you you're doing something wrong but you know you're not, almost, it's like, well...

SG: What's that like?

P: It's horrible, [SG: horrible] again it's just that feeling that, you're doing -

somebody's making you think you've done something wrong, where actually you haven't. You know you haven't, it's like, you're in control of the situation, and someone else saying, 'no actually, you're not' – it's not nice at all...

(Jessica, 679-692)

Her quote illustrates a struggle to navigate personal autonomy in a world where she experiences being told she is “*doing something wrong*”. Indeed, her last phrase suggests that although she ‘knows’ she is “*in control*”, she is ultimately left feeling disempowered. In other words, the ‘other’ seems to have the power to have the final say.

Some participants saw receiving the letter as an example of wider societal controls on their children and on themselves. Nula compared the schooling structure and the process of being weighed to a “*prison*”:

I just thought that like er, like it's, it's sort of, now it's for kids it has become like a prison or I ... what to say ... a restriction, a prison, or like school has become like a prison – it has become a prison like you have to do this that, this that, they do not have any sort of freedom I can say. And they make it so busier these lives. You have to be, it's a competitive world, so you have to do that this, learn this, this. And upon that one [being weighed], this was totally a prison thing actually. (Nula, 107-112)

Additionally, she uses words such as “*restriction*” and “*have to*”, and relates this to a lack of “*freedom*”, suggesting that children (and as a knock-on effect, adults including herself) are at the mercy of a structure that has the power to confine, enforce, and control one’s movement and life choices. Her quotation, particularly the phrase “*they make it*”, suggests that the ‘other’ is experienced as authoritarian.

Participants described feeling a loss of autonomy at the fundamental level of freedom to live their lives how they wanted to without being monitored or directed. The ‘other’ was experienced as Big Brother: “*it's like they're looking at you*” (Jemma, 64); “*It's like you are maybe being watched*” (Val, 1011). Jemma explores this more fully in the following quotations about her experience of visiting the dietician with her daughter. She described being told what actions she ‘should’ take, and the experience of being under surveillance:

I hated taking her to the dietician, being told by somebody what your daughter

should be eating and having Molly [her daughter] sit there and um, having to go through everything she eats like a food diary, [SG: Mm] and then telling her, 'oh you can't have that, you shouldn't be eating that, you can't have that, shouldn't be eating that' ... (Jemma, 56-59)

P: ...She absolutely hated the dietician experience, you know, being weighed, being measured and having to list everything she ate for a week. It's about being under surveillance and it's a horrible time, this went on for about three months, the visits backwards and forwards.

SG: I am interested about the use of the word surveillance. Is that how it felt?

P: Yes, like you are being monitored and you know. You know, just being monitored and surveyed sort of thing, you know. Everything you do is written down and everything you say is written down and it's not very nice. And it put Molly [her daughter] under pressure as well. Like it was only when we when we moved house and they didn't have our phone number because we changed it, that we managed to opt out later on because we weren't enjoying the experience. (Jemma, 348-356)

Her phrase suggests that they 'escaped' from the experience, and that she previously felt that she and her daughter were caught, and somehow bound to attend. Her use of the words "surveillance" and "monitored" also suggests that she did not experience autonomy or privacy, feeling controlled and disempowered.

In summary, this theme illustrated participants' experience of being controlled and disempowered by an 'other'. This 'other' took the form of the letter, professionals, and the media, and in all cases was felt to be ultimately more powerful and having more influence than the participants. The notion of being in a 'Big Brother' society was also explored in terms of participants' experience of being watching and monitored.

This master theme, the Disempowered Self, drew together different aspects of participants' experience of being undermined, deprived of power and influence, and controlled. This was illustrated by three themes addressing the experience of being blamed and shamed, judged and objectified, and controlled by the 'other'. Overall, the felt authority of all relevant all 'others' described, and the suggestion that participants viewed themselves as they perceived others saw them, rendered them

disempowered. Thus, the Disempowered Self was a central and invasive part of participants' experiences of receiving the letter.

As shown in the diagrammatical representation (Figure 1), the relationship between the Disempowered Self and the following master theme discussed, the Mother Self, could be described as separate but overlapping. For example, analysis suggested participants felt challenged and disempowered as mothers. This and other facets of the Mother Self are described in the following section.

6. Master Theme 3: The Mother Self

Being a mother was described as playing a key part in the overall experience of receiving the letter from the NCMP. Indeed, providing a holistic understanding of the phenomena, it was interwoven with both the previous two master themes, and, could be described as contextualising receipt of the letter. Additionally, the Mother Self provides insight into participants' experiences at a more detailed level. Three themes emerged through analysis: being a nurturer and protector; being uniquely bonded to their child; and navigating the complex myriad of varying pulls of motherhood. Indeed, this master theme went beyond the recruitment criteria of simply 'being a mother of a child who has received a letter stating that they are overweight or very overweight'.

6.1. Protecting and nurturing: Being responsible for the care of your child

Participants described ways in which they felt that they were protectors of, and were responsible for, their child: for supporting their growth and fostering an environment where they would thrive.

Participants described various means of food provision that they undertook, such as ensuring they followed the '5-a-day' rule, and contemplating whether school dinners were as 'healthy' as home-cooked meals. Food-provision, however, was not simply seen as a physiological need for survival. Val described what giving food to others meant to her:

P: You are always feeding. I don't know if it's culture [...] We just constantly offer, offer, offer all the time

SG: And what does that mean to you?

P: You feel comfortable because you are feeding someone. [...] If you come to my home, I am going to feed you and I am going to water you. It's as simple as that. It is instilled in me from when I was growing up, little [...] It's automatic, you just do it... (Val, 641-652)

Val's description of food-provision as "*instilled*" in her and "*automatic*" suggests that, over time, the behaviour has become interwoven into who she is, and is a habitual, integrated behaviour. Additionally, her repetition of the word "*offer*" and her phrase "*all the time*" provides a sense of her behaviour's unrelenting nature, as though she is never without this behaviour, and that without it something would be missing. She explains that she feels "*comfortable*", which suggests that it is more than an 'automatic' behaviour, and that without it she might feel uneasy.

Commenting further, Val described the strength of her desire to offer food, and her personal "*satisfaction*" of doing so, within the context of her relationship with her daughter:

P: ...As soon as she comes through the door, 'oh have that'; as soon as I pick her up, 'have that', I bring something. It's little things and you don't realise.

SG: What's it like to be able to give her something in that way?

P: God you feel good. [...] there is a satisfaction that she has got that to keep her until we get home. If I don't bring anything she is upset... (Val, 652-659)

Not only does her quote identify her personal enjoyment of giving her daughter food, but it also suggests the significance it plays in their interpersonal relationship: as a means of providing pleasure. The interplay between food, nurturing, and love is also illustrated by Kate. She describes taking her children chocolate buttons as "*Friday treats*" (Kate, 355). The word "*treats*" suggests that food-provision is also a way of giving a gift to another, intended to provide a positive and enjoyable experience. Here, food-provision is less about the dietary benefits, and the use of food as an expression of love may run counter to what is best nutritionally.

Participants highlighted a number of ways in which being a nurturer was a key part of the phenomenon outside of food-provision – or other basic human survival needs.

The desire to care for and protect one's child emotionally and psychologically was also seen across all participants. For example, Nula discussed how she hopes she would behave towards her daughter should her daughter be overweight in the future:

...If in that situation I don't want to make her scared, or hard words, or beat her or anything like that, or pressurise or force her. I don't want to do that.

(Nula, 584-587)

Her overriding concern is to be kind, offer reassurance, and interact with her daughter with a sense of 'ease' and in accordance with her daughter's wishes. Alongside providing insight into how she wants to be with her daughter, this quote also suggests the kinds of ways of being she wants to protect her daughter from.

Many participants illustrated ways in which they embodied the role of protector. Anne explained that she experienced this role more intensely, "*on a different level*", after she became a mother:

[Laughs] ...Yeah, I had never experienced it before I had my kids. But yes it is on a different level, the way you feel about your kids, and if anyone says anything detrimental, it is taken to a different level when you have got kids. And when people say things like I would kill for my kids, you know where they are coming from, because you are so protective, and I had never known anything like that before I had my children.

(Anne, 153-157)

Her quote highlights her belief in the strength of the maternal protective instinct as she explains her empathy towards someone else saying that they would kill for their child.

The desire to protect one's child from the potential psychological harm that the letter might bring was shown across all participants. For example, the majority of participants (all but Jemma) withheld the contents of the letter from their child. Val explained that the contents of the letter, specifically being told you are 'overweight', was experienced as potentially harmful:

I just think that's too much for a child's shoulders, your school is saying you are overweight. That is too much for a little person's shoulders.

(Val, 885-887)

Protecting her child not only meant shielding her from real or potential harm, but, also, as implied above, choosing to carry the 'heavy burden' of the letter herself.

This was also illustrated by Jemma, whose daughter did read the letter. She explained that she chose to withhold sharing her feelings about the experience with others for the sake of her daughter:

SG: What would it have meant to you if you had spoken out?

P: I was betraying Molly [her daughter] I suppose. I was telling everybody her business, sort of thing, and then her friends would know and she would be upset by it. I suppose that's why I never told anybody either, I just told the people in my family who I knew wouldn't say anything. (Jemma, 665-668)

She also identified the proactive role she took in trying to protect her daughter from ruminating further on her weight:

... I think Molly [her daughter] dwelled on it for ages. It was just, it was all she kept saying, 'oh, I'm fat Mum, fat'. It was me having to reassure her and say, 'look Molly you're not'. (Jemma, 563-565)

Her last words are emphatic, suggesting that she sought to step in and prevent her daughter feeling further distress.

Some participants were explicitly concerned that the letter might lead to harm, such as the development of disordered eating and body image concerns. For example, Anne discussed her concerns about weight-related bullying:

Well, just I don't want my children being overweight, you know. It has got all the health implications, it has got the bullying implications, especially at school the last thing you want is for them to be bullied and called, I don't know, 'fatty' or whatever it is they are going to get called if they are overweight. (Anne, 340-343)

Similarly, Jessica expands this by exploring the potential psychological impact of the letter on her daughter, and her hope to shield her daughter from experiencing this:

...[the letter] could be, start chain of events that could cause that person to be quite insecure and withdraw and that you only look good, that certain size in life. It's not something I want for my daughter... (Jessica, 263-265)

Jemma also expressed her desire to protect her daughter, and explained that she “kept an eye” on her daughter’s eating after the letter was received:

P: I think it can stop the children from eating, you know, they feel like, cause they've seen the word 'obese', they think 'oh my god, I'm fat, I can't eat anything' [SG: Mm] or they could go the opposite way and start like, bulimia, and make themselves sick, you know, you've got to be so careful, I think...

SG: And how did this make you feel, thinking about that?

P: Just angry, I'm lucky that she didn't go down that road, [SG: Mm] cause I did keep an eye on her [SG: Mm] thinking that it's upsetting to think of yourself described as that way [SG: Mm] so I kept an eye on her that she was still eating...

(Jemma, 97-103)

In summary, this theme highlighted participants' experience of being a protector and nurturer, someone who cares for and ensures their child's physical and psychological needs are met. The relationships between food-provision and the meaning of food-giving within a family, and the emotional experience of food-giving, were highlighted as particularly meaningful to some participants. Receipt of the letter was experienced as a direct challenge to participants' duty of care for their child and their ability to nurture them. The desire to protect one's child from realised and potential harm emerged strongly within the context of weight – both in terms of prompting certain ways of being and choices, and withholding from other ways of being and choices. Overall, participants perceived themselves as having a uniquely maternal, strong instinct to protect and nurture their children. The following theme nestles alongside this theme as it explores the unique bond between participants and their children in more depth.

6.2. Connected to your child: Being biologically bonded and a role model in their development

As mothers, participants identified their unique bond with their child. This bond was experienced as a biological connection, and as a passing on of modelled behaviour from mother to child.

The unique bond between participants and their children was illustrated by Kate as she described the transition she experienced when she became a mother with the following metaphor:

...you go from being the picture to being the frame around the picture when you become a mum.
(Kate, 134-135)

Her quote suggests a unique transition from being the main image to ‘holding’ the main image, or offering a casing between the image and the rest of the world. Specifically, her quote suggests that, in some ways, her children are ‘within’ her.

Anne also illustrates a unique transition felt when she became a mother, which she described within the context of birthdays:

... Just silly things like birthdays. You know, when it was my birthday it was all about me, but now with my children when it's their birthdays it's all about them, but it's also about me, because it was my special day. So yeah, just, things change, really do change, yes.
(Anne, 377-379)

Her quotation illustrates how birthdays mark a shared unique day for both mother and child and, again, it provides insight into the connectedness felt by the mother towards her child.

Jessica explored this connection with regard to her relationship with her daughter within the context of receiving the letter. She explained that receiving the letter was like “*somebody saying, ‘you’re fat’*” (Jessica, 159):

I think your child is you, isn't it, I s'pose, [SG: Mm] it's a product of yourself, you, you, well I am the way I am with my daughter... I treat her... as me... that sounded really bizarre, but your daughter is you and you give them the best...
(Jessica, 178-180)

The biological bond she feels is shown through the use of the word “*product*”, and the phrases “*I treat her... as me*” and “*your daughter is you*” illustrate the ‘oneness’ she feels with her daughter. As with other participants, this sense of mother-child ‘oneness’ echoes through the transcript as a whole, and may provide insight into why receipt of the letter was so meaningful to participants. Her statement “*that sounded really bizarre*” highlights the contrast between describing her lived experience as it happened and reflecting upon her lived experience in the present moment of the interview. She acknowledges that she and her daughter are two separate people, yet that the felt experience is of ‘oneness’. The word “*bizarre*” suggests her surprise at the contrast between what is reality and what is felt within her experience.

This fine line between the connectedness with one's child and being two separate individuals is echoed by Lucy. The following quotation contains a shift in the subjective pronoun from 'we' to 'he' at the mid-point, suggesting a change from what is felt, the unity, to what is logically known, her son as a person separate from herself:

I think I started to look at him then - and actually we are not obese, we are, he is a large child, and I'm not going to say, he's not skin and bones, but he's certainly not the category... (Lucy, 293-295)

Alongside the fundamental bond felt between participants and their children, they also outlined ways in which their own character was 'taken on' by, or incorporated into, their child's person. For example, Kate identified herself as a "role model" to her children. She explored the importance of her actions and ways of being in the world:

I'm really aware of myself as a role model for them, um, er, to wear, to wear what you want without worrying about how it looks, you know, to be able to choose what you feel comfortable in and to not be... well to be eating healthily so that you have enough food, not constantly on a crash diet. (Kate, 389-393)

This quote illustrates personal values that Kate aims to model and pass on to her children. Her actions span beyond eating and clothing choices. Indeed, they offer the potential to experience a life free from worry, where one is self-assured enough to follow personal choices, and physically and psychologically fit.

Exploring this relationship further, Val compared children to "sponges" in the following quotation:

They are sponges, we know they are sponges, they absorb things. I remember saying something silly like, 'oh seaside head', she repeats it and I was like, 'ok so I have got to watch you because you are repeating everything I said'. (Val, 626-628)

The metaphor of a child as a 'sponge' provides an image of one who is constantly absorbing what is around them. It is as if Val experiences herself, and particularly her words, as the 'water' from which her daughter draws, which aids and shapes her

daughter's development and growth as a person. The statement "*I have got to watch you*" seems to highlight a moment of realisation for Val. She becomes aware of the impact she has on her daughter's development. Through this experience, she then applies this realisation to her eating-related behaviours:

....so that means if you are repetitive over what I am saying, your eating patterns... I pick food, I don't sit down and eat meals, I pick at food. I had to consciously make a decision since when I have had Tamara and she is starting to go through the eating stage, I have to eat with her and have a meal, not in between meals I am picking at something, because they are watching your pattern... (Val, 629-633)

She further discussed the potential of her daughter taking on what she models as she described her own weight struggles:

P: If you are battling, probably with your own weight, which I am battling with now; I am not massive, but I have never been this big. I think you have got that going on in your head, thinking; I don't know you kind of think, have I pushed that on to my child?

SG: What's that like?

P: It's a guilt trip really. It's a guilt trip like what have I...? I don't want to give her the sort of hang-ups that I had. (Val, 499-505)

Her words "*pushed*" and "*give*" suggest that the connection between her and her daughter is close enough that she can pass on ways of being, even ones that she does not want to pass on.

It is possible that when participants shared the same gender as their child, they experienced another facet of connectedness. Kate explores why she might not feel as concerned about her son being weighed as opposed to her daughter:

I'm just trying, questioning in my mind why I would be more concerned about the girls than Tim [her son], I think just because of the media, the way, the way women are portrayed. (Kate, 323-325)

...its, the whole thing like air brushing and how - and even myself I'd look at magazines and think 'God look, isn't she gorgeous' and then think, remind myself

'that's not real, it's all a lie...'

(Kate, 362-364)

These quotations suggest that Kate's own experience of navigating her relationship with her body and the expectations imposed by media, and perhaps as other parts of the interview support, she does not want her daughter to worry about her own body in the same way she has found herself doing at times. Similarly, Jessica indicates that she the news of her daughter's weight category brings her own uncertainties about her weight and herself to the surface:

...as women we question ourselves, our weight, and then to be told that your daughter is... 'big' [...] And I was just like 'oh my god', I just felt like I wanted to cry on the playground...

(Jessica, 78-83)

Her latter phrase seems to indicate the immediacy and depth of emotion evoked.

Speaking about her son, Anne elaborated on the reluctance to pass on her "problems", within the context of dieting, in the way that she has incorporated her own mother's dieting behaviour:

I am just so conscious of him [my son] going that way because my mum has battled with her weight. I always remember her being on diets and trying all these different wonderful techniques to try to lose weight and I have gone exactly down the same road [...] And I don't want my kids having those problems.

(Anne, 333-338)

As Anne indicates, participants not only explore the mother-child bond they felt with their children, but also that with their own mothers. Many participants explained that they reached out to their own mothers after receiving the letter. For example, Marie explained that her mother was the first person she called after reading the letter, waiting to tell her husband when he got home from work:

Yeah, I was in my kitchen at the kitchen table, and just read it not expecting it so say anything bad at all, and just being quite shocked and - I, re-read it about 3 times and put it down and then I called my mum – just, just because I, I don't know, I wanted to tell somebody and to, to probably [intake of breath] to gauge her reaction from it too and she was quite shocked as well and said she said 'oh its rubbish don't pay any attention to it' um just to kind of make me feel a little bit better.

(Marie, 37-43)

Her quote suggests she hoped to find reassurance from her mother. It also shows the important role her mother held and the impact that her mother's reaction had on Marie's experience: as her mother rejected the letter, she felt "*a little bit better*". Lucy explored this further, explaining that she often reaches out to her mother, as she did to "*verify*" her thoughts about the letter:

P: Yeah, I always like my mum to verify what I am thinking and just agree with what – er, that you are not doing something wrong so yeah, she just verified that I was, that what I, the conclusion that I had come to in my own mind, and, yeah.

SG: what do you think that is about being able to have verification from your mum, who is also your mum?

P: yeah, that's, I think with everything I do in life, for everything I question, I always try and run it past my mum and hope that she will [intake of breath] approve of... (Lucy, 525-532)

These quotations suggest that for some participants, the connection between mother and child is experienced both 'upwards' and 'downwards', and that this bond is not only experienced when one person is a child by age. Going full circle, Kate also indicated that she wanted her children to experience her, as their parent, as someone they are connected to, who was in the "*picture*" with them:

I spend a lot of time taking photographs of them, um, and it occurred to me a couple of years ago that I'm never in the photographs, I'm always behind the camera and I thought maybe, I don't, I don't want them to remember me as someone who was never in the picture with them – metaphorically speaking - so I am trying very hard to be in the moment with them rather than... I'm not always in their face, but I try and live it with them. And it means – it means everything really. (Kate, 125-131)

Her phrases "*I am trying very hard to be in the moment with them*" and "*...I try and live it with them*" suggests she is continually aiming to create connecting experiences with her children, maintain a bond with them, and, as her last sentence conveys, this is very important to her.

In summary, this theme shows that receiving the letter held particular significance for participants within the context of the extraordinarily close bond they felt as mothers with their children. This bond is illustrated through participants' description

of the oneness that they feel with their child, and unlike any other relationship, they describe their child as an extension of who they are. This is felt at a biological level and as they consider the integral role they play in their child's character development. The bond between mother and child was also highlighted between participants and their own mothers.

The third and final theme illustrates the multiple struggles and demands of motherhood that participants experienced.

6.3. Navigating the complexities of motherhood: Juggling multiple 'pulls' and demands

The third theme aims to capture the complexities of being a mother, and the multi-faceted 'pulls' that are experienced in participants' daily lives. The term 'pulls' is akin to 'demands' and is used to capture the participants' phenomenological experience of being demanded of – psychologically and physically. Instead of reducing motherhood to a discrete role, this subtheme illustrates the opposite, where the experience of being a mother involves being expected to live within a rich, dynamic, and demanding world.

At an overarching level, participants highlighted a sense of 'trying' and 'doing one's best' when facing and engaging with the struggles of their lives. This suggests that participants feel it is not possible to be the 'perfect' mother, and at best, a mother can put her best intention forward and engage with what the world offers back. More specifically, analysis suggested that participants felt 'pulled' by circumstantial aspects of their lives, by time, by the different feelings evoked when they considered their lives from the role of a mother versus a non-mother role, and as they considered ideals versus their reality in relation to being a good mother.

Generally speaking, the letter was experienced as an additional demand on participants' attention, an additional pressure to work through, and was perceived as another challenge to being a good mother. Jessica explains:

...as parents you question everything that you do anyway, and it's just one more thing...
(Jessica, 188-189)

Similarly, Val explained that along with a significant amount of health-related information, the letter is “another thing on top”:

I think, in a way, we are getting bombarded by it. Like the Sure Start staff and the healthy life, those campaigns [...] I think that's just another thing on top. I think it's maybe a bit 'insult to injury' sort of thing. Like you are getting all this bombarding.
(Val, 995-999)

These quotes suggest that participants are living already ‘full’ lives, and that as they are inundated with yet more things to ‘take in’, it may evoke or increase any strain, or perceived criticism, experienced. This is contextualised by participants’ description about the time limitations they experienced. Jessica notes that “*there is never a lot of time*” (Jessica, 742). The felt strain of this was further influenced by the number of caregivers available: “*...I am a single mum as well, you do, do as much as you can*” (Val, 9-10); the number of children: “*Having 4 children as well, it is stressful*” (Jemma, 175); and whether or not mothers worked: “*I work as well, so I'm not always at the school*” (Jessica, 747-748). These phrases explicitly and implicitly highlight the felt reality of busy lives, with numerous, often competing, ‘pulls’. They also highlight the important part played by participants’ unique circumstances on their overall experience of receiving the letter. For example, alongside those identified above, the age of the participants’ children emerged as having an important influence on their experience. Whereas participants of children in Reception Year chose to keep the letter and its contents away from their child, Jemma and Kate highlight the ‘pull’ of the older child’s greater autonomy in terms of their knowledge of the letter (Jemma) and their behaviours (Jemma, Kate). They both described striving to find a balance between being the parent who is responsible for her child, but also seeing their older child as a person who is becoming more responsible and in control of their own lives. This is shown, for example, by Jemma, as she continually described taking her daughter’s wishes into consideration when considering the next steps to take during the interview. Kate illustrated this with regard to her son within the context of developing eating habits:

...we were, my husband probably more than I was, controlling what he [my son] was eating. And I said, 'do you know, when he's a teenager, you won't be able to have that control and perhaps he needs to learn to control it himself now, because he's not

going to wake up one day and know how to do it'. So um, I now say to him, if you want to eat, then there are carrots in the fridge [laughs]. [...] The carrots are to allow him to control and, and deal with that situation. (Kate, 145-153)

In relation to this theme, this sense of striving to find the balance of being responsible for their child and allowing their child to develop their autonomy could be described as contradictory 'pulls' that Jemma and Kate were navigating, trying to find a balance that felt 'right'. It is likely that as new life events occur, striving to find this balance is an on-going enquiry, and that it requires effort from the enquirer.

A similar sense of shifting from one position to another emerged as participants described being a mother as a 'role' (i.e. Jemma, 207). This suggests that being a mother is not the whole self, but rather one aspect, or it is a 'position' that can be adopted.

The possibility of both experiencing oneself as a mother and being able to separate oneself from that 'role' was explored by participants: *"I have got the practitioner part and the mum part"* (Val, 890). They explained that 'roles' were not always easy to negotiate:

P: ...with my non-mum hat on it's probably a good thing, but as a mum, its um, you just don't want your kid to be there.

SG: Is it easy to mediate between mum hat and non-mum hat?

P: No, not at all, no definitely not. [laughs] [...] you are split, because you know why they are doing it [NCMP] and it's for a good reason and all the rest of it; but then you have got your mum's head on and it's like 'arrgggh, how could you say that about my child?!' [laughs] (Anne, 181-206)

The tension between the 'mum' and 'non-mum' hats seems loosely synonymous with love/emotion versus logic/knowledge. In line with this, Nula described her experience of implementing change in response to the letter, yet struggling with the loving part of her that wanted to give her child *"freedom"* (Nula, 293):

... it was like very bad I can say, sometimes you can say you can cry some night, because you won't feel good, like [...] just having had this and just having set so much rules and everything, so it was just like too much. (Nula, 140-143)

She later likens this experience to taking “*medication*”(Nula, 165) that you “*don’t like*” (Nula, 165) for an “*infection*” (Nula, 164), but that you wish to “*cure*”. These phrases seems to highlight the different, and seemingly at times conflicting, actions and emotions that are evoked as a mother who loves her child.

Similarly, Jemma stated that motherhood can be “*stressful*”:

Well you know, it’s a very stressful role and you try to do your best and I try to give healthy meals... I try and help as much as I can, but she’s, she’s not like an active child...
(Jemma, 206-209)

The combination of words “*I try...but*” suggests that she feels somewhat hopeless in her role as she concedes that there is a limit to what she can do to help her daughter.

As suggested by the quotes above (i.e. “*it is stressful*”, Jemma, 175; “*cry some night*”, Nula, 140), analysis suggested that experiencing multiple ‘pulls’ could be emotionally and psychologically straining. Val also highlighted the physiological strain:

... you constantly have to be using your brain. You have to be on the ball and sometimes that’s tiring, that is just draining for me sometimes.
(Val, 149-151)

Her phrase ‘on the ball’ also suggests the need to be ready and performing well. It could be possible that this includes unexpected as well as planned daily events, which is touched on by Jessica, who explained that parenting comes without a ‘manual’:

I just think it’s... it’s a learning, everything is a learning curve isn’t it. You learn things, and you don’t get a manual as a parent, and you just have to deal with things and do what you think is best.
(Jessica, 816-818)

Alongside the ‘pulls’ described above, participants also explored their experience of considering how their personal realities matched culturally sculpted views of the ‘ideal’ parent:

...I think there’s the pressure to be almost, somebody you are not I think. And I think it’s understanding yourself and knowing the boundaries...
(Jessica, 255-256)

The word “pressure” particularly provides insight into the experience of living within the ‘pull’ of the ideal and the ‘pull’ of reality. The latter sentence seems to suggest that Jessica has found a ‘space’ within these dimensions where she feels more grounded. Similarly, Val described how her experience differs from the ‘ideal’ in terms of meal planning:

In an ideal world it would be perfect to do planning and think of a food plan. It doesn't always work because I get tired. Come a certain time and I think, oh I don't want to work my brain around sorting this out. (Val, 798-800)

Val touches on the gap between what she believes would be the ideal course of action, and her human limitations in terms of physical and cognitive tiredness. Although this is not identified explicitly, her quote suggests that she may feel that she is not behaving as she feels she ‘should’ be, which might add to her felt tiredness.

In the following quotation, Marie describes the ‘ideal’ parent in more detail. She then goes on to highlight that this ‘ideal parent’ is generally applied to mothers rather than to fathers:

P: The perfect parent can hold down a job and look after the children, do all the house work, cook healthy meals, erm do all the laundry and still be happy and fun and smiley and still able to join in activities with the kids, which I think is impossible. It's pretty hard but that is the idea that you are given that you are supposed to be like – that you should be able to multi task and do everything really well and still be smiling at the end of the day. [Laughs] Which is – not the case.

SG: And do you think that that's the idea of the perfect parent?

P: Erm, its more specifically mothers, I think erm, women in general, feel the pressure to do a lot more – not in every family but mainly because although, because a lot of families both parents work now but the father will tend to come home from work, have his dinner and kind of then, he can relax, play with the kids and have his own time, whereas the mum tends to come home, feed the children, there's still household chores to do and lots of things with the children to do. You know the uniforms, and lunches and there is bath time, and I know nowadays dads do erm help out a lot more, but I do still think ultimately it is more on the mother cause you know it always has been. It has eased off over the years but I do think pressure is mainly on the mother definitely [laughs]. (Marie, 173-191)

Marie highlights the mismatch between the ‘ideal’ parent and her own experience. Her words suggest that the pull of the ideal parent is to be ‘perfect’ in both action and disposition. Additionally, she distinguishes gender differences with regard to parenting that suggest an experience of being pulled into both a current age where both parents work, and a historical legacy where childcare is primarily the responsibility of mothers.

In summary, this theme illustrates how receiving the letter and the experience that followed cannot be viewed separately from the multitude of pressures and demands that mothers feel in their daily lives. Receiving the letter was one more pressure within an already full life, where mothers are navigating, for example, circumstantial variables, time limitations, different roles, and cultural ideals. Additionally, the letter was perceived as having meaning about motherhood itself, and appeared to challenge participants’ view of themselves as a good mother.

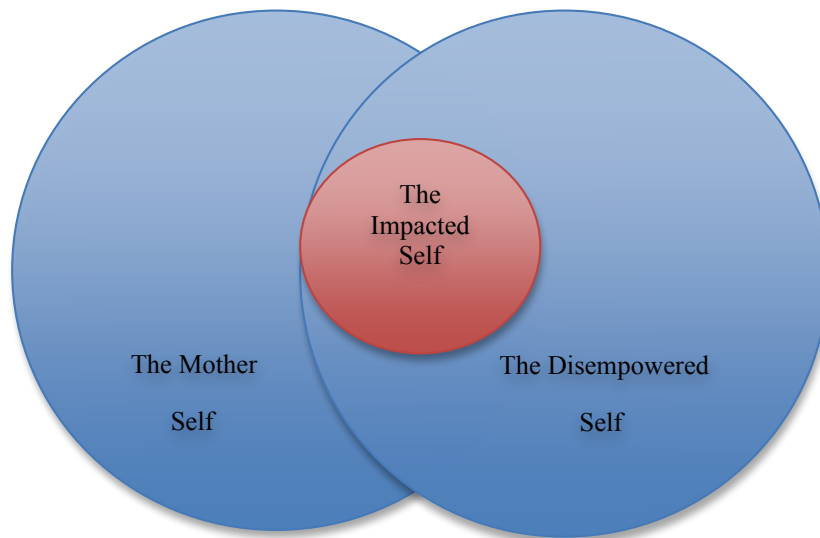
This master theme, the Mother Self, outlined the rich and complex experience of being a mother who has been told their child is overweight, and showed that this ‘role’ is a central part of this experience. As shown in the diagrammatical representation of themes, the Mother Self acted as part of the background for the phenomena, receiving the letter, to occur within.

7. Diagrammatical representation of the relationship between master themes

Although the relationship between the master themes is not the focus of this write-up, as I became more aware of these relationships through analysis, I felt that it evoked an additional layer of understanding of participants’ experiences. As such, I felt it was useful to provide a brief overview of their relationship here. Simply put, the Impacted Self illustrates a time-based process participants evolved through, spanning from the time participants received the letter, onwards, to the time of our interview. The Disempowered Self and the Mother Self could be described as discrete themes, but also overlapping with one another. Analysis suggested that experiences captured by the Impacted Self did not occur independently of the other two master themes. Indeed, the Disempowered Self and the Mother Self could be described as pervasive. As such, the place where the Disempowered Self and the Mother Self overlap could

be described as contextualizing, or the background to, the Impacted Self. The diagram below aims to illustrate these relationships (the size of the circles has no bearing on these relationships):

Figure 1. Diagrammatical representation of the relationship between master themes



Three master themes were explored in this chapter: the Impacted Self, the Disempowered Self, and the Mother Self. The relationship between these master themes was also outlined (Figure 1). In the following chapter, the findings are discussed with reference to relevant literature.

CHAPTER 4

DISCUSSION

1. Overview of Chapter

In this chapter, firstly, I discuss the findings within the context of broader literature. Following this, I discuss the findings in relation to the small body of research that has been conducted on parental perceptions and experiences of the NCMP and similar programmes. Then, I consolidate ways in which the findings of the study may be helpful for the development of childhood BMI measurement and feedback programmes. Next, I discuss potential areas of research that are prompted by the limitations and findings of this study. Lastly, I discuss some final thoughts on personal reflexivity.

2. Contextualizing the Findings Within a Broader Frame of Research

‘Phenomenological themes’ are “the stars that make up the universe of meaning we live through. It is by the light of these themes that we can navigate and explore such universes.”

Van Manen (1984, p.59).

In the following section, I discuss the findings with two aims in mind: to review what findings tell us about the maternal experience of being told that your child is overweight or obese as part of the NCMP; and to consider the ways in which the findings may help development of BMI measurement and feedback programmes. The latter aim is prompted by consideration of the relevance of the research study within its wider context. Wardle and Steptoe (2005) stressed the importance for psychologists to think beyond completion of their research, to develop advocacy skills, and to create opportunities to disseminate research findings so that they may meet audience needs. Smith (2009) also commented on the relevance of IPA studies in contributing to changes in practice and policy by offering insight into ‘outcome’-generated quantitative research. Whilst being a piece of work in its own merit, one

of the strengths of the study is that it does dovetail with, and complement, previous studies that offer limited or no qualitative insight.

Each master theme is discussed with reference to pertinent literature, and comments regarding potentially useful learning points are threaded through the narrative where appropriate. When choosing literature to support the discussion, I have tried to maintain a balance between acknowledging I am guiding the selection and providing a piece of work that holds validity and relevance to the topic in hand (Gough, 2003, cited in Langdridge, 2007). My background in counselling psychology plays a part in this, as does my motivation to provide a piece of work which is helpful rather than punitive to mothers who have been told that their child is overweight.

2.1. The Impacted Self

This master theme is distinct from the other two in that it portrays a linear phenomenological process that is rooted in time and represents how participant experiences evolved over time. The emergence of this process brings Heidegger's concept of temporality to the foreground: As humans exist within time, they continually move forward, continually creating, their present moment being related to their past and to the future they are evolving into (Langdridge, 2007). This mirrors the process that emerged, as participants returned to relevant past experiences, described their experiences in the present moment of the interview, and remarked on shifts that occurred during or as a result of the interview. How participants described the phenomena in relation to time passing also made their experience meaningful in particular ways. This is shown, for example, when considering Lucy, who described an ability to more-or-less 'move on' within a day or two, versus Jemma, who explained that, years later, she 'still' thinks and speaks about it. Being able to contextualise experience in relation to time highlights the extent to which the 'emotional charge' of the experience is markedly different in the two accounts.

The findings showed that participants were initially surprised, shocked, and in disbelief when they received the news of their child's BMI category. Following their initial experience, participants described feeling a variety of emotions such as upset and anger. They expressed varying degrees of uncertainty, ruminating on and

questioning the meanings they previously held with regard to their child's weight and their role in it.

One way of considering this experience is in reference to the concept of the 'assumptive world'. This concept refers to what people "assume to be true about the world and the self on the basis of previous experiences; the assumptions or beliefs that ground, secure, stabilize, and orient people" (Beder, 2004-5, p. 258). The concept is most commonly used within the context of bereavement. However, recently more literature has examined non-finite losses (Harris, 2011), based on the premise that some:

life-changing events can cause us to feel deeply vulnerably and unsafe, as the world we once knew, the people we relied on, and the images and perceptions of ourselves are no longer relevant in light of what we have now experienced. (p. 250)

Generally speaking, this seems to summarise participant experience well, and whilst participants did not experience a physical loss or bereavement, it is possible that the receipt of the letter did signal the loss of the 'healthy' child and, in turn, the 'good' mother. Considering this concept further highlights ways in which receiving the letter may have impacted participants' lived experiences. Janoff-Bulman (1992) (as cited in Beder, 2004-5) outlined three core assumptions that shape people's assumptive worlds: the world is benevolent, the world is meaningful, and the self is worthy. In my study, each of these three core assumptions is challenged as participants process news of their child's BMI category. The world is no longer benevolent: the findings highlight participants' experiences as generally 'negative', they felt angry and upset, the meanings they associated with weight labels threatened their beliefs, and they felt disempowered by the process. The world is no longer meaningful: The news did not seem congruent to participants, and the meanings they associate with being overweight do not fit with their view of their child or themselves. Beder (2004-5) noted, "For the bereft, there are no answers, safety, logic, clarity, power, or control" (p. 259), which dovetails with participants' descriptions of anxiety, rumination, uncertainty, and vulnerability. Also, the self is no longer worthy: Participants described questioning themselves, their life choices, and their abilities, worth, and moral goodness as a mother.

The findings highlighted three ways that the participants later reacted to their initial surprise and disbelief and subsequent uncertainty, rumination, and worry. Some seemed to remain ‘within’ uncertainty, upset, and self-doubt. For others, their narratives provided a sense of ‘moving on’, either rejecting the letter as irrelevant and continuing on in their life, or being prompted by the letter to take new action, and trying to reduce their child’s weight. Considering that the assumptive world is meant to “ground, secure, stabilize, and orient” people (Beder, 2004-5, p. 258), it is possible that participants who rejected the relevance of the letter felt an inward sense of relief, or a reduction in stress and tension at being able continue to exist within their prior assumptive world regarding the way they viewed their child, their life choices, and their view of themselves. For the two participants (Nula and Val) who accepted the BMI category as a prompt to reduce their child’s weight, their narratives do suggest that, over time, they moved from one assumptive world to another. This does not appear to happen seamlessly, and their narratives suggest that it takes time for their meanings to shift and their emotional struggle to lessen. For example, Nula highlights the struggle she faces as she begins to implement new behaviours to reduce her daughter’s weight but cries at night as her restrictions do not feel in line with the way she wants to be with her daughter. Val shows a marked difference from her early reaction of anger towards the letter when she wanted to burn it, to reflecting on the programme and noting that it is likely that it is being run with good intentions. She emphasises the importance of time where she had to “*sit down and wait it out*” (Val, 362) before feeling “*willing*” (Val, 366) to implement change and work with the school.

If the news of their child’s BMI category leads mothers to experience such an emotive, stressful time, it seems highly important to consider ways in which the delivery and follow-up can be done to minimise the stress experienced.

Another way to consider the findings is within relation to stress and coping. The Transactional Model of Stress and Coping (TTSC) (Lazarus & Folkman, 1984) does not directly address the intricacies of lived experience or the toing and froing between having moved on (and outwardly coping) and still experiencing lingering concerns and emotions. However, it does provide a framework for considering how people process and cope with stressful life events, such as being told their child is overweight or obese. According to the model, if the person has adequate coping

skills, the stress experienced may be little to none to start with, or may reduce quickly. Within this framework, the ability to utilise coping skills to reduce stress may be seen in participants who either rejected or accepted the BMI category and (for the most part) were able to move on from their initial reaction of surprise. Lazarus and Folkman (1984) suggested two types of coping: problem-focused coping and emotion-focused coping. Both type of coping strategies can prove beneficial for different reasons. Lyon (2012) described problem-focused coping as: “efforts to define the problem, generate alternative solutions, weigh the costs and benefits of various actions, take actions to change what is changeable, and, if necessary, learn new skills” (p. 10). Participants described examples of problem-focused coping such as: seeking out information from the ‘red book’ about their child’s weight; talking to healthcare professionals; reappraising the intervention from ‘unwanted’ to ‘they are trying to help’; and reassessing food choices they are giving their child. In contrast, Lyon (2012) described emotion-focused coping strategies as: “directed toward decreasing emotional distress... [including] distancing, avoiding, selective attention, blaming, minimizing, wishful thinking, venting emotions, seeking social support, exercising and meditating” (p. 10). Participants described examples of emotion-focused coping such as: sharing the news with, and seeking support from, their mothers, family members, other mothers; creating boundaries regarding who they would share the news with; not approaching the school to talk to those involved; and blaming the NCMP for causing their upset. These examples highlight both adaptive and maladaptive coping strategies. This can be seen, for example, with Lucy, who perceived the conversations she had with other mothers about the letters as supportive and beneficial. She described these interactions as part of the process that allowed her to move forward, reduce stress and related emotions effectively, and as such they could be grouped under the term adaptive coping strategy. In contrast, Kate who explained that she had avoided opportunities available to talk to others about her daughter stated that she felt that some of her concerns were still lingering. It is possible that her avoidance may have perpetuated or maintained the underlying stress, and could therefore be described as a maladaptive coping strategy.

The findings highlight the evolving and continuing process of participants’ lived experience: the nuances, complexities, on-going meaning-making that participants described. This was apparent regardless of how each participant related to the

experience at the time of the interview. The residue of the experience was apparent in participants who were still struggling with the event, and for those who had ‘moved on’ alike. For the latter group, this showed up through the interview when, for example, they discussed their concerns about their younger children going through the same experience. If there are ways to assist parents, guiding them towards adaptive coping strategies and away from maladaptive strategies, this may reduce the stress and upset experienced in the longer term. The findings highlighted the interview with me as another moment in their lived experience, where, as a result of our continuing dialogue, some participants described new actions they wished to take, or that they felt some relief by being able to talk to someone. For example, Marie illustrates this in her phrase: *“I actually feel like I have got a lot off my chest”* (Marie, 225-226) as she reflects back on the interview. In my opinion, this emphasises the importance of being able to enter into dialogue with a healthcare professional as a part of the programme. This would allow people to process the phenomena, and could lead to reduced stress, and increased agency and ownership.

2.2. The Disempowered Self

This master theme encapsulates the shared experience of disempowerment. Participants explored the meanings they ascribed to themselves as a response to the perceived views of others (for example, other mothers, friends, family, the school, the government, the letter, the media). The all-powerful ‘gaze’ of the ubiquitous ‘other’, and consequences of this gaze on personal freedom, has been discussed by Sartre (1943). He suggested that as we realise we are individuals who are free to objectify others, we realise that others are free to objectify us. According to Sartre, it is this freedom and power that the other holds to objectify us that renders us powerless (and imprisoned) by their ‘gaze’. ³

³ Almost poetically, Fuchs (2002) described this experience as follows: “if this roaming gaze turns on me, I am suddenly caught, as it were, in a force field, in a section that attracts me, or in a stream that floods me. I am torn out of the centrality of my lived-body and become an object inside another world. The other’s gaze decentralizes my world. This is why every time two people catch sight of each other a subtle fight of gazes for impact, power and rank begins. My face above all is exposed to the other’s gaze, bare and unprotected. To withstand this gaze is like struggling against a torrent” (p. 226).

As I illustrated in the Analysis chapter, participants described ways in which they felt judged, blamed, and shamed as a result of receiving the letter and subsequent interactions, and they inhabited a world of extremes: right and wrong, good and bad, success or failure. Such dualistic thinking condemns participants to one position or the other. It does not allow room for the shades of grey of lived experience and human existence. They described feeling they were being addressed by a powerful authority through both the official letter and related professionals, and their concerns about how they were being thought about. Exploration of this power imbalance further emphasises the need for ethical considerations regarding health interventions like school-based weight measurement programmes, and as discussed later in more depth, how health communication is carried out.

The fear of the gaze of the other weaves its way through numerous interpersonal relationships that participants describe. For example, some participants explain that they set boundaries in order to shield themselves from the gaze of others in case they feel judged. Yet, in doing so, their fears about others' judgements about them are never explored, and continue to live on as a possibility. The findings highlight a thin line between setting supportive boundaries, and creating so much separation between oneself and others that both the fear of others' judgements and the silence itself becomes all-powerful and pervasive. These findings suggest the importance of creating a discourse around being overweight and obesity that is not shadowed by stigma and shame. In turn, considering ways to create community support seems paramount, empowering people to feel that they can be vulnerable with each other and supported rather than judged and condemned. Indeed, illustrating this point, Lucy and Jemma described two ends of the spectrum of community support between mothers. Lucy shared her news of her child's BMI within a supportive, open, useful network of mothers meeting most days to discuss life's concerns at the nearby playground. Jemma, however, carried her news in silence, experiencing weight as a taboo, and feeling separated from her peers. The different experiences of community support between mothers may be further contextualised by considering the different 'normative social influence' they experienced. Lucy provides a sense of group cohesion as many mothers discussed their experiences of reading their letters. In contrast, Jemma experienced silence on the topic in relation to other mothers; it is possible that even if she wanted to talk to other mothers about her experience, she

may have felt drawn to conform to the silence in order to meet a personal longing to fit into the group.

The impact of the support received by healthcare professionals appeared to be particularly meaningful, and was influential in how participants' lived experiences evolved. Southall and Fox (2011) suggested that mothers of overweight children may feel an "emotional drain" as they try to mediate being a 'good' mother with the perceived negative perceptions of society or professionals.

Participants explained how they felt that ascribing their children to BMI categories was objectifying and reductionist. For participants, the all-powerful 'other' again seemed to impose unwanted meaning onto them and their child, and the findings suggest that they felt powerless in the face of such 'branding'.

Stigmatised and negative meanings associated with weight were felt strongly by participants, and may explain why the experience of seeing their child's BMI category was hard to bear, and evoked feelings of shame. For participants, the word 'obese', in particular, conjured up rich emotive negative meaning and representations. Stigmatised meanings are passed on and perpetuated through numerous sources. These include the media, where there are, for example, reports that visual images of obese individuals are more commonly represented in a stigmatised manner (eating, drinking, and not doing exercise) (Heuer, McClure, & Puhl, 2011). Denzin (1995) noted that "the basic task of the mass media is to make the second-hand world we all live in appear to be natural and visible" (Denzin, 1995, p. 82). Considering the way obese individuals are represented may shed light on reasons why participants felt so adamantly that the BMI categories ascribed to their child were incorrect, and it is possible that until [images of] what constitutes an overweight child is not commonly represented at the extreme end of obesity, and within a stigmatised context, parents will find it difficult to accept that there are weight-related health concerns for their child.

Alongside the distorted visual representation of weight and BMI categories, the media may have a role to play in participants' experience of being blamed, shamed, having done something wrong, and feeling stigmatised themselves. For example, newspaper articles lead with dramatic headlines, such as 'Parents to blame for obese children' (Hope, n.d.) and 'Child obesity: Why do parents let their kids get fat?'

(Winterman, 2012), and popular television shows debate where to apportion blame, such as in ‘Are parents or general society to blame?’ (STV, 2013). Weight stigma and associated negative meanings are still commonplace, and the impact of this may not be benign. Schvey et al. (2014) found that, regardless of women’s own body weight, exposure to weight stigma can increase levels of the stress hormone cortisol, and have “potentially harmful physiological consequences” (p.1). Taking all of this into consideration, it seems highly important that researchers continue to explore ways in which weight stigma can be decreased in general. In terms of BMI measurement and feedback programmes, news that could be interpreted as stigmatising must be delivered sensitively, and in a way that does not increase stigma or put parents (and their children) in positions where they may feel stigmatised themselves. I return to this later in this chapter.

Fuchs (2002) suggested that shame is “the uncovering of a hidden action, being caught at doing something unseemly, and left unprotected to the eyes of the public” (p. 227), which seems to match participants’ experiences well. This highlights the importance to consider whether it is the BMI categories that cause a sense of shame and, hence, whether they are helpful within the context of concerns about children’s weight. Whilst the news that one’s child is overweight may never be welcomed, the evocation of shame may be particularly unhelpful. In this context, Tangney (2002) describes a potentially useful distinction between shame and guilt: “Moderately painful feelings of guilt about specific behaviours motivate people to behave in a moral, caring, social responsible manner. In contrast, intensely painful feelings of shame do *not* appear to steer people in a constructive, moral direction” (p. 2, cited in Tangney & Dearing, 2002). Additionally, in contrast to the potentially adaptive nature of guilt, Brown (2007) explained that “shame corrodes the very part of us that believes we are capable of change” (p. 197). Taking a broader view of the NCMP, and considering the intention of the programme to help children avoid the numerous health concerns that are related to being overweight, the impact that the presence of shame may have in stopping intended and desired change is concerning. Considering ways in which shame may be reduced seems highly relevant, Brown (2012) suggested that when personal stories are shared with others who are empathic and understanding, shame ends. This re-emphasises the importance of finding ways

to communicate news regarding childhood obesity to parents (and their children) with sensitivity, empathy, compassion, and understanding.

The findings also highlighted the importance of considering shifting the imbalanced one-way communication by letter to a dialogue that can embody such qualities (sensitivity, empathy, compassion, and understanding). Participants felt a degree of power imbalance and being controlled by the other, which seemed to contravene their personal freedom. The gaze of the authoritative other was felt strongly, in a seemingly Big Brother (Orwell, 1949), punitive manner: *“it’s like they’re looking at you”* (Jemma, 64); *“It’s like you are maybe being watched”* (Val, 1011), *“under surveillance”* (Jemma, 349). The strength of some mothers’ feelings that their autonomy is being encroached upon is illustrated by the title of a personal freedom campaign article: *“BMI Surveillance: The Food Police will be Watching You”* (Centre for Consumer Freedom, 2009). To rectify this, Ryan (2009) argued that BMI surveillance programmes must aim to find the balance between the *“advancement of public health and safeguarding individual rights and autonomy”* (p. 586). The findings from my study suggest that this balance has been lost.

2.3. The Mother Self

As I’ve described in the Analysis chapter, the Mother Self comprises three themes: protecting and nurturing your child; having a unique bond with your child; and navigating varying ‘pulls’ of motherhood. This master theme emerged as a key theme in that it could be described as a background for the receipt of the letter to occur within.

In considering how to explore the embodied meaning of being a mother, I turned to Van Manen’s (1984) suggestion that exploring the ‘etymological roots’ of words, can allow their full potency to come to the foreground. He explained that historical meaning is often lost or diluted when compared to present day use. Within this context, Van Manen (1984) discussed what it is to parent (in reference to the womb and bearing children) in this passage:

So to bear children is, in a broad sense, to provide place and space for them to live, to be. The child is carried, borne inside the womb at first, then it is born into the world where it remains, for a while at least, most helpless, dependent, in need of nurture,

warmth, caress, holding-fast, and safe as an embryo outside the womb. (p. 54)

This passage illuminates the past experiences of pregnancy and early childcare that are embodied in a present day experience of mothering. This study's findings suggest participants felt a strong pull to protect and nurture their child as an integral part of their experience of receipt of the letter. As Van Manen (1984) described keeping safe the embryo outside the womb, there is a sense of continuity from womb to world, and it is possible that for the participants whose children were approximately 5 and 11 years old when measured, the desire to keep safe one's child has spanned forwards to childhood and adolescence.

It is possible that when presented with the letter which labelled their child overweight or obese, participants' experience of providing a safe (protective and nurturing) "place and space" for their child "to live, to be" was threatened (Van Manen, 1984, p. 54). The findings highlighted ways in which the role of nurturing and protecting their child was experienced by participants; for example, the embedded role of food provision, the desire to shield one's child from potentially upsetting news, and overseeing their child's behaviour with a view to stepping in where necessary.

Van Manen (1984) highlighted the connection of the word 'mother' to the word 'womb' in some languages. Taken figuratively, pregnancy may be the time when the mother is most connected to her child. Although from birth onwards this physical connection stops once the umbilical cord is cut, independence takes years to reach, and over this time, the mother may carry with her memories and a 'knowing' of the genetic connection that she feels to her child. Additionally, the presence of a unique, felt, often mostly private, relationship between the mother and her infant may begin through affection, gazing, touch, and feeding (Gerhardt, 2004). In respect of food, Southall and Fox (2011) suggested that the maternal experience of being able to provide nourishment for their child may be comforting or satisfy mothers' "natural instinct". They suggested that if the meaning of food is "meshed" with love and care, mothers may find it particularly hard to withhold food from their child (Southall & Fox, 2011, p. 634). The findings of my study highlighted a powerful 'closeness' felt by the mother in relation to her child. For example, Jessica states "your child is you"; Anne explains that her children's birthdays are about both herself and her

child; and Kate describes an evolution from being the picture to being the frame around the picture. Participants also described ways in which they felt they were connected to their child as the child picked up ways of being, behaving, and believing from them. There was a particular closeness felt to daughters, and a parallel closeness felt upwards to their own mothers who seemed to offer exemplary nurturing and protective qualities to participants.

Taken together, the unique bond felt and being the nurturer and protector could be called maternal love. Whilst few of the participants used the word 'love' during their narratives, the sense of 'closeness' that emerged from the findings suggests that this is certainly a plausible interpretation. Vacek (1982) has suggested that "perhaps the phenomenon of love is too fragile, precious, or intimate to be subjected to careful scrutiny" (p. 158). Similarly, Steiner Rice (1999) wrote in her poem "A Mother's Love": "A mother's love is something that no one can explain...It is far beyond defining, it defies all explanation." Their reticence to describe 'love' seems to allow the complexity to participants' experiences of their unique bond to their child to be foregrounded.

Hence, the findings of this study indicate the importance of communicating health news to mothers in a way that considers the bond to their child, their role as protector and nurturer, and accepts the news may be felt personally.

Given that the NCMP carried out BMI measurement and feedback at Reception Year and Year 6, it is important to consider the differences in the experience that arose from the findings between participants with younger children versus the participant with an older child. Fromm (2008) explored the evolution of mother-child love over time in the following quote, which seems to touch on Jemma and Kate's narratives about mothering their older children. Fromm suggested that: "The mother-child relationship is paradoxical and, in a sense, tragic. It requires the most intense love on the mother's side, yet this very love must help the child grow away from the mother, and to become fully independent" (p.32) Children in Year 6 are either leading up to or have reached puberty, and this could be presumed to be somewhere in the middle of the journey from child to adult. This may be the time where the mother must tread through the experience of not fully shielding their child as they would when they are younger, allowing them to experience a richer array of experiences, whilst still

providing the broader remit of protection and safe-keeping. Kate explores finding this balance as she describes giving her son responsibility for the amount of food he eats rather than controlling it herself. As highlighted in the Analysis chapter, the experience of Jemma (the only mother with a child in Year 6) contrasted greatly with all other participants in the degree to which her daughter was ‘present’ in her experience. This is evident throughout her narrative as she described her daughter’s reactions and explained ways that she had taken her daughter’s wants and feelings into consideration.

Given this, it seems particularly important to consider ways in which delivery and follow-up of potentially upsetting and unwanted health news is passed on to the parents and children in Year 6, being mindful of the fact that their child is far more likely to be involved and aware of the process in different ways to those in Reception Year.

As well as potentially signalling an expression of maternal love, it is possible that the desire to protect and nurture one’s child rests within the felt responsibility of motherhood. Within the context of food provision, Zivkovic et al. (2010) noted that to be a ‘good’, morally responsible mother, women must tend to the health and wellbeing of their child, and in order to do this, they must call on numerous expert sources, and execute this ‘meticulously’ (p. 385). Similarly, Maher et al. (2010) suggested that as mothers are assigned responsibility for food provision and other factors (such as wider behaviours) that may affect their child’s weight, having an overweight child condemns her as not meeting these responsibilities. This may well lead mothers to experience emotions such as guilt and shame (as discussed above).

The findings suggest that participants experience numerous different ‘pulls’ on their time which impact on their lived experience. Some of these were logistical, time-consuming demands, such as mediating different roles (i.e. career versus homemaker), managing competing tasks as a single mother, managing the increased demands when having more than one child, or balancing one’s child’s autonomy with one’s own wishes. Additionally, participants described internally felt ‘pulls’, such as questioning their parenting choices, and striving to be the illusive ‘ideal’ mother.

Taking a broader view of the potentially demanding nature of motherhood, the findings suggest that striving to be the ‘ideal’ mother may leave participants feeling ‘lacking’ as they experience the gap between reality and the ‘ideal’. For example, participants describe the felt “*pressure...to be somebody you’re not*” (Jessica, 255-256), the need to complete numerous tasks and “*still be smiling at the end of the day*” (Marie, 178), reminding oneself that magazine images of female bodies are “*not real, it’s all a lie*” (Kate, 364), and discuss what behaviours would constitute the ‘ideal’. In their book, *The Mommy Myth*, Douglas and Michaels (2004) similarly described the guilt felt as they navigated between their own experiences of motherhood and the myth that it is “eternally fulfilling and rewarding” (p. 3), or that it is possible to meet the ideals of the ‘perfect’ mother (p. 4). This ‘ideal’ is exemplified by the new action figure ‘SuperMom’, who is described as:

Up at the crack of dawn and working long into the night, this heroine magically creates extra hours each day juggling kids, schedules, chores and career. Navigating jungles of toys and mountains of kiddie stuff she prepares tasty-yet-healthy snacks, tames dust bunnies and banishes stubborn stains. With an invisible third arm and a never-ending pursuit of work / life balance she can help with a school project and answer an all-important business call while wrist deep in dirty diapers. Part teacher, part doctor, part chauffeur, part boss...she’s all SuperMom.

(“Meet SuperMom”, n.d.)

If mothers do ‘ingest’ such ideals, it is likely that they may believe that they are lacking in some ways as they strive for a version of motherhood that is unrealistic. With this in mind, it is understandable why the news about their child’s BMI category may be experienced as ‘yet another’ way in which they are ‘lacking’ as a mother. Similarly, in striving to ‘be’ and do all that the ideal mother can, it is understandable why the letter may seem like another demand that they do not have time for.

The findings suggest that the ‘pulls’ that mothers felt are stressful, continual, and time-consuming. The impact on psychological health of such increasing time pressure may not be benign. For example, Roxburgh (2004) suggested that the “subjective experience of time pressure can be thought of as a potentially important mechanism by which lived experience is transformed into depression” (p. 115).

When considering how to deliver BMI measurement and feedback news to mothers, it may prove useful to consider the time constraints they may already be under, and the possibility that they are continually questioning their parenting choices striving to make the best decisions for their child. This calls for an individually tailored, in-person approach to feedback.

Individualising is relevant whether or not the BMI gives an accurate indication of health risk. If the measurement has indicated health risk and there are health risks, then the space provided would allow them to work through any barriers to behaviour change that arise with a healthcare professional who can work with sensitivity, empathy, and offer problem-solving skills. If the measurement has indicated health risk and there are no health risks, clarity would be reached far sooner, and families would be able to continue with their already ‘full’ lives without worrying about their child’s health or their parenting choices.

3. Comparing the Findings to Other Studies on Childhood BMI Measurement and Feedback Programmes

As outlined in the Introduction chapter, there are a limited number of studies that have specifically explored childhood BMI measurement and feedback programmes. These studies have the advantage of a full range of weight categories, and can offer quantitative estimates from their findings. However, there is a possibility that in doing so, the positive findings, for example, that the majority of parents find BMI measurement and feedback programmes helpful, may hide the full extent of the impact of these programmes in relation to children who are overweight or obese. This study differed from these other studies in the depth of the interviews that I conducted and the limitation to mothers of children who were categorised as overweight or obese – arguably, the group that the programme aims to benefit.

Despite these methodological differences, when focusing on the specific sections of these other studies that relate to children who are in overweight categories, and the qualitative aspects of the studies, their findings are broadly consistent with this study.

Mooney et al. (2010) noted that nearly half of the parents they interviewed reported feeling shocked and surprised by the results, and approximately a quarter reported

feeling angry, worried, and/or upset. They also found that parents questioned the calibre of their parenting. Falconer et al. (2014) similarly reported that over 20% of parents of children who were 'overweight' or 'obese' felt upset and approximately 15% felt angry.

Kubik et al. (2006), Mooney et al. (2010), and Grimmett et al. (2008) all reported differences between younger and older children. Kubik et al. (2006) found that parents of younger children were more likely to withhold the BMI feedback from their child, although they do not discuss why. Mooney et al. (2010) noted that, of the parents who discussed the BMI feedback with their children, all were from Year 6, and that some expressed their concern about their child reading the results. One parent in their study explained that her daughter had opened the letter and had subsequently been concerned she might die from diabetes. In their appendices, Grimmett et al. (2008) gave an example of one participant whose child opened the letter and cried; this mirrors Jemma's experience.

Mooney et al. (2010) described how some parents reported feeling guilty, ashamed, and at fault. Grimmett et al. (2008) provided an example of one participant describing feeling ashamed; and Falconer et al. (2014) reported that approximately 15% of parents of children who were 'overweight' or 'obese' felt guilty.

Mooney et al. (2010) reported that the "impersonal nature" (p. 24) of the letter was a recurring theme across their participants. Similarly, Syrad et al. (2014) noted that parents did not feel the feedback fully considered their individual child's lifestyle. Mooney et al. (2010) noted that a few people found the letter "harsh", "patronising", "too blunt", and "not sensitive enough" (p. 25). Grimmett et al. (2008) reported that two parents had called in and explained that they found it hard to see their child's weight category written down. Mooney et al. (2010) provided an example of this when the participant stated that she felt her child had been "put into a category" and "just considered statistically" (p. 24).

In reference to the emotive unwanted meaning ascribed to weight labels, Mooney et al. (2010) noted that participants objected to weight labels rather than weight measurement itself, and several people noted they would have preferred to be told their child was 'outside' the normal range than assigned labels. They found that,

instead, participants used terminology such as “solid” and “big boned” (p. 22), which is similar to Val’s use of “*chubby, chunky, puppy fat*” (Val, 587-588).

In reference to the pivotal position of healthcare professionals and the experience of parents either feeling supported or further alienated, Mooney et al. (2010) reported that some parents openly rejected the BMI category ascribed to their child as a part of the NCMP based on subsequent conversations with their healthcare providers. Grimmett et al. (2008) provided an example of one parent who explained that they felt information about their child’s weight was relevant to their GP alone. The quote implies that conducting weight surveillance and feedback outside the parameters of the GP-patient relationship may be experienced as living within a ‘Big Brother’ society (p. 687).

Grimmett et al. (2008) noted that some parents expressed their fears for the physical and psychological wellbeing of their children. Mooney et al. (2010) noted that a few parents were concerned about the potential negative impact this might have on their children, such as evoking anxiety, or leading to eating disorders. Grimmett et al. (2008) also raised parental concern about “weight based teasing, decreases in body esteem, or the onset of unhealthy dieting practices” (p. 686), and as to whether a school environment is the most appropriate place for BMI screening.

In contrast to my study, Mooney et al. (2010) reported that the majority of parents (with children in all weight categories) found the results helpful. (They noted, however, that of parents with ‘overweight’ and ‘very overweight’ children 25% found it unhelpful. They also noted that very few of this group of parents made comments about the survey.) They explained that parents of overweight children were “generally pleased” to be informed so that they could act on the news (p. 23). They provided a few examples of the very few parents of children in the overweight category who made positive comments; for example, one parent stated she was “happy” to find out so she could implement change (p. 24). Grimmett et al. (2008) also reported that some of the parents found the feedback “helpful and informative” (p. 686).

4. Further Thoughts on Programme Development

Exploring ways to adapt BMI programmes may be ethically important, and may improve engagement. Ryan and Deci (2000) suggested that when contexts support “autonomy, competence and relatedness” (p. 68), they foster proactivity and engagement. Not meeting these needs leads to “lack of initiative and responsibility”, “passivity” (p. 76), “alienation” (p. 74), and “distress and psychopathology” (p. 76).

In their report addressing concerns regarding BMI measurement in schools, Nihiser et al. (2007b) suggested that “BMI screening programs should ensure that parents receive a clear and respectful explanation of the BMI results and appropriate follow-up actions” (p. 4). The findings of this study suggest that the experience of participants did not match this.

With this in mind, I now summarise some of the ways BMI programmes might be improved, based on the findings of this study.

4.1. Weight labels

As discussed above, the findings highlighted the strong reaction participants had to weight terminology, particularly the word ‘obese’. Kyle and Puhl (2014) suggested that the use of ‘people-first’ language avoids assigning people an identity based on a chronic disease; so, in the case of obesity, people are not assigned the identity ‘obese’. Mooney et al. (2010) noted that several parents explained that they would have preferred the letter to omit the phrases ‘overweight’ or ‘very overweight’. Whilst there is an argument that the importance of the message regarding associated risks may be lost if these labels are dropped, it may also be true that the reaction to them ‘distracts’ people from taking the desired action, and may lead to disengagement with the programme.

4.2. Mothers

Luman et al. (2003) suggested that healthcare professionals may not always realise the opportunity that they have to optimise the reach of healthcare of children by working with mothers. Further understanding the experiences of mothers, and ways in which more individualised ways of communicating BMI reporting and feedback

are experienced, could encourage greater alliance between families and healthcare professionals, and have a greater potential to see desired change implemented. Recognising the areas of concern that mothers may have within this context, treating them as individuals and adapting programme procedures to work ‘with’ them rather than doing something ‘to’ them seems highly desirable. Being sensitive to the relationship between mothers and their children seems to be vital, as the findings suggest that they take the news personally, and may interpret it as a direct criticism regarding their abilities as a mother and their life choices. This may affect their psychological health – as well as increasing the likelihood of being disengaged in the programme. Lack of sensitivity to the extraordinary bond between a mother and her child may therefore result in the programme not having its intended consequences.

4.3. Delivery

Whether or not health news is considered ‘bad’ depends on how the receiver appraises this information (Lee et al., 2002). The findings of this study indicate that being told that their child was overweight or obese was unwanted, distressing, and held ‘negative’ meaning. Therefore, it is likely participants might appraise the news as ‘bad’. Receiving what is perceived to be ‘bad’ health news can impact the receiver’s psychological wellbeing and adjustment (Mager & Andrykowski, 2002). Within medical spheres, literature suggests that the way ‘bad’ health news is communicated and subsequent emotional support received from the doctor is of great importance (Fujimori & Uchitomi, 2009). Indeed, Fallowfield and Jenkins (2004) noted that “if bad news is communicated badly it can cause confusion, long lasting distress, and resentment; if done well, it can assist understanding, acceptance, and adjustment” (p. 317). Medical professionals are encouraged to be confident, empathetic, humane, personal, forthright, respectful, and thorough with their delivery (Li, 2006); and psychological professionals are asked to “understand the need to respect, and so far as possible uphold, the rights, dignity, values and autonomy of every service user including their role in the diagnostic [...] process” (HCPC, 2012a, p. 6).

Clearly, receiving a letter with their child’s weight/BMI information prevents parents from gaining any immediate emotional support or further information from a healthcare professional. In order for healthcare professionals to be empathic,

personal, and respectful, they need to be able to tend to the present situation, which cannot be done via letter or a standardised approach. The needs and disposition of the individual must be taken into account and responded to sensitively. It is not sufficient to have in person delivery; the delivery must be in line with these values. This may be particularly true when addressing health concerns that are subject to stigma and bias. Indeed, research suggests that if people feel stigmatised by their doctor, approximately 20% would avoid future appointments or find a new healthcare professional (Puhl, Peterson, & Luedicke, 2012).

4.4. Age

As I've described above, research to date suggests that the experiences of children and parents with children in younger versus older age groups is substantially different (Mooney, 2010). Older children are far more likely to be aware of and involved in the process of BMI measurement and feedback programmes. How best to support this age group and their parents needs more consideration. It may be more appropriate to feedback results to parents in person where their child is not present so that they can a) discuss any concerns or next steps prior to talking to their child; and b) decide how to share the news with their child in a way that is empathic and sensitive. Whilst this study does not focus on the experiences of children who are being weighed, Jemma's narrative often brought her daughter, metaphorically speaking, 'into the room' during the interview. Whilst it is important to ground insights gained into her daughter's experience with an understanding that it is Jemma's own perception of her daughter's experiences, Jemma's description of the shame and teasing her daughter experienced does support suggestions (Soto & White, 2010; Nihiser et al., 2007a, Grimmer et al., 2008) that it is of the utmost importance to consider the emotional impact on children who are involved in weight-related programmes and interventions. The specific age of children in Year 6 may prove particularly relevant. There may be no hard and fast rule about when individuals go through changes related to puberty; however, the Tanner Scale indicates that by Year 6, children may have experienced bodily, psychological, and behavioural changes, such as acne, "unexplained mood swings, low self-esteem, aggression and depression" (National Health Service, 2012). Centres for Disease Control and Prevention (2014) also noted that ages 9-11 years may signal the onset of body

image concerns and eating problems, as well as important peer relationships. This re-emphasises the importance of considering when and how to carry out BMI measurement and feedback programmes in a sensitive, empathic manner; and brings into question whether or not the school environment is the most appropriate place to carry out the measurements.

5. Further Research Addressing Limitations of the Study

With regard to service development, the issues in the previous section would be worthy of further research. In this section, I describe a few specific research ideas that I feel are prompted by the methodological limitations of the study.

5.1. Focusing on the children in Year 6

Both the challenge of recruiting mothers of children who were weighed in Year 6, and the evidence from this and other studies of a distinct experience related to the older age group, argue for further study of screening in Year 6. As noted in the Methodology chapter, three mothers who previously stated their interest in taking part withdrew due to the request of their older child. This suggests that, on some level, their child was not comfortable with them taking part.

Whilst IPA does attend to the individual experience, IPA researchers aim to draw a cohesive narrative of the findings in a manner that balances idiosyncratic and shared experience. Through drawing out shared themes, there is some loss to individual experience. This was particularly relevant for in this study for the one participant, Jemma, who had an older child. In order to gain further insight into what the experience of receiving a letter was like for mothers of children weighed in Year 6, further studies could focus their efforts on this age group only. Given the potential difficulty of recruiting this sample, it could also be worth considering the value of conducting single case studies.

5.2. Discourse analysis

As this study employed an interpretative phenomenological analytical methodology, there were limitations to the depth and ways the data could be considered.

Conducting a similar study employing a discourse analytic procedure would allow the researcher to look at the positions available to participants by the ways that they construct themselves, their child, and their child's weight. This is true, for example, in reference to participants' fears regarding their child developing eating disorders. From a discourse analytic perspective, insight would be gained into how such constructs positioned them, and how these positions serve them. Using discourse analysis could be useful in terms of considering health promotion or communication material, as it would allow authors of this material to be mindful of positioning people in certain ways.

6. Personal Reflexivity: Final Thoughts

6.1. Being a mother

After I had conducted all the interviews, I became pregnant myself and I gave birth to my son part way through writing up the study. In some senses, completing the thesis (and the DPsych more generally) feels as though it parallels that of giving birth. Pregnancy, birth, and the first year of motherhood allowed me new, challenging, and rewarding experiences, and my relationship to the participants' narratives shifted. After I became a mother, in relation to this aspect of the research, I shifted from outsider to insider. Some phrases hit me in new ways: what had been surprising now seemed obvious, and what had not seemed particularly meaningful now did. This was evident even in the smallest of ways. For example, a few of the participants explained they turned to the "red book" to check their child's weight curve. I remember receiving my son's red book after his birth, and being reminded of the participants' accounts of how this red book served them; it felt as though I held something very important in my hands. As I leafed through the red book, I felt surprisingly connected to the participants, as though I had received my entry certificate to the mothers' club. When I returned to the study after the birth of my son, I found that I drew strength from some of the participants' quotes about motherhood, feeling less alone and more connected to this new group that I was now a part of. This experience re-emphasised to me the potency of human connection made possible through sharing - authentically - the messy, complex parts that often hide behind shiny, neat fronts.

I was aware, too, that not only was I changed by my experiences, but that as I continued to write up the study, my new experiences might impact the ways that I engaged with the data, and wrote up my findings. I questioned whether the degree of empathy and, at times, outrage that I felt when listening to their stories had changed now I had experienced the connection to my own child. I concluded that whilst I will never know for certain because I can never ‘go back’, it is likely that my desire to speak out for fellow mothers and against potential suffering of children has evolved in ‘felt’ ways that were simply not possible before.

6.2. Being a researcher

*“To understand the rose,
One person may use geometry
And another the butterfly”
Paul Claudel (1929)*

Prior to completing this study, I felt more uncertain about my abilities as a researcher than as a practitioner. As completion of the research was a necessary part of the training, I embarked on the research as a predominantly academic project. However, through completion of this qualitative study, my relationship to being a researcher has shifted substantially. In particular, my relationship to being a researcher now includes meanings such as privilege and responsibility. What was an academic endeavour is now also a human encounter. I felt very privileged to have been entrusted with participants’ experiences and was, at times, moved by their stories. Coupled with this privilege, I felt a responsibility to conduct a piece of work that honoured their willingness to share (sometimes difficult and painful) accounts of their lived experiences. I have concluded that this may be felt more substantially when using methodologies such as IPA where the researcher is required to be interpretative. As I described earlier, my view of where my research might end up shifted whilst conducting this study. I was struck by the words of Chalmers (2012), who argued that “failure to publish research results is by far the most common and worrying form of scientific and ethical misconduct in health research” (para. 1) and that “publication is a moral imperative” (para. 8). Woven together, my experiences of conducting the research has meant that, whilst completing this study was still a

requirement of the training, it became far less about that, and more about my relationships with the ‘other’ – the participants, other mothers, other healthcare professionals, the communities I am part of, and general society. Ultimately, it has called me to consider the greater impact of my choices as a researcher, and my values as a scientist-practitioner. It has allowed me to see beyond personal insecurities that arise as I stand in the gaze of the ‘other’ and find new meaning in the potential ways that I, and other researchers and psychologists, can be of service.

References for the Thesis

- Ahearne-Smith, S. (2008). *An approach to primary prevention of obesity in children and adolescents*. National Obesity Forum. Retrieved from www.nationalobesityforum.org.uk/images/stories/An_approach_to_Primary_Prevention_of_Obesity_in_children_and_adolescent1.doc.
- Beckford, L., & Broome, M. R. (2007). Ethics and the payment of research subjects. *Psychiatry*, 6, 83-85.
- Beder, J. (2004-5). Loss of the assumptive world: How we deal with death and loss. *OMEGA*, 50(4), 255-265. Retrieved from <http://www.ualberta.ca/~jennyy/PDFs/16913955.pdf>
- Health and Care Professions Council. (2012). *Standards of Proficiency: Practitioner Psychologists*. (Publication code 20101001POLPUB).
- Bridges, S., & Thompson, J. (2010). *Children's BMI, overweight and obesity*. The health and social care information centre. Retrieved from <http://www.hscic.gov.uk/catalogue/PUB03023/heal-surv-eng-2010-resp-heal-ch11-chil-bmi.pdf>
- Brown, B. (2007). *I thought it was just me (but it isn't): Making the journey from "what will people think?" to "I am enough"*. London, England: Penguin Books Ltd.
- Brown, B. (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead*. London, England: Penguin Books Ltd.
- Butland, B., Jebb, S., Kopelman, P., McPherson, K., Thomas, S., Mardell, J., & Parry, V. (2007). *Foresight: Tackling obesity: Future choices – Project report (2nd Edition)*. Government Office for Science. UK: Department of Innovation Universities and Skills. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287937/07-1184x-tackling-obesity-future-choices-report.pdf
- Carr, A. (2009). The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy*, 31, 3-45.
- Centre for Disease Control and Prevention. (2014, March, 11) *Middle childhood (9-11 years of age)*. Retrieved from <http://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/middle2.html>

- Chalmers, I. (2012). Publish or perish. *Project Syndicate*. Retrieved from <http://www.project-syndicate.org/commentary/publish-or-perish#eEWoY651ybohswqw.99>
- Claudel, P. (1929). *L'oiseau noir dans le soleil levant*. Paris, France: Gallimard.
- Daily Mail Reporter. (2011, June 13). Youngster, 5, branded overweight by health chiefs - even though he weighs less than 4st and runs around all day. *The Daily Mail Online*. Retrieved from <http://www.dailymail.co.uk/health/article-2002750/Youngster-5-branded-overweight-health-chiefs--weighs-4st-runs-day.html>
- Davidson, K. K., & Birch, L. L. (2001). Weight status, parent reaction, and self-concept in five-year-old girls. *Pediatrics*, 107(1), 46 -53.
- Deitz, W. H., Story, M. T., & Leviton, L. (2009). Issues and implications of screening and reporting of children's BMI. *Pediatrics*, 124, S98-S101.
- Denzin, N. K. (1995). Symbolic interactionism. In U. Flick, E. von Kardorff & I. Steinke (Eds.), *A companion to qualitative research* (pp. 81-87). (2004) London, England: Sage Publications Ltd.
- Department of Health. (2011). Healthy Lives, Healthy People: A call to action on obesity in England. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213720/dh_130487.pdf
- Donaldson, L. (2008). *The Chief Medical Officer's report 2007. Under their skins: Tackling the health of the teenage nation*. London: Department of Health. Retrieved from http://www.em-online.com/download/medical_article/36923_DH_086193.pdf
- Douglas, S. J., & Michaels, M. W. (2004). *The mommy myth: The idealization of motherhood and how it has undermined women*. New York, NY: Free Press, Simon & Schuster, Inc.
- Draper, H., Wilson, S., Flanagan, S., & Ives, J. (2009). Offering payments, reimbursement and incentives to patients and family doctors to encourage participation in research. *Family Practice*, 26, 231-238.

- Dunsmuir, S. M., & de Sausmarez, E. (2011). Factors associated with overweight and obese children's weight-related behaviours and cognitions: Assessment and intervention. *Educational and Child Psychology*, 28(3), 14-22.
- Eatough, V., & Smith, J. A. (2006). I feel like a scrambled egg in my head: An idiographic case study of meaning making and anger using interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 79, 115-135.
- Eatough, V., & Smith, J. A. (2008) Interpretative phenomenological analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology*, (pp. 179-194). London: Sage.
- Edmunds, L. D. (2005). Parents' perceptions of health professionals' responses when seeking help for their overweight children. *Journal of Family Practice*, 22, 287-292.
- Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: A practical guide. *Proceedings of the Nutrition Society*, 63, 647-6.
- Falconer, C. L., Park, M. H., Croker, H., Skow, A., Black, J., Saxena, S., ... Kinra, S. (2014) The benefits and harms of providing parents with weight feedback as part of the national child measurement programme: a prospective cohort study. *BMC Public Health*. Retrieved from: doi:10.1186/1471-2458-14-549
- Fallowfield, L., & Jenkins, V. (2004). Communicating sad, bad, and difficult news in medicine. *The Lancet*, 363, 312-319.
- Fromm, E. (2008). *The sane society*. UK: Routledge Classics.
- Fuchs, T. (2002). The phenomenology of shame, guilt and the body in body dysmorphic disorder and depression. *Journal of Phenomenological Psychology*, 33, 223-243.
- Fujimori, M., & Uchitomi, Y. (2009). Preferences of cancer patients regarding communication of bad news: A systematic literature review. *Japanese Journal of Clinical Oncology*, 39(4), 201-216.

- Gard, M., & Wright, J. (2000). *The obesity epidemic: Science, morality and ideology*. Abingdon: Routledge.
- Gerhardt, S. (2004). *Why love matters: How affection shapes a baby's brain*. Hove, England: Brummer-Routledge.
- Golan, M., & Crow, S. (2004). Parents are key players in the prevention and treatment of weight-related problems. *Nutrition Reviews*, 62(1), 39-50.
- Govea, J. (2011). Ethical concerns regarding interventions to prevent and control childhood obesity. *Preventing Chronic Disease: Public Health Research, Practice, and Policy*, 8(5):A91. Retrieved from http://www.cdc.gov/pcd/issues/2011/sep/10_0288.htm.
- Gray, W. N., Kahhan, N. A., & Janicke, D. M. (2009). Peer victimization and pediatric obesity: a review of the literature. *Psychology in the Schools*, 46(8), 720-727.
- Grimmett, C., Croker, H., Carnell, S., & Wardle, J. (2008). Telling parents their child's weight status: Psychological impact of a weight-screening program. *Pediatrics*, 122, e682-e688.
- Harris, D. L. (2011). Introduction. In D. L. Harris (Ed.), *Counting our losses: Reflecting on change, loss and transition in everyday life*. (pp. xvii-xxiv). Hove: Routledge.
- Happy Worker. 'SuperMom' action figure: Meet SuperMom. Retrieved from <http://www.happyworker.com/supermom>
- Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology*, 12(4), 1464-5300.
- Health & Care Professions Council (2012a). *Standards of proficiency: Practitioner psychologist*. Retrieved from: https://www.hcpc-uk.org/assets/documents/10002963SOP_Practitioner_psychologists.pdf
- Health & Care Professions Council (2012b). *Guidance on conduct and ethics for students*. Retrieved from http://www.hpc-uk.org/assets/documents/10002D1B_Guidanceonconductandethicsforstudents.pdf

- Heuer, C. M., McClure, K. J., & Puhl, R. M. (2011). Obesity stigma in online news: A visual content analysis. *Journal of Health Communication, 0*, 1-12. Retrieved from http://www.yaleruddcenter.org/resources/upload/docs/what/bias/ObesityStigmaOnlineNews_JHC_5.11.pdf
- Hope, J. (n.d.). Parents to blame for obese children. *The Daily Mail online*. Retrieved from <http://www.dailymail.co.uk/health/article-12391/Parents-blame-obese-children.html>
- Howard, K. R. (2007). Childhood overweight: Parental perceptions and readiness for change. *The Journal of School Nursing, 23*(2), 73-79.
- Ipsos MORI Social Research Institute. (2010). *National Child Measurement Programme: Proactive follow-up*: Hull PCT. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122566.pdf
- James Li, J. T. C. (2006). The quality of caring. *Mayo Clinic Proceedings, 81*(3), 294-296.
- Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.
- Jansen, W., & Brug, J. (2006). Parents often do not recognize overweight in their child, regardless of their socio-demographic background. *European Journal of Public Health, 16*(6), 645–647. Retrieved from <http://eurpub.oxfordjournals.org/content/16/6/645.full.pdf+html>
- Jebb, S. A., Rennie, K. L., & Cole, T. J. (2003). Prevalence of overweight and obesity among young people in Great Britain. *Public Health Nutrition, 7*(3), 461-465.
- Keenan, J. & Stapleton, H. (2010). Bonny babies? Motherhood and nurturing in the age of obesity. *Health, Risk & Society, 12*(4), 369-383.
- Kinston, W., Loader, P., & Miller, L. (1988). Talking to families about obesity: A controlled study. *International Journal of Eating Disorders, 7*, 261-275.

- Kokkonen, R. (2009). The fat child: A sign of 'bad' motherhood? An analysis of explanations for children's fatness on a Finnish website. *Journal of Community & Applied Social Psychology*, 19(5), 336-347.
- Kubik, M. Y., Fulkerson, J. A., Story, M., & Rieland, G. (2006). Parents of elementary school students weigh in on height, weight, and Body Mass Index screening at school. *Journal of School Health*, 76(10), 496-501.
- Kubik, M. Y., Fulkerson, J. A., Story, M., & Rieland, G. (2006). Parents of elementary school students weigh in on height, weight, and Body Mass Index screening at school. *Journal of School Health*, 76(10), 496-501.
- Kvale, S., & Brinkmann, S. (2008). *InterViews: Learning the craft of qualitative research interviewing (2nd edn.)*. USA: Sage Publications.
- Kyle, T. K., & Puhl, R. M. (2014). Putting people first in obesity. *Epidemiology/Genetics*, 0(1). Retrieved from http://www.yaleruddcenter.org/resources/upload/docs/what/bias/Putting%20People%20First%20in%20Obesity_Obesity_3.14.pdf
- Langdrige, D. (2007). *Phenomenological psychology: Theory, research and method*. Harlow, England: Pearson Education Ltd.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer Publishing.
- Latner, J. D., & Stunkard, A. J. (2003). Getting worse: The stigmatisation of obese children. *Obesity Research*, 11(3), 452-456.
- Lee, S. J., Back, A. L., Block, S. D., & Stewart, S. K. (2002). Enhancing physician-patient communication. *Hematology American Society of Hematology Education Program 2002 (1)*. 464-483.
- Ley, R. (2012, May 9). Why are hundreds of healthy and happy children like these being branded OBESE by the NHS? *The Daily Mail Online*. Retrieved from <http://www.dailymail.co.uk/femail/article-2142014/Obese-children-UK-NHS-branding-hundreds-healthy-happy-children-obese.html#ixzz2YdrdPupM>

- Luman, E. T., McCauley, M. M., Chu, S. Y., Boyle, C., Elam-Evans, L., & McMillan, J. A. (2003). Introduction: An integrative perspective: Mothers' influence on child health preconceptionally, prenatally, and in early childhood. *Pediatrics*, 111(1), 1129.
- Lyon, B. L. (2012). Stress, coping, and health: A conceptual overview. In V. H. Rice (Ed.), *Handbook of stress, coping, and health: Implications for nursing research, theory, and practice* (2nd edn.) (pp. 2-19). USA: Sage.
- Madill, A., Jordan, A., & Shirley, C. (2000) Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91(1), 1-20.
- Mager, W. M., & Andrykowski, M. A. (2002). Communication in the cancer 'bad news' consultation: Patient perceptions and psychological adjustment. *Psycho-Oncology*, 11(1), 35-46.
- Maher, J. M., Fraser, S., & Wright, J. (2010). Framing the mother: Childhood obesity, maternal responsibility and care. *Journal of Gender Studies*, 19(3), 233-247.
- McLeod, J. (2003). Qualitative research methods in counselling psychology. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.) (2nd edn.), *Handbook of Counselling Psychology* (pp. 74-92). London: Sage.
- Milton, M. (2005). Political developments and the evolution of counselling psychology. *Counselling Psychology Review*, 20(4), 41-43.
- Monster [Def. 1 & 2]. (n.d.). In *Oxford Dictionaries*. Retrieved from <http://www.oxforddictionaries.com/definition/english/monster>
- Mooney, A., Statham, J., Boddy, J., & Smith, M. (2010). *The National Child Measurement Programme: Early experiences of routine feedback to parents of children's height and weight*. Thomas Coram Research Unit & Institute of Education and Social Research. Retrieved from http://www.obesitywm.org.uk/resources/temp_-_early_experiences_of_routine_feedback.pdf

- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2), 13-22.
- Myers, S., & Vargas, Z. (2000). Parental perceptions of the preschool obese child. *Paediatric Nursing*, 26(1), 23-30.
- National Health Service. (2012, June 11) *Symptoms of puberty*. Retrieved from <http://www.nhs.uk/Conditions/Puberty/Pages/Symptoms.aspx>
- National Health Service. (2009, September 1) 'The National Child Measurement Programme'. *NHS choices website*. Retrieved from <http://www.nhs.uk/Livewell/childhealth1-5/Pages/ChildMeasurement.aspx>
- National Institute for Health and Care Excellence. (2013) *Costing report: Overweight and obese children and young people - lifestyle weight management services*. Retrieved from <http://www.nice.org.uk/nicemedia/live/14298/65539/65539.pdf>
- National Institute for Health and Care Excellence. (2006, Jan). *CG43: Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children*. Retrieved from <http://www.nice.org.uk/nicemedia/pdf/CG43NICEGuideline.pdf>
- National Obesity Observatory. (2011). *A simple guide to classifying Body Mass Index in children*. Retrieved from http://www.noo.org.uk/uploads/doc/vid_11601_A_simple_guide_to_classifying_BMI_in_children.pdf
- Mohney, G. (2014, July 3). Woman With Hair Loss Condition Captures Transformation in Time Lapse Video. *ABC news online*. Retrieved from <http://abcnews.go.com/Health/woman-hair-loss-condition-trichotillomania-captures-transformation-time/story?id=24416514>
- Neovius, M., Linne, Y., Barkeling, B., & Rossner, S. (2004). Discrepancies between classification systems of childhood obesity. *Obesity Review*, 5(2), 105-114.

- Nihiser, A. J., Lee, S. M., Wechsler, H., McKenna, M., Odom, E., Reinold, C., Thompson, D., & Grummer-Strawn, L. (2007a). Body Mass Index measurements in schools. *Journal of School Health*, 77, 651-671.
- Nihiser, A. J., Lee, S. M., Wechsler, H., McKenna, M., Odom, E., Reinold, C., Thompson, D., & Grummer-Strawn, L. (2007b). Body Mass Index measurements in schools. Report for Centers for Disease Control and Prevention.
- Ogden, J. (2004). *Health psychology: A textbook (3rd edn.)*. New York: Open University Press.
- Orbach, S. (1988). *Fat is a feminist issue*. London: Arrow Books.
- Orwell, G. (1949). *1984*. London, England: Secker & Warburg.
- Parker, I. (1994). Qualitative Research. In P. Banister, E. Burman, I. Parker, M. Taylor, & C. Tindall (Eds.), *Qualitative methods in psychology: a research guide* (pp. 92–107). Buckingham: Open University Press.
- Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In: N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 245-273). Hove: Psychology Press.
- Pierce, J. W., & Wardle, J. (1997). Cause and effect beliefs and self-esteem of overweight children. *Journal of Child Psychology & Psychiatry*, 38, 645-650.
- Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology*, 52(2), 126-136.
- Puhl, R. M., & Latner, J. D. (2007). Stigma, obesity, and the health of the nation's children. *Psychological Bulletin*, 133(4), 557-580.
- Puhl, R., Peterson, J. L., & Luedicke, J. (2012) Motivating or stigmatizing? Public perceptions of weight-related language used by health providers. *International Journal of Obesity*, 1-8. Retrieved from http://www.yaleruddcenter.org/resources/upload/docs/what/bias/PerceptionsHealthProvidersWeightLanguage_IJO_7.12.pdf

- Rafalin, D. (2010). Counselling psychology and research: Revisiting the relationship in the light of our 'mission'. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 41-55). Oxford: Wiley-Blackwell.
- Roxburgh, S. (2004). 'There just aren't enough hours in the day': The mental health consequences of time pressure. *Journal of Health and Social Behavior*, 45(2), 115-131.
- Ryan, K. W. (2009). Surveillance, screening, and reporting children's BMI in a school-based setting: A legal perspective. *Pediatrics*, 124, S83-S88. Retrieved from http://pediatrics.aappublications.org/content/124/Supplement_1/S83.full
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68-78.
- Scientific Advisory Committee on Nutrition & Royal College of Paediatrics and Child Health. (2012). *Consideration of the issues around the use of BMI centile thresholds for defining underweight, overweight and obesity in children aged 2-18 years in the UK*. Retrieved from http://www.sacn.gov.uk/pdfs/sacnrcpch_position_statement_bmi_thresholds.pdf
- Sartre, J. (1943). *Being and nothingness*. New York: Gallimard
- Schvey, N. A., Purl, R. M., & Brownell, K. D. (2014). The stress of stigma: Exploring the effect of weight stigma on cortisol reactivity. *Psychosomatic Medicine*, 76, 00-00. [published ahead of print on January, 16, 2014]. Retrieved from http://www.yaleruddcenter.org/resources/upload/docs/what/bias/Physiological_Stress_Stigma_PsychosomaticMed_1.14.pdf
- Schwartz, M. B., & Purl, R. (2003). Childhood obesity: A societal problem to solve. *Obesity Reviews*, 4, 57-71.
- Smith, J., & Osborn, M. (2003). Interpretive phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51-80). London: Sage

- Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. in J Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd edn.) (pp. 53-80). London: Sage.
- Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, England: Sage.
- Soto, C., & White, J. H. (2010). School health initiatives and childhood obesity: BMI screening and reporting. *Policy, Politics, & Nursing Practice*, 11(2), 108-114.
- Southall, O., & Fox, J. R. E. (2011). Maternal perceptions of overweight and obesity in children: A grounded theory study. *British Journal of Health Psychology*, 16, 626-641.
- Spruijt-Metz, D. (2011). Etiology, treatment, and prevention of obesity in childhood and adolescence: A decade in review. *Journal of Research on Adolescence*, 21(1), 129-152.
- Steiner Rice, H. (1999). A mother's love. In V. Ruehlmann & H. Steiner Rice (Eds.), *Mother, I love you*. Michigan, USA: Baker Book House Company.
- Stewart-Brown, S., & Farmer, A. (1997). Screening could seriously damage your health: Decisions to screen must take account of the social and psychological costs. *British Medical Journal*, 314, 533-534. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2126029/pdf/9055702.pdf>
- Strauss, R. S., & Pollack, R. S. (2003). Social marginalization of overweight children. *Archives of Paediatrics & Adolescent Medicine*, 157, 746-752.
- Stay Puft Marshmallow Man. (n.d.). In *Wikipedia*. Retrieved from http://en.wikipedia.org/wiki/Stay_Puft_Marshmallow_Man
- STV. (2013, August 9). Are parents or general society to blame? Retrieved from <http://shows.stv.tv/this-morning/real-life/235524-childhood-obesity-debate-are-parents-or-general-society-to-blame/>
- Syrad, H., Falconer, C., Cooke, L., Saxena, S., Kessel, A. S., Viner, R., ... Croker, H. (2014) 'Health and happiness is more important than weight': a qualitative investigation of the views of parents receiving written feedback on their child's

weight as part of the National Child Measurement Programme. *Journal of Human Nutrition and Dietetics*. Retrieved from: <http://onlinelibrary.wiley.com/store/10.1111/jhn.12217/asset/jhn12217.pdf?v=1&t=i3irvtbv&s=74ac1flabdaa5ddd3006f420a542a22f6f1de871>

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York: The Guilford Press.

The British Psychological Society. (2010). *Code of Human Research Ethics*. Retrieved from http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

The British Psychological Society. (n.d.) *Division of Counselling Psychology: Professional Practice Guidelines*. Retrieved from http://www.bps.org.uk/sites/default/files/documents/professional_practice_guidelines_-_division_of_counselling_psychology.pdf

The British Psychological Society. (n.d.) Division of Counselling Psychology website. Retrieved from <http://dcop.bps.org.uk/dcop/>

The Centre for Consumer Freedom: Promoting Personal Responsibility and Protecting Consumer Choice. (2009, April 16). *BMI Surveillance: The Food Police Will Be Watching You*. Retrieved from <http://www.consumerfreedom.com/2009/04/3878-bmi-surveillance-the-food-police-will-be-watching-you/>

Theodore, L. A., Bray, M. A., & Kehle, T. J. (2009). Introduction to the special issue: Childhood obesity. *Psychology in the Schools*, 46(8), 693-694.

Vacek, E. V. (1982). Scheler's phenomenology of love. *The Journal of Religion*, 62(2), 156-177.

Van Manen, M. (1984). Practicing phenomenological writing. *Phenomenology & Pedagogy*, 2(1), 36-69.

Walsh, Y., & Frankland, A. (n.d.). *Division of Counselling Psychology website: Values*. Retrieved from http://dcop.bps.org.uk/dcop/home/values/values_home.cfm.

- Wardle, J., & Steptoe, A. (2005). Public health psychology. *The Psychologist*, 18, 672-675. Retrieved from http://www.thepsychologist.org.uk/archive/archive_home.cfm/volumeID_18-editionID_129-ArticleID_947-getfile_getPDF/thepsychologist%5C1105Hwar.pdf
- Warin, M., Turner, K., Moore, V., & Davies, M. (2008). Bodies, mothers and identities: Rethinking obesity and the BMI. *Sociology of Health & Illness*, 30(1), 97–111.
- Washington, R. L. (2011). Childhood obesity: Issues of weight bias. *Preventing chronic disease: Public Health Research, Practice, and Policy*, 8(5), 1-5. Retrieved from: www.cdc.gov/pcd/issues/2011/sep/10_0281.htm
- Wertz, F. J. (2005). Phenomenological research methods for counselling psychology. *Journal of Counselling Psychology*, 52(2), 167-177.
- Willig, C. (2008). *Introducing Qualitative Research in Psychology* (second edition). Berkshire: McGraw-Hill.
- Willig, C., & Stainton-Rogers, W. (2008). *The SAGE handbook of qualitative research in psychology* (Eds.). London: Sage Publications Ltd.
- Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. New York: McGraw-Hill.
- Winterman, D. (2012, September 26). Child obesity: Why do parents let their kids get fat? *BBC News Magazine online*. Retrieved from <http://www.bbc.co.uk/news/magazine-19661085>
- World Health Organization, (n.d.). *Childhood overweight and obesity*. Retrieved from <http://www.who.int/dietphysicalactivity/childhood/en/>
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215-228.
- Zivkovic, T., Warin, M., Davies, M., & Moore, V. (2010). In the name of the child: The gendered politics of childhood obesity. *Journal of Sociology*, 46(4), 375-392.

PART D

JOURNAL ARTICLE

**“It’s like a horrible tag on you or something”:
the maternal experience of being told your child is ‘overweight’**

Abstract

Children in the UK currently take part in the National Child Measurement Programme (NCMP) a UK government-funded childhood weight surveillance and feedback programme. This study explored the maternal experience of being told one's child is overweight or obese as part of the NCMP. The participants were recruited within the UK, and the data were analysed using Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009). The focus of this article is exploration of one of the three master themes that emerged: the Disempowered Self. This theme was selected due to the potential insights it holds for the future development of childhood weight surveillance and feedback programmes.

Keywords

childhood, overweight, obesity, mother, NCMP

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Introduction

Setting the scene (prevalence and consequences of childhood obesity)

Childhood obesity has been described as “one of the most serious [global] public health challenges of the 21st century” (World Health Organization). In the UK, approximately 28% of children (aged 2 to 15) were classified as ‘overweight’ or ‘obese’ in 2012 (Ryley, 2013). Butland et al. (2007) predicted that if no preventative measures are taken, 25% of children (those under 20 years old) will be ‘obese’ by 2050. These figures are compared to current (at the time of publication) figures of childhood obesity (those under 20 years old) at 10% males and 8% of females (Butland et al., 2007). There are concerns regarding individual, societal, and economic consequences of obesity (Department of Health, 2011); and evidence continues to accumulate that being overweight or obese is associated with both

physical and psychosocial problems (Theodore et al., 2009). Being overweight or obese in childhood is strongly linked to obesity in adult life (Jebb et al., 2003), meaning that children who are overweight or obese may experience adverse consequences through the full course of their lives (Spruijt-Metz, 2011).

Due to the cost and complexity of measuring fat per se, weight is used as a surrogate: a person with a weight above a predefined level is considered to be overweight. Weight clearly depends on more than body fat and adjustments are made in an attempt to take this into account – the commonest factors adjusted for are height, age, and sex. The most widely used measure is the Body Mass Index (BMI) (weight (kg) divided by height (m) squared). Statistical analysis of populations led to classification into categories such as ‘underweight’, ‘normal weight’, ‘overweight’, and ‘obese’. There is currently no uniform BMI classification system for children. Debate continues regarding which BMI cut-offs should be used (NICE, 2006; SACN and RCPCH, 2012), and due to the potential for misleading measurement errors, the National Institute for Health and Care Excellence (NICE) (2006) cautions that BMI thresholds should be used as an estimate only.

Measuring children’s BMI in schools is increasingly common (Kubik et al., 2006), with parts of the USA, Australia, and England implementing broadly similar initiatives (Nihiser et al., 2007; Lazarus et al., 1996; Grimmett et al., 2008). Whilst, in broad terms, screening aims to inform public, professional, and parental understanding, questions have been raised in respect of the children measured (and their carers) regarding classification accuracy, privacy, stigma, parental, and children’s response to the screening, and overall effectiveness (Soto and White, 2010).

The NCMP was set up in 2005 as part of a government initiative aimed at reducing childhood obesity (Grimmett et al., 2008). By basing measurement in schools, the NCMP provides comprehensive data on children’s weight and height; it is funded jointly by the Department of Health and the Department of Education. Children are weighed and their heights measured in reception year (age 4-5 years old) and year 6 (age 10-11 years old). Prior to the measurements being taken, parents are informed

that they can ‘opt-out’ of the scheme if they do not wish their child to participate, and are provided with information about how they will receive their child’s results (NHS, Livewell, NCMP website). The BMI of the child is included in the feedback letter along with the weight classification.

Questions remain regarding what parents’ views of BMI reporting are, whether they want to be told their child’s BMI (Soto and White, 2010), and how best to feedback this information to them (Deitz et al., 2009). Whilst a number of studies point towards positive parental perceptions of BMI screening, there are also reported exceptions to this, for example, increased parental concern about the psychological impact on their children (Soto and White, 2010).

Whilst the effects of school-based childhood measurement programmes have been examined in predominantly quantitative studies (Grimmett et al., 2008; Mooney et al., 2010; Kubik et al., 2006), the impact of providing parents with BMI feedback is still largely unknown (Soto and White 2010). These studies reported that most parents indicated that they found the feedback letter “acceptable” (Grimmett et al., 2008, p. 682), “comfort with the letter” (Kubik et al., 2006, p. 496) and were supportive of measurement and feedback programmes (Mooney et al., 2010; Kubik et al., 2006). However, they also stated that it is usually parents who have children who are classified as ‘overweight’ or ‘very overweight (obese)’ that do not agree with the results (Mooney et al., 2010) or report “distress” (Grimmett et al., 2008, p. 682), or “discomfort” (Kubik et al., 2006, p. 496). For example, Mooney et al. (2010) explained that some parents reported feeling guilty, ashamed, at fault; and Grimmett et al. (2008) provided an example of one participant who described feeling ashamed. Mooney et al. (2010) reported that the “impersonal nature” (p. 24) of the letter was a recurring theme across their participants, and that a few people found the letter “harsh”, “patronising”, “too blunt”, and “not sensitive enough” (p. 25). Grimmett et al. (2008) reported that two parents had called in and explained that they found it hard to see their child’s weight category written down; and Mooney et al. (2010) noted that one participant explained that she felt her child had been “put into a category” and “just considered statistically” (p. 24). Mooney et al. (2010) further noted that participants objected to weight labels rather than weight measurement

itself, and several explained that they would have preferred to be told their child was ‘outside’ the normal range than assigned labels. Whilst these studies explored parental perceptions of childhood weight measurement and feedback programmes, Mooney et al. (2010) noted that a higher number of mothers participated than fathers. This seems to echo literature that suggests that mothers play a pivotal role in nurturing and feeding children (Warin et al., 2008; Keenan and Stapleton, 2010) and that, within the context of childhood obesity, the position of parent is more commonly constructed as ‘female’ (Kokkonen, 2009).

The insights gained from Grimmett et al. (2008), Kubik et al. (2006), and Mooney et al. (2010) highlight the importance of exploring the experiences of mothers who have children who are classified as ‘overweight’ or ‘very overweight (obese)’ in more depth, and closing the gap in the current understanding of the impact of such initiatives on those involved.

Experience from other health-related screening programmes illustrates how the impact of any screening intervention must be carefully considered at individual and societal levels (Stewart-Brown and Farmer, 1997). Such consideration should encompass whether interventions are ethical, and how further development could enable them to be both more acceptable and more effective. With regard to childhood weight measurement and feedback programmes, Grimmett et al. (2008) highlighted concerns related to potential impact of excessive parental worry, such as implementation of restrictive diets. Similarly, Purl and Latner (2007) suggested that it is possible parents may become critical towards their child if they feel negatively evaluated for having an ‘overweight’ child. These concerns further highlight the importance of considering the impact on parents who have been told that their child is overweight.

This article explores in depth the maternal experience of being disempowered as part of the wider phenomenon of receiving the news that her child is ‘overweight’ or ‘obese’.

Methodology

Participants

Participants (n=8) were recruited via online advertising, paper advertising, and word-of-mouth. They were mothers of a child weighed in reception year (aged 4-5 years) (n=7), or year six (added 10-11 years) (n=1). Elapsed time between receipt of the letter and the interview varied between a few months and a few years. The sample contained both mothers who were employed outside the home and those who were not. Seven participants spoke English as a first language, and one as an additional language.

Data collection

Semi-structured interviews were completed in person (n=7) or over video Skype (n=1). In-person interviews took place in locations convenient to the participant (five in private rooms in libraries, one in a private room at a university, and one in a private room at the participant's place of employment). The median interview was 68 minutes (range 30-82 minutes). After being debriefed, participants were given a £15 voucher as a gesture of thanks for participation.

Transcription and analytic procedure

Interviews were transcribed verbatim, and the data were analysed using IPA (Smith et al., 2009). Pseudonyms are used in this article to ensure participant anonymity.

Analysis

Overview of the findings: Three master themes

Analysis led to the emergence of three master themes: 'the impacted self', 'the disempowered self' and 'the mother self'. The impacted self illustrated a process

experienced by participants (spanning from receipt of the letter through to our interview). Analysis highlighted three stages of this process: initial surprise at receiving the news that their child was overweight or obese; subsequent uncertainty and rumination regarding whether or not the category ascribed to their child was appropriate and, if so, concern regarding their role in the event; and an evolving experience, where participants indicated that they were able to either move on and reject the category, or move on and accept the category, or remain stuck within uncertainty. The mother self comprised three themes: being a nurturer and protector in relation to their child; experiencing a unique bond to their child both emotionally and biologically; and navigating complexity of varying motherhood ‘pulls’, both logistical and psychological. The disempowered self – the focus of this article – illustrates ways that participants felt their power, authority, or confidence was undermined or removed. It draws attention to the impact of the gaze of the ‘other’ on participants’ individual and collective experience. The all-powerful nature of the gaze of the ‘other’ (arising in many forms such as other mothers or the NCMP, for example) is highlighted as participants explore how the views they hold about themselves are influenced by the ways that they believed they are perceived by the ‘other’. It comprises three themes: the experience of being judged, blamed and shamed; the experience of being branded and reduced to a weight label; and the experience of being controlled by numerous others, such as professionals, the letter, and societal meanings.

I chose the ‘disempowered self’ as the focus of this article because of the important insights it provides for the future conduct of child measurement programmes. Both childhood weight programmes and health professionals fall into the position of the ‘other’ within the context of participants’ experience. Hence, insights presented in this article may potentially be taken forward and directly acted upon by those involved in programme development and delivery.

Detailed exploration of the Disempowered Self

Theme 1: Being judged: Experiencing blame and shame. Participants described ways in which they felt judgement from sources such as the government, other mothers, the school, and other interpersonal relationships: for example, that they had “failed”, were “bad”, or had done something “wrong”, which led to feelings such as sadness, disappointment, guilt, and anger. As an overarching shared experience, participants felt that they were blamed (at fault) and shamed (disgraced).

One way in which this experience evolved was within a life world where absolute ‘right’ and ‘wrong’ exist. Within this context, receipt of the letter was experienced as a direct commentary on the ‘rightness’ or ‘wrongness’ of participants’ parenting:

*...You are not doing it all right and you want to do everything right by your kids.
And yeah, that’s hard, to be told that actually you are not doing it right.
(Anne, 223-235)*

This was also often experienced as a personal failing, where it was not a behaviour that was right or wrong, or good or bad, but the participant herself: Jessica said that the phenomenon symbolised “*the culmination that ‘well actually I’m a bad mum’*” (Jessica, 191-192), and, like other participants, experienced feelings of inadequacy, inferiority, and shame related to her ‘mother self’ as a consequence of the phenomenon.

External judgement was experienced from a number of sources, both explicitly and implicitly. For example, whilst participants generally suggested that they felt supported by their partners and family members, Jemma described a different experience with her ex-partner:

*[I was] made to feel like I’ve done something wrong, [SG: yeah] you know, that she shouldn’t have got the letter if I was looking after her properly and like a big vicious circle come back to me again.
(Jemma, 196-198)*

Her words “*made to*” suggest she feels that her ex-partner and the health service have the power to make her feel a certain way about herself, and that it is because of them that she feels she may have done something “*wrong*”.

Additionally, participants described being disempowered by potential judgement. For example, Marie described this in relation to food-giving:

Parents judge other parents particularly [...] I think you are constantly being judged as a parent – all the time you feel – you know, like, if you gave your child a packet of sweets you sometimes feel like you might be getting a dirty look from somebody...

(Marie, 162-167)

Her phrase “*you feel like you might*” suggests that she may fear a potential event rather than one that has actually occurred. However, this does not seem to lessen Marie’s ‘felt experience’, and provides insight into the perceived morality of food choices. The word “*dirty*” is particularly emotive, suggesting that Marie experiences being disapproved of, reinforcing a view of the world as a place of right or wrong, or good or bad. Other participants mentioned that they saw professionals as another potential source of judgement:

...you wonder, you know, what other, what professionals are thinking about you and are they, are they judging you...

(Lucy, 128-129)

Lucy’s comment suggests that she feels she may be under scrutiny. Whilst Lucy questions the views of professionals from afar, Jemma describes her personal experience with a dietician:

...it’s like they’re looking at you, like... you know, you’ve, you’re doing something wrong [SG: Mm], it’s like, reflected in you, as a parent, I think...

(Jemma, 64-65)

Similar to her previous quotation, Jemma’s phrase describes a process of marrying external judgement with her own self-concept. The words “*they’re looking at you*” suggest she feels critically appraised by the ‘all-powerful professional’. The word “*wrong*” suggests that she internalises her perception of what they may be thinking, and that she may experience feelings of shame. The phrase “*reflected in you*”

suggests that it is her awareness of being seen by the other, in this case, the dietician, that may lead to humiliation and shame.

Participants highlighted protective measures they took to avoid experiencing judgement from others, and related emotions. Specifically, participants described sharing the receipt of the letter carefully: actively choosing to keep their experiences within certain parameters, such as immediate family members, close friends, medical professionals, and other mothers. Nula described ways in which she prepared herself and her internal world prior to engaging with her external world. She noted that “*you have to be prepared*” (Nula, 640) and described adjusting her “*mind setting*” (Nula, 636) so that when engaging with others she avoided feelings of “*shame*” (Nula, 638) and feeling “*embarrassed*” (Nula, 638). Lucy explained that she had a condition that had to be met before sharing her experiences with others:

If I was convinced that they, that they wouldn't judge me for, for having the child – if they would support me.
(Lucy, 180-181)

Her phrase indicates that she sought high-level certainty, needing to protect herself from any unwanted interactions, judgement, and feelings such as shame.

Whilst deciding whom to share one's experience with could be seen as an empowering action, it might have also maintained participants' fears of being judged by others, and fed secrecy and feelings of shame. Secrets, by their nature, create separation between people: those who know and those who do not. Participants differed in the groups and numbers of people with whom they felt 'safe' enough to share their experiences. At one end of a continuum, Lucy, for example, described the support of the mothers in her local community talking together in the playground – including about the letter and their related experiences. Other mothers explained that they believed that having an 'overweight' child meant that you were “*a failure*” (Val, 722), sharing their experiences only with selected people. At the other end of the continuum, Jemma experienced silence amongst her fellow mothers:

Yes, it's like a taboo subject. No-one will say I have got a letter and my daughter was so and so. They won't ... Nobody speaks about it [...] You wouldn't get

another parent come up to you and say 'oh guess what my letter said'. No-one spoke about it, so you had no idea what anybody else had you know. So just, as I said, it was just between me and Molly [Jemma's daughter] at first and she shoved it in a book and didn't want anyone to know... (Jemma, 312-317)

Jemma highlights a perpetuating cycle of silence and secrecy. She kept quiet and experienced other mothers doing the same, which she later notes is very different to other topics usually discussed in the playground. With regard to her fellow mothers, she remained isolated. Her emphasis on this lack of communication suggests that the silence itself felt all-powerful, and later she notes: “*Obviously you feel like you can't talk to anybody else because no-one has mentioned it, so therefore you don't say anything*” (Jemma, 325-326). She did not explore why she felt unable to be the first person to raise the topic; however, her earlier word “*taboo*” suggests that for Jemma the topic felt forbidden, and that speaking out would go against the ‘powerful’ societal norm. Her description of keeping the letter “*just between*” herself and her daughter, and that her daughter “*shoved it in a book*”, offers an evocative illustration of shame.

Theme 2: Branded child, branded self: Being reduced by a label. Participants identified their struggle to accept the particular weight categories ‘overweight’ or ‘obese’ assigned to their child. Personal meanings of the words ‘overweight’ and ‘obese’ did not correspond with how they saw their child. Generally, participants felt the words were negative and some saw them as a gateway to discrimination and suffering – expressing concern about what their child might experience should they be labelled ‘overweight’ or ‘obese’. Some participants also found the term directly “insulting” at a parental level, whilst others noted that the experience led them to feel a decreased sense of “self-esteem”.

None of the participants volunteered their child’s factual weight and height during the interviews. Although some participants noted that children’s weight does tend to go up and down, no one disputed the weight figure or height figures in the letter; what was disputed, however, was the weight category:

I accept that, the weight that he is – I accept the height he is – what I don't accept is

*the categorisation if you like, and the fact of the um, the, I am not sure how to say...
how they label it...(Lucy, 204-206)*

Lucy clearly experienced both acceptance and rejection in relation to the letter. Even if participants did not recall the exact wording of the letter, the majority remembered what category their child had been placed in; and it was this 'term', and how it was experienced, that held most meaning overall.

Participants commonly used words such as "*label*", "*tag*", and "*branded*" to describe how they saw the process of weight categorisation. Words such as "*label*" and "*tag*" suggest that the person to whom it is applied is now a classified entity. When associated with the literal meaning, the use of the word "*branded*" suggests that to be placed in an 'overweight' or 'obese' category is experienced by participants as a permanent, painful, and potentially torturous act.

Not only did participants describe their struggle with their child being 'tagged', they also highlighted their own feelings of powerlessness in relation to the process. For example, Jemma described the effect on her self-esteem:

P: It's horrible. I don't think you should be labelled as something like that. It's like a horrible tag on you or something.

SG: It's like having a tag?

P: Yes, aha

SG: OK. And what do you feel the impact of this is?

P: Just self-esteem and how she feels about herself and how I feel about myself, you know, as a parent.
(Jemma, 700-706)

The weight category was also seen as objectifying: reducing the person from human to category. For example, Anne noted:

He has become a Government statistic now, when it comes on the news that seventy percent of children under five are overweight. You are like, that's him now, he is one of those statistics.
(Anne, 45-47)

...he is probably on someone's computer somewhere with a big red flag on it.

(Anne, 167-168)

Similarly, participants used phrases which illustrate their view that weight categories contain and single out a person: “*on that pedestal*” (Val, 582)”, “*pigeon holed*” (Anne, 173), “*put in this little box*” (Anne, 173).

Certain images and behaviours associated with these categories were seen as at odds with how participants viewed their child. For example, Jemma described the images that came to her with regard to her daughter being categorised as ‘obese’:

I think, it just comes across as, you know, you’re like a big, a marshmallow man, it makes it sound like she’s massive, [...] she’s not [SG: Mm] a big huge massive girl, and I just hate, hate the word [SG: Mm] it’s a horrible word. (Jemma, 118-120)

...to me it would imply that she was about fifty stone and took up about four chairs when she sat down. Do you know what I mean? Like a huge monster, that’s what it felt like to me. (Jemma, 435-437)

Jemma provided evocative images of the “*marshmallow man*” and “*monster*”, which convey the association between the term ‘obese’ and being grotesque. The marshmallow (a fictional character from the film *Ghostbusters*) is described as “a giant, lumbering paranormal monster” (“Stay Puft Marshmallow Man”, n.d.). Similarly, a monster is a “large, ugly, and frightening imaginary creature; a thing of extraordinary or daunting size” (“Monster”, n.d.). Additionally, Jemma used other words which provide an image of someone at an extreme or unrealistic weight: “*big huge massive*”; “*four chairs*”; and “*fifty stone*”.

For Lucy, her difficulty associating the term ‘obese’ with her child had more to do with associated behaviour than visual size:

It conjures up an image from the media, erm, of a very, very overweight child who does nothing. Especially in childhood obesity - a child who does nothing, who sits and plays video games, or... and eats junk food – that was my perception of an obese child, um, and I didn’t feel any of those stereotypes we fitted into. (Lucy, 229-233)

Participants also revealed the significance of exposure to media sources and stereotypes; making alignment with perceived weight stereotypes was difficult for them:

... if someone was saying that I was overweight it would mean that I don't take care of myself. Particularly, if you are saying a child is, its ultimately down to the parent, erm because the, the children eat what they are given and they do, do what their parents encourage them to do, or bring them places to do. So erm, it's an insult because it says, like, almost you don't care about your child enough to make sure that they are not overweight, erm and that they are well looked after, or that you care enough to, you know, cook them proper meals that are, you know, healthy.

(Marie, 95-102)

The quotation illustrates the felt knock-on effect of having a child categorised as 'overweight' or 'obese'. It suggests that as participants perceived that their child was branded, they felt that they, as parents, were branded too.

Theme 3: Controlled by the 'other'. Participants described feeling controlled by an, often faceless, 'other'. This 'other' took the form of the letter itself, the message contained within the letter, professionals, and their interpretation of wider societal meanings. Often, the 'other' did not allow collaborative communication, and was experienced as disempowering.

The anonymous nature of the phenomenon was illustrated by participants' description of their experience of the programme: none of the participants volunteered that the programme was run by the NCMP; some mentioned the involvement of 'the government', and 'child-related programmes', but most commonly, they used generic words to describe a faceless entity: "*someone*", "*these people*" (Kate, 208).

One powerful 'other' was the letter itself. For example, Val explains that receiving the information by letter affected her experience, even prior to opening it:

*Then I thought, oh God yeah, I've got those letters. I never want to open them.
Because they look so official, I don't want to open them. (Val, 91-93)*

Even the appearance of the letter holds significance for Val. The use of the word "official" suggests that she may associate a degree of 'authority' with the letters, or a powerful 'them'. She does open the letter, but there is a sense of doing something because she feels she should, or needs to, rather than because she wants to or does so entirely willingly.

None of the participants was expecting the weight category ascribed to their child, and for some participants, the letter itself came as a surprise. From the outset, the letter held power: it only allowed one-way communication, meaning that participants did not have the opportunity to engage in dialogue, speak back, or ask questions. This suggests that instead of being a collaborative encounter, the letter was experienced as distant and all-powerful. Marie stated:

In a letter you don't, you don't get the chance to say anything. You are being told something and that's the end of it, accept it. And you know, they've just made it, very much, that's it."

(Marie, 205-207)

You want to get that out, you want to get your, er, point across and you haven't got the opportunity to.

(Marie, 220-222)

Marie's quotations illustrate the power imbalance felt by participants, and a sense of separation between the individual, 'I', and those who sent the letter, 'them'.

Whilst some participants (Kate and Val) actively chose to avoid formally responding to the letter, suggesting that they might have felt disempowered to some degree, others sought contact with someone involved in the programme. Jessica said that she tried to call but "*nobody [was] available*" (Jessica, 330). Jemma was in contact with someone as a result of calling the number in the letter, but her quotations below show that this was not an empowered proactive action:

There was a number on the sheet, and I phoned it up straight away and er, I immediately got an appointment for the dietician thing as I felt that's what was asked of me, and then I cried afterwards cause I was so angry with, with the letter [...] I just cried with anger and annoyance, you know, I thought this was horrible [...] it was put across really, it's like 'advised to' in other words you 'need to' [...] it'd be like if you didn't do it, it would be looked upon as wrong sort of thing.

(Jemma 275-283)

Jemma's quote, especially the phrase “*need to*”, suggests that she felt she had no choice but to make the call. She explained that she made the call before having a chance to experience and communicate her upset and anger, suggesting that the perceived demands of the ‘other’ felt immediate and authoritative. This suggests that she felt both controlled and disempowered.

Jessica explored the impact of feeling that ‘someone’ is dictating how she ‘should’ live in relation to receiving the letter:

... then someone's kind of almost telling you, you are not doing what you should be doing [...] It's like an unwritten rule isn't it [...] you've got someone telling you you're doing something wrong but you know you're not, almost [...] It's horrible, [SG: horrible] again its just that feeling that, you're doing - somebody's making you think you've done something wrong, where actually you haven't. You know you haven't, it's like, you're in control of the situation, and someone else saying, 'no actually, you're not' – its not nice at all...

(Jessica 679-692)

Jessica's quote illustrates a struggle to navigate personal autonomy in a world where she experiences being told she is “*doing something wrong*”. Indeed, her last phrase suggests that although she ‘knows’ she is “*in control*”, she is ultimately left feeling disempowered. In other words, the ‘other’ seems to have the power to have the final say.

Some participants saw receiving the letter as an example of wider societal controls on their children and on themselves. Nula compared the schooling structure to a “*prison*”:

I just thought that like er, like its, its sort of, now its for kids it has become like a prison or I ... what to say ... a restriction, a prison, or like school has become like a prison – it has become a prison like you have to do this that, this that, they do not have any sort of freedom I can say. And they make it so busier these lives. You have to be, it's a competitive world, so you have to do that this, learn this, this. And upon that one [being weighed], this was totally a prison thing actually. (Nula; 107-112)

Additionally, she uses words such as “restriction” and “have to”, and relates this to a lack of “freedom”, suggesting that children (and, consequently, adults including herself) are at the mercy of a structure that has the power to confine, enforce, and control one’s movement and life choices. Her quotation, particularly the phrase “they make it”, suggests that the ‘other’ is experienced as authoritarian.

Participants described feeling a loss of autonomy at the fundamental level of freedom to live their lives how they wanted to without being monitored or directed. The ‘other’ was experienced as Big Brother: “it’s like they’re looking at you” (Jemma, 64); “It’s like you are maybe being watched” (Val, 1011). Jemma explores this more fully when speaking about visiting the dietician with her daughter. She describes being told what actions she ‘should’ take, and the experience of being under surveillance:

P: ...She absolutely hated the dietician experience, you know, being weighed, being measured and having to list everything she ate for a week. It’s about being under surveillance and it’s a horrible time, this went on for about three months, the visits backwards and forwards.

SG: I am interested about the use of the word surveillance. Is that how it felt?

P: Yes, like you are being monitored and [...] surveyed sort of thing, you know. Everything you do is written down and everything you say is written down and it’s not very nice. And it put Molly under pressure as well. Like it was only when we when we moved house and they didn’t have our phone number because we changed it, that we managed to opt out later on because we weren’t enjoying the experience.

(Jemma, 348-356)

Jemma's phrase suggests that they 'escaped' from the experience, and that she previously felt that she and her daughter were caught, and somehow bound to attend. Her use of the words "*surveillance*" and "*monitored*" also suggests that she did not experience autonomy or privacy, but felt controlled and disempowered.

Discussion

The Disempowered Self draws together different aspects of participants' experience of feeling undermined, deprived of power and influence, and controlled. This is illustrated by three themes addressing the experience of being blamed and shamed, judged, and objectified, and controlled by the 'other'. Participants illustrated ways in which they perceived themselves in light of how they believed the all-powerful 'other' viewed them, leading them to be at the mercy of how they believed they were perceived. Thus, the Disempowered Self was a central and pervasive part of participants' experiences of receiving the letter.

The all-powerful 'gaze' of the ubiquitous 'other', and consequences of this gaze on personal freedom, has been discussed by Sartre (1943). He suggested that as we realise we are individuals who are free to objectify others, we realise that others are free to objectify us. According to Sartre, it is this freedom and power that the other holds to objectify us that renders us powerless (and imprisoned) by their 'gaze'. The fear of the gaze of the other weaves its way through numerous interpersonal relationships that participants describe. For example, some participants explained that they set boundaries in order to shield themselves from the gaze of others in case they feel judged. Yet, in doing so, their fears about others' judgements about them are never explored, and continue to live on. The findings highlight a thin line between setting protective boundaries, and creating so much separation between oneself and others that both the fear of others' judgements and the silence itself becomes all-powerful and pervasive. These findings suggest the importance of creating a discourse around being overweight and obesity that is not shadowed by stigma and shame. In turn, considering ways to create community support seems

paramount, empowering people to feel that they can be vulnerable with each other and supported, rather than judged and condemned.

Participants explained how they felt that ascribing their children to BMI categories was objectifying and reductionist. For participants, the all-powerful ‘other’ again seemed to impose unwanted meaning onto them and their child, and the findings suggest that they felt powerless in the face of such ‘branding’. The word obese, in particular, conjured up rich emotive negative meaning and representations. Stigmatised weight meanings and bias are perpetuated through numerous sources (Puhl and Latner, 2007). These include the media, where there are, for example, reports that visual images of obese individuals are more commonly represented in a stigmatised manner (eating, drinking, and not doing exercise) (Heuer et al., 2011). Denzin (1995) noted that “the basic task of the mass media is to make the second-hand world we all live in appear to be natural and visible” (Denzin, 1995, p. 82). Considering the way obese individuals are represented may shed light on reasons why participants felt so adamantly that the BMI categories ascribed to their child were incorrect, and it is possible that until [images of] what constitutes an overweight child is not commonly represented at the extreme end of obesity, and within a stigmatised context, parents will find it difficult to accept that there are weight-related health concerns for their child.

Alongside the distorted visual representation of weight and BMI categories, the media may have a role to play in participants’ experience of being blamed, shamed, having done something wrong, and feeling stigmatised themselves. For example, newspaper articles lead with dramatic headlines, such as “Child obesity: Why do parents let their kids get fat?” (Winterman, 2012). Weight stigma and associated negative meanings are still commonplace, and the impact of this may not be benign. Schvey et al. (2014) found that, regardless of women’s own body weight, exposure to weight stigma can increase levels of the stress hormone cortisol, and have ‘potentially harmful physiological consequences’ (p. 1). Taking all of this into consideration, it seems highly important that researchers continue to explore ways in which weight stigma can be decreased in general. In terms of BMI measurement and feedback programmes, news that could be interpreted as stigmatising must be

delivered sensitively, and in a way that does not increase stigma or put parents (and their children) in positions where they may feel stigmatised themselves.

Fuchs (2002) suggested that shame is “the uncovering of a hidden action, being caught at doing something unseemly, and left unprotected to the eyes of the public” (p. 227), which seems to match participants’ experiences well. This highlights the importance of considering whether it is the BMI categories that cause a sense of shame and, hence, whether they are helpful within the context of concerns about children’s weight. Whilst the news that one’s child is overweight may never be welcomed, the evocation of shame may be particularly unhelpful. In this context, Tangney (Tangney and Dearing, 2002) describes a potentially useful distinction between shame and guilt: “Moderately painful feelings of guilt about specific behaviours motivate people to behave in a moral, caring, social responsible manner. In contrast, intensely painful feelings of shame do *not* appear to steer people in a constructive, moral direction” (p. 2). Additionally, in contrast to the potentially adaptive nature of guilt, Brown (2007) explained that “shame corrodes the very part of us that believes we are capable of change.” (p. 197). Taking a broader view of the NCMP, and considering the intention of the programme to help children avoid the numerous health concerns that are related to being overweight, the impact that the presence of shame may have in stopping intended and desired change is concerning. Considering ways in which shame may be reduced seems highly relevant. Brown (2012) suggested that when personal stories are shared with others who are empathic and understanding, shame ends. This re-emphasises the importance of finding ways to communicate news regarding childhood obesity to parents (and their children) with sensitivity, empathy, compassion, and understanding. Kyle and Puhl (2014) suggested that the use of ‘people-first’ language avoids assigning people an identity based on a chronic disease; so, in the case of obesity, people are not assigned the identity ‘obese’. In their study, Mooney et al. (2010) noted that several parents explained that they would have preferred the letter to omit the phrases ‘overweight’ or ‘very overweight’. Whilst there is an argument that the importance of the message regarding associated risks may be lost if these labels are dropped, it may also be true that the reaction to them ‘distracts’ people from taking the desired action, and may lead to disengagement with the programme.

The findings also highlighted the importance of considering shifting the imbalanced one-way communication by letter to a dialogue that can embody preferred qualities (for example, sensitivity, empathy, compassion, and understanding). Participants felt a degree of power imbalance and being controlled by the other which seemed to contravene their personal freedom. The gaze of the authoritative other was felt strongly, in a seemingly Big Brother punitive manner: *“it’s like they’re looking at you”* (Jemma, 64); *“It’s like you are maybe being watched “* (Val, 1011), *“under surveillance”*. (Jemma, 394). To rectify this, Ryan (2009) argued that BMI surveillance programmes must aim to find the balance between the “advancement of public health and safeguarding individual rights and autonomy” (p. 586). The findings from this study suggest that this balance has been lost. Clearly, receiving a letter with their child’s weight/BMI information prevents parents from gaining any immediate emotional support or further information from a health professional. Yet, this relationship may be particularly meaningful. For example, Mooney et al. (2010) reported that some parents openly rejected the BMI category ascribed to their child as a part of the NCMP based on subsequent conversations with their healthcare providers; and Grimmett et al. (2008) provided an example of one parent who explained that they considered that information about their child’s weight was relevant to their GP alone. In order for healthcare professionals to be empathic, personal, and respectful (Li, 2006), they need to be able to tend to each situation individually, which cannot be done via letter or a standardised approach. The needs and disposition of the individual must be taken into account and responded to sensitively. This may be particularly true when addressing health concerns that are subject to stigma and bias.

Conclusions

Whilst the strength of this study lies in the opportunity to explore the maternal experience of being told one’s child is ‘overweight’ or ‘obese’ as part of the NCMP in depth, one of the most important weaknesses to note is the lack of exploration of the distinction between participants with children in reception year versus year 6. Participants with children in the older age group were harder to recruit (at times due

to the reported request of the child for their mother not to take part). Both this and the differences that emerged through analysis highlight the importance of considering these differences in future research. Older children are far more likely to be aware of and involved in the process of BMI measurement and feedback programmes. How best to support this age group and their parents needs more consideration. It may be more appropriate to feedback results to parents in person where their child is not present so that they can a) discuss any concerns or next steps prior to talking to their child; and b) decide how to share the news with their child in a way that is empathic and sensitive. Whilst this study does not focus on the experiences of children who are being weighed, Jemma's narrative often brought her daughter, metaphorically speaking, 'into the room' during the interview. Whilst it is important to ground insights gained into her daughter's experience with an understanding that Jemma's narrative details her personal perception of her daughter's experiences, Jemma's description of the shame and teasing her daughter experienced does support suggestions (Soto and White, 2010; Nihiser et al., 2007, Grimmett et al., 2008) that it is of the utmost importance to consider the emotional impact on children who are involved in weight-related programmes and interventions. The specific age of children in Year 6 may be particularly relevant in terms of the bodily, psychological, and behavioural changes that occur with puberty (CDC, NHS).

This article has detailed one aspect of the maternal experience of being told one's child is overweight or obese as part of a childhood weight surveillance and feedback programme in the UK. The importance of considering the wider potential psychological impact of such programmes is illuminated, particularly in relation to stigmatised weight meanings and programme delivery and communication. The topic of childhood obesity is undoubtedly complex. Whilst there may be no quick-fix solutions to this multi-faceted modern day phenomenon, this study hoped to both provide insights that may lead to more effective programme development, and give a voice to those who had not been fully represented in prior research.

References

- Brown B (2007) *I thought it was just me (but it isn't): Making the journey from "what will people think?" to "I am enough"*. London: Penguin Books Ltd.
- Brown B (2012) *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead*. London: Penguin Books Ltd.
- Butland B, Jebb S, Kopelman P, McPherson K, Thomas S, Mardell J, and Parry V (2007) *Foresight: Tackling obesities: Future choices – Project Report* (2nd Edition). Report, Government Office for Science, UK. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287937/07-1184x-tackling-obesities-future-choices-report.pdf
- Centers for Disease Control and Prevention. (2014) Middle childhood (9-11 years of age). Available at: [tp://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/middle2.html](http://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/middle2.html) (accessed 1 July 2014).
- Deitz W H, Story M T and Leviton L (2009) Issues and implications of screening and reporting of children's BMI. *Paediatrics*, 124, S98-S101.
- Department of Health. (2011) *Healthy lives, healthy people: A call to action on obesity in England*. Report, Department of Health Publications. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213720/dh_130487.pdf
- Denzin N K (1995) Symbolic Interactionism. In: Flick U, von Kardorff E and Steinke I (eds) *A Companion to Qualitative Research*. (2004) London: Sage Publications Ltd, pp.81-87.
- Fuchs T (2002) The phenomenology of shame, guilt and the body in body dysmorphic disorder and depression. *Journal of Phenomenological Psychology*, 33: 223-243.

- Grimmett C, Croker H, Carnell S and Wardle J (2008) Telling parents their child's weight status: Psychological impact of a weight-screening program. *Paediatrics*, 122: e682-e688.
- Heuer C M, McClure K J and Puhl R M (2011) Obesity stigma in online news: A visual content analysis. *Journal of Health Communication*, 0: 1-12.
- James Li J T C (2006) The quality of caring. *Mayo Clinic Proceedings*, 81(3): 294-296.
- Jebb S A, Rennie K L and Cole T J (2003) Prevalence of overweight and obesity among young people in Great Britain. *Public Health Nutrition*, 7(3): 461-465.
- Keenan J and Stapleton H (2010) Bonny babies? Motherhood and nurturing in the age of obesity. *Health, Risk & Society*, 12(4): 369-383.
- Kokkonen R (2009) The fat child: A sign of 'bad' motherhood? An analysis of explanations for children's fatness on a Finnish website. *Journal of Community & Applied Social Psychology*, 19(5): 336-347.
- Kubik M Y, Fulkerson J A, Story M and Rieland G (2006) Parents of elementary school students weigh in on height, weight, and body mass index screening at school. *Journal of School Health*, 76(10): 496-501.
- Kyle T K and Puhl R M (2014) Putting people first in obesity. *Epidemiology/Genetics*, 0: 1. Available at: http://www.yaleruddcenter.org/resources/upload/docs/what/bias/Putting%20People%20First%20in%20Obesity_Obesity_3.14.pdf
- Mooney A, Statham J, Boddy J and Smith M (2010) *The National Child Measurement Programme: Early experiences of routine feedback to parents of children's height and weight*. Report, Thomas Coram Research Unit, Institute of Education. University of London.
- National Health Service (2009) *NHS Choices: The National Child Measurement Programme*. Available at: <http://www.nhs.uk/Livewell/childhealth1-5/Pages/ChildMeasurement.aspx> (accessed 1 July 2014)

- National Health Service (2012) *Symptoms of puberty*. Available at: <http://www.nhs.uk/Conditions/Puberty/Pages/Symptoms.aspx> (accessed 1 July 2014)
- National Institute for Health and Care Excellence (2006) *CG43: Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children*. NICE guidelines. Available at: <http://www.nice.org.uk/nicemedia/pdf/CG43NICEGuideline.pdf>
- Nihiser A J, Lee S M, Wechsler H, McKenna M, Odom E, Reinold C, ... and Grummer-Strawn L (2007) Body mass index measurements in schools. *Journal of School Health*, 77: 651-671.
- Orwell G (1949) *1984*. London: Secker & Warburg.
- Puhl R M and Latner J D (2007) Stigma, obesity, and the health of the nation's children. *Psychological Bulletin*, 133(4): 557-580.
- Ryan K W (2009) Surveillance, screening, and reporting children's BMI in a school-based setting: A legal perspective. *Paediatrics*, 124: S83-S88.
- Ryley A (2012) *Children's BMI, overweight and obesity*. Report, Health & Social Care Information Centre Publication. Available at: <http://www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch11-Child-BMI.pdf>
- Sartre J (1943) *Being and nothingness*. New York: Gallimard.
- Schvey N A, Purl R M and Brownell K D (2014) The stress of stigma: Exploring the effect of weight stigma on cortisol reactivity. *Psychosomatic Medicine* 76, 00-00. Epub ahead of print January 16 2014. Available at: http://www.yaleruddcenter.org/resources/upload/docs/what/bias/Physiological_Stress_Stigma_PsychosomaticMed_1.14.pdf
- Scientific Advisory Committee on Nutrition and Royal College of Paediatrics and Child Healthy (2012) *Consideration of the issues around the use of BMI centile thresholds for defining underweight, overweight and obesity in children*

aged 2-18 years in the UK. Report. Available at: http://www.sacn.gov.uk/pdfs/sacnrcpch_position_statement_bmi_thresholds.pdf

- Smith J A, Flowers P and Larkin M (2009) *Interpretative phenomenological analysis: Theory, method and research*. London: Sage Publications Ltd.
- Soto C and White J H (2010) School health initiatives and childhood obesity: BMI screening and reporting. *Policy, Politics, & Nursing Practice*, 11(2): 108-114.
- Spruijt-Metz D (2011) Etiology, treatment, and prevention of obesity in childhood and adolescence: A decade in review. *Journal of Research on Adolescence*, 21(1): 129-152.
- Stewart-Brown S and Farmer A (1997) Screening could seriously damage your health: Decisions to screen must take account of the social and psychological costs. *British Medical Journal*, 314: 533-534.
- Tangney J P and Dearing R L (2002) *Shame and guilt*. New York: The Guilford Press.
- Theodore L A, Bray M A and Kehle T J (2009) Introduction to the special issue: Childhood obesity. *Psychology in the Schools*, 46(8): 693-694.
- Warin M, Turner K, Moore V and Davies M (2008) Bodies, mothers and identities: Rethinking obesity and the BMI. *Sociology of Health & Illness*, 30(1): 97-111.
- World Health Organization (n.d.) *Global Strategy on Diet, Physical Activity and Health: Childhood overweight and obesity*. Report, World Health Organization. Available at: <http://www.who.int/dietphysicalactivity/childhood/en/>
- Winterman D (2012) Child obesity: Why do parents let their kids get fat? *BBC News online*, September 26. Available at: <http://www.bbc.co.uk/news/magazine-19661085>

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Appendices – Part B

Appendix 1 – DSM-IV-TR Desk Reference, Trichotillomania

Impulse-Control Disorders Not Elsewhere Classified

321.39

Trichotillomania

Recurrent pulling out of one's hair resulting in noticeable hair loss.

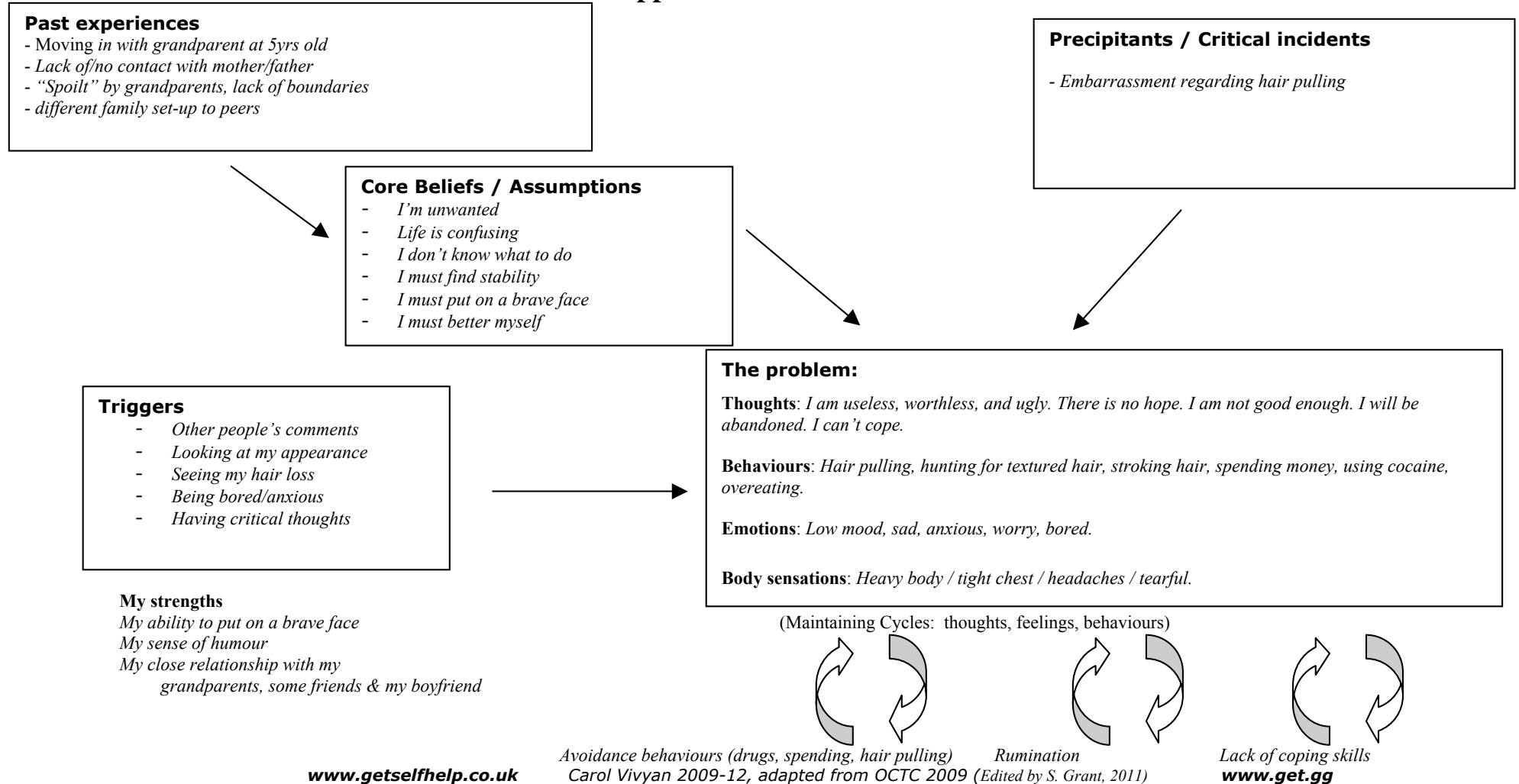
An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behaviour.

Pleasure, gratification, or relief when pulling out the hair.

The disturbance is not better accounted for by any other mental disorder and is not due to a general medical condition (e.g., a dermatological condition).

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix 2 – Client Formulation



Appendix 3 – MGH Hair Pulling Scale

The Massachusetts General Hospital (MGH) Hair Pulling Scale

Subject Number: _____

Date: _____

Instructions: For each question, pick the one statement in that group which best describes your behaviours and/or feelings over the past week. If you have been having ups and downs, try to estimate an average for the past week. Be sure to read all the statements in each group before making your choice.

For the next three questions, rate only the urges to pull your hair.

1. **Frequency of urges.** On an average day, how often did you feel the urge to pull your hair?

- 0 This week I felt no urges to pull my hair.
- 1 This week I felt an **occasional** urge to pull my hair.
- 2 This week I felt an urge to pull my hair **often**.
- 3 This week I felt an urge to pull my hair **very often**.
- 4 This week I felt **near constant** urges to pull my hair.

2. **Intensity of urges.** On an average day, how intense or "strong" were the urges to pull your hair?

- 0 This week I did not feel any urges to pull my hair.
- 1 This week I felt **mild** urges to pull my hair.
- 2 This week I felt **moderate** urges to pull my hair.
- 3 This week I felt **severe** urges to pull my hair.
- 4 This week I felt **extreme** urges to pull my hair.

3. **Ability to control the urges.** On an average day, how much control do you have over the urges to pull your hair?

- 0 This week I could **always** control the urges, or I did not feel any urges to pull my hair.
- 1 This week I was able to distract myself from the urges to pull my hair **most of the time**.
- 2 This week I was able to distract myself from the urges to pull my hair **some of the time**.
- 3 This week I was able to distract myself from the urges to pull my hair **rarely**.
- 4 This week I was **never** able to distract myself from the urges to pull my hair.

For the next three questions, rate only the actual hairpulling.

4. **Frequency of hairpulling.** On an average day, how often did you actually pull your hair?

- 0 This week I did not pull my hair.
- 1 This week I pulled my hair **occasionally**.
- 2 This week I pulled my hair **often**.
- 3 This week I pulled my hair **very often**.
- 4 This week I pulled my hair so often it felt like I was **always** doing it.

5. **Attempts to resist hairpulling.** On an average day, how often did you make an attempt to stop yourself from actually pulling your hair?

- 0 This week I felt no urges to pull my hair.
- 1 This week I tried to resist the urge to pull my hair **almost all of the time**.
- 2 This week I tried to resist the urge to pull my hair **some of the time**.
- 3 This week I tried to resist the urge to pull my hair **rarely**.
- 4 This week I **never** tried to resist the urge to pull my hair.

6. **Control over hairpulling.** On an average day, how often were you successful at actually stopping yourself from pulling your hair?

- 0 This week I did not pull my hair.
- 1 This week I was able to resist pulling my hair **almost all of the time**.
- 2 This week I was able to resist pulling my hair **most of the time**.
- 3 This week I was able to resist pulling my hair **some of the time**.
- 4 This week I was **rarely** able to resist pulling my hair.

For the last question, rate the consequences of your hairpulling.

7. **Associated distress.** Hairpulling can make some people feel moody, "on edge," or sad. During the past week, how uncomfortable did your hairpulling make you feel?

- 0 This week I did not feel uncomfortable about my hairpulling.
- 1 This week I felt **vaguely uncomfortable** about my hairpulling.
- 2 This week I felt **noticeably uncomfortable** about my hairpulling.
- 3 This week I felt **significantly uncomfortable** about my hairpulling.
- 4 This week I felt **intensely uncomfortable** about my hairpulling.

Appendix 4 – Behavioural Experiment Worksheet

Step 1 – Belief or Rule to be tested	
- <i>None of the HRT competing bespoke training will work</i>	
Right now, the strength of this belief is	95
%	
An alternative might be	
- <i>Perhaps they might help</i>	
Strength of this belief is	10
%	
Step 2 – Planning	
The experiments we've agreed:	
<i>Wear a hat in bed</i>	
<i>Wear a hat in the car</i>	
<i>Wet down hair</i>	
<i>Pull dental floss between fingers</i>	
<i>Pull wool between fingers</i>	
<i>Brush hair</i>	
<i>Wear perfume on hands</i>	
<i>Keep a journal</i>	
<i>Use the stress ball</i>	
What do you predict will happen?	
- <i>None of these will make a difference</i>	
Step 3 – Experiment	
Now carry out the experiment and note what happened / what didn't happen	
Step 4 – Debrief	
What happened? Did it fit with your prediction?	
<i>Wearing the hat in bed was annoying and I found it hard to sleep.</i>	
<i>Wetting my hair, pulling wool and wearing perfume didn't help.</i>	
<i>Pulling dental floss between my fingers, keeping a journal, wearing the hat in the car, and using the stress ball did help.</i>	
Re-rate your belief in the original prediction	
10 %	
What can I conclude from this experiment? How can my original belief be modified?	
<i>-Some things did help and some thing didn't help. The more I try, the better equipped I will be to help myself and reduce my hair pulling.</i>	

Appendix 5 – Thought Record (Self-Compassion)

Triggering events, feelings or images	Unhelpful thoughts and images (and their meaning)	Feelings (name the emotion or feeling)	Self-compassionate alternatives to unhelpful thoughts & images	Outcome: Understanding and change in feelings. What I did that helped.
I pulled more hair out this week <i>What, where, when, who with?</i> <i>What actually happened? What was the trigger?</i>	I'm useless. I'll never get better. I shouldn't have pulled. I should be better the whole time. I shouldn't relapse and pull more. <u>If I don't maintain progress all the time, it means I am useless.</u> <i>What went through your mind at that time? What are you thinking about others and what they might be thinking about you? What are you thinking about yourself and your future?</i>	Low, sad, frustrated, ashamed. <i>What are/were your main feelings and emotions at that time?</i>	It has been a difficult week. I felt upset about my medical results. I wanted a hug and to be told it would be ok. It was worrying – I was responding to a real need of mine. My progress cannot be taken away from me. Even if I have 'down days', I have come a long way in therapy. <i>What would you say to a friend in this situation? What would a caring friend say to you about this? Is there another way of looking at this? Is this fact or opinion? What is the evidence for this new perspective? In what way is this an example of self-compassion?</i>	I feel a bit calmer. I still feel sad but more able to deal with the sadness and hopefully do kind things for myself. Maybe I could go dancing with [removed] on Tuesday. I will call and ask after therapy. <i>Write down any change in your feelings, and what you did that helped. (e.g. notice and change focus of attention)</i>

Appendix 6 – Positive Data Log

Evidence or experience that supports: “I am OK as I am”

1	<i>I did well managing my work load this week.</i>
2	<i>[Name removed] told me he loves me.</i>
3	<i>I enjoyed dinner with my grandparents.</i>
4	<i>I went dancing with [name removed] and had a good time.</i>
5	<i>We laughed a lot at dancing.</i>
6	<i>I pulled hair out today but did not get angry. I just listened to myself and saw that I was tired.</i>
7	<i>I had a nice chat with a friend.</i>
8	<i>My boss told me that she was putting me in the new discussion group.</i>
9	<i>I went to the new discussion group and had something to say.</i>
10	<i>I used some CBT skills and felt better.</i>
11	<i>I used the meditation tape today and good that I had done it. I also felt calmer afterwards.</i>

Appendix 7 – Diary of Positive Personal Qualities

Keep a daily log of activities which suggest or confirm your personal positive qualities (personality traits, characteristics, strengths), or times when you've shown or felt a personal positive quality. Write them down! It's easy to dismiss or minimise positives, as we tend to filter out the positives and only notice the negatives. Notice that your mind does that, then write what actually happened.

Examples of personal positive qualities: *kind, gentle, strong, resilient, caring, assertive, hard-working, reliable, honest, practical, responsible, loyal, mature, creative, consistent, appreciative, capable, quick, sensitive, perceptive, patient, thoughtful, fit, trustworthy, shows initiative, motivated, versatile, educated, willing, experienced, efficient, open-minded, logical, serious, supportive, resourceful, realistic, funny, punctual, friendly, humane – and many others!*

Day / Date	What I did	Positive Personal Quality or Qualities <i>What positive quality did I show or feel?</i>
[removed]	I took call at work that were challenging I saw a friend, and made them laugh I talked to a friend who was upset I went to the cinema I went to dance class I started/continued with therapy	Committed, courageous Fun, friendly, sense of humour Kind, caring, good friend Fun Courageous, fun Committed, shows discipline

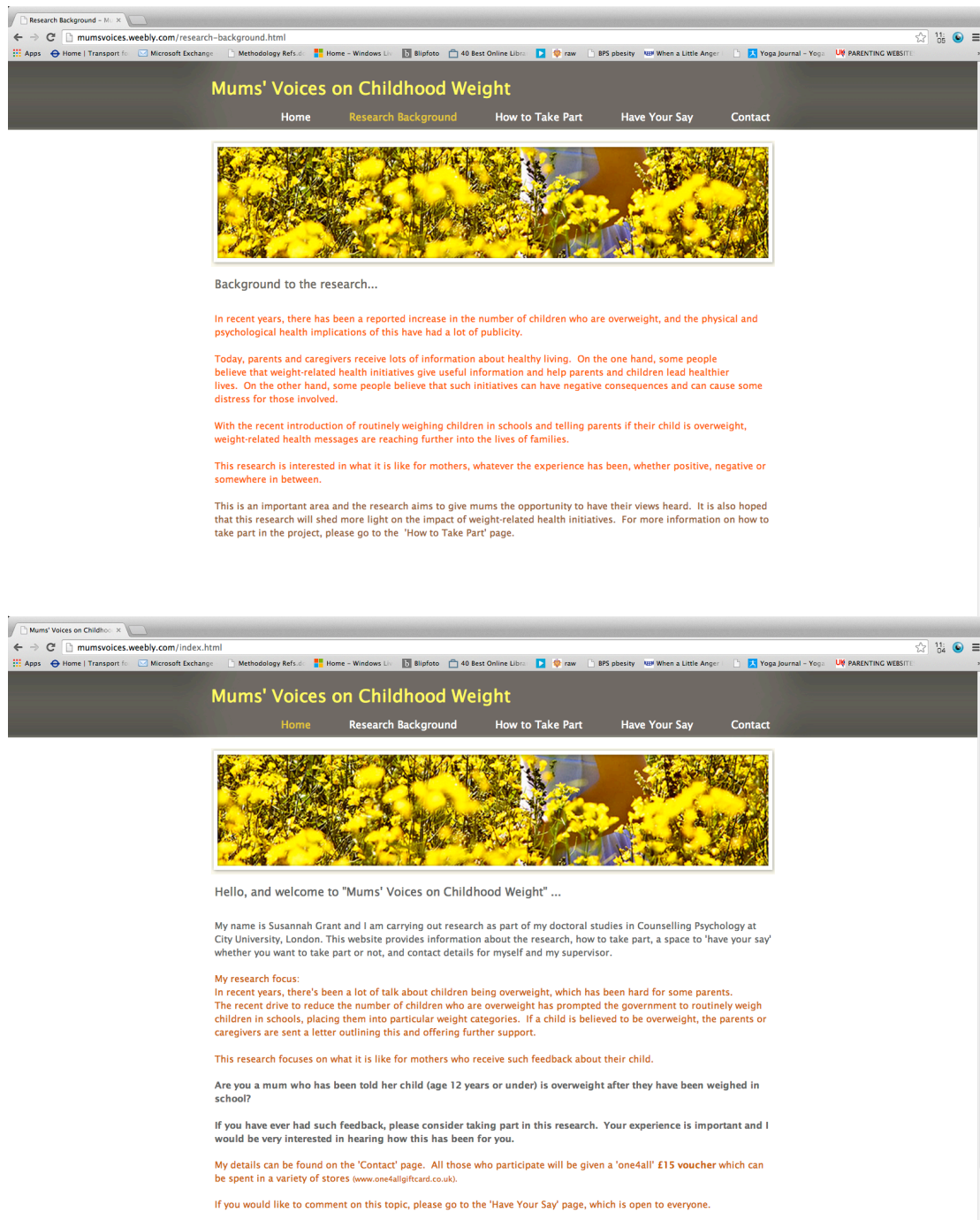
Appendix 8 – Thought Record (7 Columns Version)

Situation / Trigger	Feelings Emotions – (Rate 0 – 100%) Body sensations	Unhelpful Thoughts / Images	Facts that <u>support</u> the unhelpful thought	Facts that provide evidence <u>against</u> the unhelpful thought	Alternative, more realistic and balanced perspective	Outcome Re-rate emotion
Thinking about therapy with Susannah ending \\ <i>What happened? Where? When? Who with? How?</i>	Panic (95%) Upset / sad (95%) Worry (95%) <i>What emotion did I feel at that time? What else? How intense was it? What did I notice in my body? Where did I feel it?</i>	I am not going to be able to cope. I am not going to be able to talk to another therapist. I'm being abandoned again. <i>What went through my mind? What disturbed me? What did those thoughts/images/memories mean to me, or say about me or the situation? What am I responding to? What 'button' is this pressing for me? What would be the worst thing about that, or that could happen?</i>	I haven't coped before when I felt like this. I don't like being open and honest with others about myself. <i>What are the facts? What facts do I have that the unhelpful thought/s are totally true?</i>	I have made BIG progress. I have many more skills than before. I was / am open with Susannah, I can be with someone else. <i>What facts do I have that the unhelpful thought/s are NOT totally true? Is it possible that this is opinion, rather than fact? What have others said about this?</i>	I can cope. It is likely that I will be able to talk to someone else, and build a relationship. <i>STOPPP! Take a breath.... What would someone else say about this situation? What's the bigger picture? Is there another way of seeing it? What advice would I give someone else? Is my reaction in proportion to the actual event? Is this really as important as it seems?</i>	Panic (45%) Sadness (80%) Worry (60%) <i>What am I feeling now? (0-100%) What could I do differently? What would be more effective? Do what works! Act wisely. What will be most helpful for me or the situation? What will the consequences be?</i>

Appendices – Part C

Appendix A – Research Study Website

Details of webpages



How to Take Part - Mums' Voices on Childhood Weight

Home Research Background **How to Take Part** Have Your Say Contact



How to Take Part in the Project...

"Do I fit the criteria to take part?"
If you are a Mum who has been told your child (aged 12 years and under) is overweight after routine weighing, please consider taking part in this research. Start by reading this page and then contact me to express an interest in taking part or for further information (details found on the 'Contact' page).

If you don't fit this criteria, but have something to say about this topic, please feel free to go to the 'Have Your Say' section found on the next page. Or for more information about the project please feel free to contact me (details found on 'Contact' page).

"I fit these criteria - what would be involved?"
After you have expressed your interest in taking part, you will be sent some more information about the research and invited to an interview with me. The interview will take 60-90 minutes and take place at a location convenient to you. Interviews can take place in person, or over Skype. All those who take part in the interview will be given a £15 voucher (www.one4allgiftcard.co.uk).

"If I choose to take part, can I change my mind later on?"
Yes, you are free to withdraw from the research at any time, and any information you have given will not be used.

"Will my identity be protected?"
Yes, you will remain anonymous and your involvement with the research will remain confidential at all times.

"How will the information be used?"
The information will be used in the research only. Names will not be mentioned in connection with any findings.

To find out more or to express an interest in taking part, contact me (details found on the 'Contact' page).

Mums' Voices on Childhood Weight

Home Research Background How to Take Part **Have Your Say** Contact



Have Your Say...
08/25/2011 17 Comments RSS Feed

This research is interested in what it is like for mums when told their child is overweight...

Whether or not you wish to participate in the research, please feel free to leave comments about this topic.
Please note that while these comments are not the focus of the research, comments left will be included in some form. (No identifying information will be included).

[Tweet](#) [Like](#)

17 Comments

Create a free website with weebly

Contact - Mums' Voices on Childhood Weight

mumsvoices.weebly.com/contact.html

Home Research Background How to Take Part Have Your Say Contact



For more information or to express an interest in taking part, please contact....

My details:
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Research Supervisor's details:
 Professor Carla Willig
 City University, London
 Email: c.willig@city.ac.uk
 Telephone: 020 7040 8522

This research forms part of a Professional Doctorate in Counselling Psychology being undertaken at City University, London. It has been approved by the university's ethics committee, and is conducted under professional supervision.

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Have Your Say... - Mums' Voices on Childhood Weight

mumsvoices.weebly.com/1/post/2011/08/mums-being-heard-is-interested-in-what-it-is-like-for-mums-when-told-their-child-is-overweight.html#comments

Comments

09/20/2011 04:45

When I had My first child, she was a very hungry baby and was breastfed, but after 10 weeks of continually being attached to my breast and very tired I had to start weaning her to give me some timeout! My Daughter was diagnosed with sleep apnoea and about 6 months and I was told this was because she was over weight despite being only 6 months old, she was always a very very healthy eater eating only fresh fruit and veg and having more than her five a day (she still like this!) She was never slow at developing, but I was told to put her on a strict diet and water all her milk down when she was put on formula and was given a limit as to how much she could have. It was a strain on me when she was 9 months old and I returned to work as I could not always be certain if someone had given her the correct amount of food and milk on her allowance. I can tell you that she has lost weight now and alot of it, she is a very tall and slim 4 year old who weighs 2.5 stone and is in 4-5 clothing due to her height, but they are far to big around the waist band. She will now only drink water, she is very way of how much she eats and I regret the doctors ever making a decision to cut out dairy and put her on a diet! She will eat plain bread with water, not nice to see your child choose such a bland food source, but what can I do? I also have a son who is very big for his age he is not quite 2 but wears 3-4 clothing and is very chunky, but this is due to his intake of steroids for asthma, and yes I have already had the doctors and health visitor tell me to cut out foods ect, but you want to know what, I am not and that is my choice as a good mother!

Reply

09/20/2011 05:17

I would definitely like to! My daughter is so thin yet she was given borderline overweight!! I was furious, she is now so picky with food and I do worry it's cos of that! She is way above average for her height. There is just NO way she can be anywhere near overweight!

Reply

09/20/2011 05:19

To be honest, I have found the opposite in regard to my 7 year old son. He has always been above average height and weight for his age and it has been a struggle to get any help. The health visitors and school nurses I have been in contact with always said it was puppy fat and nothing to worry about. When he was 5 and weighing 5 stone I took him to the doctor and asked for a dietician referral. I got one but she wasn't much use either. She said he was large for his age but should just make him eat less and move more! I feel that some professionals are just trying to be politically correct and skirt round the issue. I have looked it up on child weight charts and my son is classed as obese, but no professional I came into contact with has referred to him as such. I am currently trying to restrict his diet a bit, but without him noticing too much as I don't want him to get a complex about being overweight at such a young age, and he has lost a few pounds recently, and will hopefully lose a bit more as he now weighs 6 stone at age 7, and I wouldn't like to think he will weigh the same as his age in the future.

Reply

09/20/2011 05:49

Have Your Say... - Mumt... x

mumsvoices.weebly.com/1/post/2011/08/mums-being-heard-is-interested-in-what-it-is-like-for-mums-when-told-their-child-is-overweight.html#comments

11:06

Apps Home | Transport | Microsoft Exchange | Methodology Refs | Home - Windows | Blipfoto | 40 Best Online Libr... | raw | BPS pbesity | When a Little Anger | Yoga Journal - Yog... | PARENTING WEBSITE

09/20/2011 05:49

I am definitely interested in participating in your research. I have received a letter in the last week informing me that my 11 year old daughter is overweight. However, she was weighed at school prior to her 11th birthday in around January time. Firstly, I was appalled that the letter had been sent through the post for the attention of the 'parents of K F'. What concerned me the most was that my daughter could have opened the letter herself and read the diagnosis that she is overweight. What damage could that have done and what if she had then chosen to hide the letter from us? She would have been left to deal with such information on her own. The leaflet that was provided on healthy eating I found very patronising. I am more than aware of what constitutes a healthy diet and really don't need any interference from anyone who doesn't even know my daughter. As I've mentioned previously, my daughter is 11 years old and was the tallest child in her class at Primary School. She is an active child who can be quite fussy about what she eats. There is no denying that she is 'solid' as I would describe her, although I wouldn't share that information with her. I can't ever imagine her being thin as that is not her genetic make up. However, she is healthy and that to me is what really matters. I am particularly sensitive to such matters as I have suffered with anorexia nervosa in the past, something which I do not want any of my children to experience.

Thanks
Denise

Reply

09/20/2011 06:14

My 2nd daughter has always been an ideal weight, never thin and never chubby (thankfully she didn't inherit my genes!) When she was in Reception class, she was weighed by the school nurse. I was then sent a letter saying she was "OBESE". She was 1lb over their 'normal' weight chart. I told them... Jesus, she can poo a pound!!!! I don't know what chart they were reading from but it wasn't in line with my doctor or health visitor,

Reply

09/20/2011 06:41

Hi, my son has a blood disorder and has 6 monthly check ups with a paediatric consultant. On our last visit we had a new consultant who told me (in front of my 3 year old son) that he was obese and also I could do with losing weight too! At first I was raging, but later, thinking about it I realized that because of his disorder, I'd been compensating with chocolate and sweets. My son will not eat chips, burgers, chicken nuggets or anything like that but he does love toast and cheese. He is a really fussy eater and normally has casseroles or lasagne or some type of meat and veg which I thought was healthy. Anyway, it was a wake up call and we are all trying to be more conscious of what we eat and how much physical activity we do.

Reply

09/20/2011 07:56

My son is 5. Last year half way through reception I had a letter saying that my son was over weight. I was soo upset and angry!. He is quite small for his age he was 4 and a half and wore 3-4 yr clothes. But he is a heavy boy. Lots of ppl say he should play rugby! Lol He is an extremely fussy eater but also very active and outgoing so I know lack of exercise isn't an issue! He is a heavy boy but in no way is it due to his diet.

Reply

Have Your Say... - Mumt... x

mumsvoices.weebly.com/1/post/2011/08/mums-being-heard-is-interested-in-what-it-is-like-for-mums-when-told-their-child-is-overweight.html#comments

11:06

Apps Home | Transport | Microsoft Exchange | Methodology Refs | Home - Windows | Blipfoto | 40 Best Online Libr... | raw | BPS pbesity | When a Little Anger | Yoga Journal - Yog... | PARENTING WEBSITE

09/20/2011 07:16

Hi everyone, I just thought I would share my experiences with children being weighed in schools, my son is 5 and is of perfect weight according to the letter we had home after he had his height and weight checked in reception. However since then with all the constant talk about getting fat, eating healthy and getting lots of exercise my son has now developed a phobia of food and is not eating properly at all, he has become very thin and is now underweight, he is very pale and is complaining that he is tired all the time. It has become a vicious circle, he won't eat because he thinks he will get fat, so he gets tired and has no energy to do his after school sports clubs, which he used to really enjoy, so thinks he is going to get fat because he doesn't exercise!!!! At mealtime every mouthful is a struggle but we are slowly managing to get a little bit more in, we are just trying not to make a big deal of it and not focus on what he is eating at the table, we just ignore him (which sounds awful I know) but it seems to be slowly working because we are not watching every mouthful he seems more comfortable, he sometimes will eat his dinner in another room which I don't like but as long as he is eating I don't care where he sits. I just wish that people who make up all these rulings really thought about the long term affects on children and their families and allow children to be children.

Reply

09/21/2011 04:02

My daughter was weighed in reception class. she was right at the top of normal weight. both she and her elder sister are short for their age but did 7 1/2 hours of gymnastics a week plus the usual running around, pe, ballet etc so they are both muscular. I still felt worried though.

I have always struggled with my weight so I am constantly worrying about then becoming overweight but also about making them obsessive! we eat healthily as a family but I still see them drawn to unhealthy rubbish if they had the chance. I just try to make them realise the consequences of what they eat and train them to make healthy choices but it's hard, I know the pull of cake too!

Reply

09/21/2011 12:12

my family are nearly grown now but my observations of overweight children is this. I am slim and my husband is not. He has struggled with his weight all his life. We have four children. The eldest is overweight and always has been. The next is slim, the next normal and the youngest tiny. Just like all their behaviours they unconsciously decide to copy different aspects of mine and my husbands behaviour. My youngest who is 13 has just been weighed at her school And been told she is underweight. This causes problems as she thinks she is odd even though she eats well. Kids need good examples (which is difficult as we are all imperfect) and positive messages. If they love themselves and accept themselves they will get healthy in their own time. Just like my eldest who is learning to be good to herself.

Reply

10/08/2011 14:11

We have two children in primary school. Our son was part of the screening programme in reception and our daughter will be measured later in the year. Luckily he was within the "normal" limits, so my viewpoint will probably less emotive than someone who's child has been labelled overweight.

Have Your Say... - Mums' - x

mumsvoices.weebly.com/1/post/2011/08/mums-being-heard-is-interested-in-what-it-is-like-for-mums-when-told-their-child-is-overweight.html#comments

10/08/2011 14:11

We have two children in primary school. Our son was part of the screening programme in reception and our daughter will be measured later in the year. Luckily he was within the "normal" limits, so my viewpoint will probably less emotive than someone who's child has been labelled overweight.

I feel that this screening programme is beneficial as a public health strategy in reception children as long as the parent carries the responsibility of weight management as calorie reduction can be undertaken unbeknown to the child at this age and need not be a burden for the child.

With regard to older children, I guess this is much harder psychologically for both parent and child, therefore highlighting the importance of monitoring in early years, by competent, consistent and knowledgeable professionals.

Our son has always been a fussy eater, though tall and chunky and the attention he managed to gain through eating/not eating - positive or negative was phenomenal. Therefore, like one of the other ladies said, we now remove his plate at the end of meal times, full or not. If he doesn't eat it, he certainly does his next meal. He seems to respond well to this boundary.

Our daughter on the other hand has a really healthy attitude to food, which could be attributed to many variables. E.g. personality, the fact she went to nursery rather than a childminder, we didn't have time to pander to her needs as much as her brother, we were more confident...who knows?

I was a pretty fat child, rewarded with sweets and food for good behaviour. When my parents split up, again given food for emotional comfort. I am aware it is different for everyone but for me, looking at my relationship with food allowed me to avoid carrying on this cycle.

Interesting research, I look forward to reading it when it is published!

10/08/2011 19:26

While I had two healthy children well within the healthy weight range, I have seen as a high school teacher those students who are not a healthy weight. Those students do not seem to be concerned, which makes me think that perhaps their parents are not concerned. Over-weight is a slow killer, putting stress on all the organs. An American nutritionist named Dr. Joel Fuhrman books Eat to Live and Eat for Health are excellent resources for any parent who wants to start making changes of their children's eating habits as well as their own. The task of changing the way we look at food and eat food is the beginning of the reversal of poor health.

10/11/2011 17:28

Wow, these comments are really interesting to me - as far as I'm aware we don't do weigh-ins in school here in Canada, and anyway my sons aren't school-aged. But when my son was 18 months I was told he was falling off his growth curves and given a very stern talking to at the Drs. It was so stressful, scary, and depressing. Food is such an emotional issue.

As a parent, to get a letter simply saying my child is overweight would make me so embarrassed and upset! Those feelings of upset would likely result in negative behaviours - one of which would almost certainly be eating, including with my child.

On the other hand, if the letter came with information - and maybe incentives - about local sports amenities, e.g. cycle tracks, swimming pools, badminton courts, toy libraries, walks, parks, art or drama activities - with positive information about attractive things to do that don't involve eating, I might be able to refocus my attention re what to do with my child.

Many years ago an anti-graffiti campaign was piloted in Liverpool - which resulted in more local graffiti purely because all it focused on was the graffiti.

"Don't eat sweets, they aren't good for you", is apparently not heard as a complete message. Only the word "sweets" creates a picture in the mind - being the only concrete concept in the sentence, and the only one the mind can therefore make a picture of - resulting in behaviour related to sweets (eating them!).

So what I'd experienced as a "kicking off" wouldn't change my behaviour - it would still focus my mind on my food and my child's food. Whereas invitations to enjoyable local activities that increase the metabolic rate and general health of my child might be more effective.

Good luck with this important research. I hope lots of mums join in, sounds really worth it.

11/08/2011 15:52

My daughter was told she was overweight. We had a letter from the local school nurse which stated she was two pounds over the normal weight. It was an upsetting year as she was about to start her periods and it made her very insecure. The letter was sent with no guidance to help us as her parents to address the issue. My daughter started to miss meals and exercise too much. She is a healthy size 8 and it has took over 2 years for us to build up her confidence and self esteem.

02/22/2012 14:52

Having started out as a big baby (10lbs 8oz) I have known my son would always hover around the top centiles on his charts. When I took my son for a weigh-in around his 1st birthday, as requested by my health visitor, I was told he was too heavy having gone out of the "grey shaded area" and was advised to control his diet. I was fuming, he was a big baby and wasn't likely to just "shrink". He was suffering with a lot of mucus (in nose and ears) so I asked how could I help it and soya was suggested, which the health visitor added would help stabilize his weight. I took him back at 2 and I was told he's doing well and it's good to see him back within the top centile. I mentioned his soya diet must have helped and the health visitor said "Diet? you don't need to diet a baby!" (so I was fuming again!) He recently started school and, although he likes to hop on the scales at home and I take a quick peek, I was dreading the letter home. I didn't need to as it was fine, his weight is nearing the top of his graph (95th centile) and his height is about 34 of the way up (75th centile) and I was told he's fine. I do however think sometimes it's based on "postal codes" with regards to weight/height correlation, I'm sure some place would say "weight: 95th centile, height: 75th centile = obese".

Appendix B – On-Line Recruitment Material

In recent years, there has been a lot of talk about children being overweight. This has been difficult for many parents. Today, children are being routinely weighed, and parents are told if their child is overweight. I am interested in what this is like for mothers.

- Are you the mother of a child under 12 years old?**
- Have you been told this child is overweight?**

If you answered yes to these questions, I would like to hear from you.

This is your opportunity to have your voice heard, and add value to new research.

£15 voucher reward for participating

For more information or to express an interest in participating, please contact me at: [REDACTED] or on [contact number].

Appendix C – Paper Recruitment Material


**CITY UNIVERSITY
LONDON**

Research approved by City University ethics board, and conducted under professional supervision

In recent years, there has been a lot of talk about children being overweight, which has been hard for some parents. Today, children are being weighed in school and feedback is sent to parents. This research focuses on what this is like for mothers.

Are you a mum who has been told that your child (age 12 or under) is overweight, after being weighed in school?

If you answer yes, please consider taking part in this research. Your experience is important and I would be very interested in hearing how this has been for you. All those who take part will be given a £15 voucher (www.one4allgiftcard.co.uk).

To find out more and to take part, contact: Telephone/text: [REDACTED]
Email: [REDACTED] Website: www.mumsvoices.weebly.com

Website: www.mumsvoices.weebly.com Email: Susannah.grant.1@city.ac.uk Telephone: 07925 843719	Website: www.mumsvoices.weebly.com Email: Susannah.grant.1@city.ac.uk Telephone: 07925 843719	Website: www.mumsvoices.weebly.com Email: Susannah.grant.1@city.ac.uk Telephone: 07925 843719	Website: www.mumsvoices.weebly.com Email: Susannah.grant.1@city.ac.uk Telephone: 07925 843719
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Appendix D – Initial Contact: Invitation To Participate, Participant Information Sheet & Participant Consent Form

[Date]

Research project

**Counselling Psychology Doctorate Research
Project**

Researcher: Susannah Grant

Email: [REDACTED]

Telephone: [REDACTED]

Research Supervisor: Professor Carla Willig

Address:

City University

Northampton Square

London EC1V 0HB

“Mums Voices of Childhood Weight” ~ Understanding the Maternal Experience of being told your Child is Overweight

Dear [Name],

Thank you for your interest in finding out more about taking part in this research.

This research focuses on what it is like for mothers when they are told that their child (age 12 years or under) is overweight after routine weighing in school. The aim of the research is to gain an understanding of what this experience is like for mothers.

Your involvement would require you to participate in one interview lasting approximately 60 minutes. During the interview you would be invited to share about your experiences. The interview would take place at a location that is convenient to you, on a day and time agreed between you and the researcher.

All participants will be given a £15 voucher (www.one4allgiftcard.co.uk) as a gesture of thanks for taking part.

Along with this letter please find attached an (1) **information sheet** that provides you with more information about the research being conducted and a (2) **consent form** for you to look through. If you are happy, after reading this, to take part in the research, you will need to sign the consent form before interviews can go ahead. This can be done at the time of the interview.

Thank you very much for your time and consideration in taking part. I look forward to hearing from you soon.

Kind Regards,

Susannah Grant

Researcher: Susannah Grant (City University London)

Information sheet

I would like to invite you to be interviewed about what it was like for you to be told that your child (age 12 years and under) was overweight after being weighed in school.

This information sheet provides further details about the research. Please take your time to read the information below.

Counselling Psychology Doctorate Research

Project

Researcher: Susannah Grant

Email: [REDACTED]

Telephone: [REDACTED]

Research Supervisor: Professor Carla Willig

Address:

City University
Northampton Square
London EC1V 0HB

What is the study?

- I am interviewing mothers who have been told their child (age 12 years or under) is overweight after being weighed in school.
- I hope that this research will allow an understanding of how this phenomenon is experienced by mothers, and that it will be taken into consideration as such initiatives are adapted / taken forward.

Do I have to take part?

- If you are happy to take part, you will be asked to sign a consent form but you are not obliged to take part if you do not feel comfortable to do so.
- Once giving your consent, you still have the right to withdraw at any point in the research, and you will not have to provide any reason for doing so.

What will I have to do if I agree to take part?

- If you are happy to participate you will be interviewed about what it was like to be told that your child was overweight.
- At the start of the interview you will be asked to read and sign a consent form to show that you understand what is involved in the research and are happy to take part. The whole experience should last approximately 60-90 minutes and will take place at a location convenient for you. The interview will be tape-recorded and later transcribed for use in the research analysis.
- The consent form will ask you to consent to the interview being recorded.

Confidentiality?

Only I, the researcher, will have access to any data collected, which will be kept on a password-restricted computer. I may have to share some of the data with my research supervisor, who will also be bound by confidentiality. In the write up of this research, quotations may be included but your identity will not be revealed. I will make every attempt to anonymise wherever possible. Your information will not be passed on and will not be used irresponsibly. Data will be kept securely for up to five years after research completion, after which it will be destroyed.

Advantages and Disadvantages?

Advantages: All interviews will be included in the research, and through taking part you will have the opportunity to have your experience heard. I hope that I will be able to share results with relevant parties, and those implementing such health initiatives, so that the findings may be taken into consideration moving forward.

Disadvantages: While it is not intended, recalling your experiences may make you feel some uncomfortable emotions. Should you feel any discomfort at any time during the interview, you are free to withdraw from the research. You also have the right to only answer questions during the interview that you feel comfortable answering.

What happens after the research is completed?

I will be happy to share the results of the research with you once it is completed, please let me know if you would like summary of the findings. The data from this research will be used in my doctoral thesis and viva, and academic research papers and conferences. In this way, the results of this study can be shared with those interested in how this phenomenon is experienced by mothers.

Review and Ethics Approval

This research has been reviewed by my research supervisor, Professor Carla Willig, who can be contacted by email: [REDACTED]; or telephone: [REDACTED]

The research has also passed the City University, London Ethics Review Process.

If I want to take part, what do I do next?

If you are happy to take part after reading the above information, please contact me on [REDACTED] or at [REDACTED] and I will get in contact with you to arrange a mutually convenient time for us to meet. If there is anything else you would like to discuss or any problems or worries, please do not hesitate to contact me or my supervisor.

Interview Consent Form

“Mums Voices of Childhood Weight” ~ Understanding the Maternal Experience of being told your Child is Overweight

Date of interview:

Please tick each box if you are happy to take part in this research

1. I confirm that I have read and understood the information sheet for the above study, that I fit the participant criteria outlined, and that I have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and I can withdraw at any time I feel the need to, without having to give a reason to the researcher. ☐

3. I am happy for the researcher to interview me to explore what it was like for me to be told my child was overweight. ☐

4. I am happy for the interview to be audio-recorded and I am aware that the recording will be retained for the write up and transcribed by the researcher. I understand the data will be destroyed 5 years after the research is completed. ☐

5. I understand and am happy with the confidentiality aspects of the study, and the use of anonymised quotes in the write up of this research. ☐

6. I agree to take part in the above research study. ☐

Name : _____ Signature: _____

Date: ____/____/____

Researcher : _____ Signature: _____

Date: ____/____/____

Appendix E – Participant Debriefing Form

Participant Debriefing Form

Understanding the Maternal Experience of being told your Child is Overweight

Thank you for participating in this research interview. Please read the information below and ask me any further question you might have.

Purpose of the study

The purpose of this study was to gain an understanding what it is like for mothers when they are told their child is overweight after they have been weighed in school.

Background to the study

Previous research has suggested that there might be some negative impact of increased focus on weight. With the recent introduction of weighing children in schools, there is currently a gap in the research that considers what this experience is like for mothers. This research aims to shed light on this area, and give a voice to mothers' experiences of this phenomenon.

Confidentiality

As stated in the Participant Information Sheet and Consent Form, your identity will remain confidential, and all identifiable details will be removed from the final write up of the findings. This will remain the case where anonymised quotes are used and if the findings of the study are published.

Final Report

If you are interested in obtaining a copy of the final report of this study, please feel free to contact me using the details below.

Further Information

After participating in this research some participants may decide that they wish to seek further information or support, or pursue psychotherapy to have the opportunity to discuss their experiences in more detail.

A list of psychotherapists can be found via the British Association for Counselling and Psychotherapy:

Website: <http://www.bacp.co.uk/>

Telephone number: 01455 883300.

A list of chartered psychologists can be found via the British Psychological Society:

Website: <http://www.bps.org.uk/e-services/find-a-psychologist/>.

Telephone number: 0116 254 9568

The Samaritans provides confidential non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair:

Website: <http://www.samaritans.org/>

Telephone Number: 08457 90 90 90

Websites for mothers / parents:

Mumsnet: <http://www.mumsnet.com/>

Netmums: <http://www.netmums.com/>

Only Mums (focus on single parenting): <http://www.onlymums.org/>

Parents Online: <http://www.parents.org.uk/>

UK Parents Lounge: <http://www.ukparentslounge.com/>

Family Lives: <http://familylives.org.uk/about>

Advisory Centre for Education: <http://www.ace-ed.org.uk/>

Contact

If you have any questions regarding this study, please feel free to contact me at:

██████████ or on: ██████████.

You may also contact my supervisor Carla Willig at: ██████████ or on:

██████████

**Thank you for your participation in this study, your time and efforts
are much appreciated.**

Appendix F – Transcript, Analysis Notes & Emerging Themes Excerpt for Jemma

Emergent themes	Line No.	Transcript	Analysis Notes
<i>Felt responsibility / blame</i>	218	P: I think it is like <u>put down to me</u> , and obviously I know she aware of her weight, you know,	'Down to me' - personal responsibility; 'obviously' - indicates close relationship?
	219	compared to other people, so I <u>try</u> and you know, just <u>do what I can for her</u> , and just um, I know it	'Try' - sense of attempting without always succeeding?
	220	must <u>still be in her head to have kept the letter</u> , cause I <u>found it the other day in one of her books it</u>	Letter is physically still in her life; sense of split experience/ ownership between self and daughter;
	221	<u>was still in there, shut, she didn't want anyone to see it</u> [SG: mm] - she didn't want her dad to see the	'Still' - sense of suspension of time; daughters desire for privacy /shame
	222	letter, didn't want my husband to see it, [SG: mm] cause I have remarried again (laughs)... [SG: yes] she didn't	
	223	want him to see it, she was really self conscious of this letter, <u>it was only me and her that was allowed</u>	Indicative of close relationship between self and daughter; secrecy/shame; at the mercy of daughter's wishes
<i>Shared secrecy, close bond</i>	224	<u>to read it, nobody else, not her brother, none of her friends could know...</u>	Shared secret, a bond between self and daughter, but separating between us and the world/others - impact of this on self/daily life?
	225	SG: So this is something that you two have shared, this experience [P: Yeah] of actually getting the letter	
	226	[P: mm hm] reading it and seeing it [yeah mm hm] ... and how do you feel, I know you have touched on	
	227	some of this, but how do you feel that has been, you know, that very...	
	228	P: Yes very ... I know, <u>I know</u> it's still there in her bedroom in a book, where, where she's put it, and	
	229	it <u>still makes me angry, and it still makes me cross and it still makes me annoyed.</u>	Repetition of 'still' - stuck within the experience/ stuck emotions/ over years
<i>Temporal aspect, changes (or lack)</i>	230	SG: What do you think when you think I'm angry and I'm annoyed?	
	231	P: <u>Just I just don't think it should have been done in the first place really. I just don't think there was</u>	Wanting to push experience away/wishing it didn't occur? Possibly indicative of anger, sense of 'it should not have happened'
	232	<u>a need [mm], you know, its quite damaging I think...</u>	'Damaging' - to be injured or harmed - powerful word evoking
<i>Over time</i>			

			<i>sense of being attacked</i>
<i>Psychological impact/ impact on self esteem</i>	233	SG: What does the word “damaging” mean to you in this context?	
	234	P: Just erm, to with her <u>self esteem</u> I think, you know the way she feels about herself [yeah], you	<i>Impact of self esteem of daughter and self - implies that she feels it has a negative impact</i>
	235	know, and the <u>way I feel about myself.</u>	
<i>Morality; good vs. bad/ right vs.</i>	236	SG: Tell me more about how you feel?	
<i>Wrong, extremes</i>	237	P: I just er, just feel like I’ve <u>obviously ... perhaps I’ve done something wrong</u> you know to, <u>to make</u>	<i>‘Wrong’ - moral, to be judged, bad; ‘make’ - at fault, responsible</i>
	238	<u>her this way and [mm], you know, its in our family that we are all, we are not “Skinny Minnies”</u>	<i>Family script; ‘skinny minnies’ - language used to compare to extremes</i>
	239	<u>(laughs) you know, we [yeah] are not gonna be like stick thin you know, it runs through the family, and</u>	<i>‘Laughs’ - indicating felt absurdity? Another sense of stuckness / this is the way it is</i>
	240	<u>we joke about having the... the bum, (laughs) you know, but that’s the way we are in our family so</u>	
	241	<u>she’s not ever going to be super skinny and Molly knows that you know, but she says she does</u>	
	242	<u>know, that she’s different, you know...</u>	<i>‘Different’ - narrative suggests being overweight is different, separating from others</i>
	243	SG: So it feels different somehow?	
	244	P: Yeah, she knows, she’s not, you know she’ll say oh I hate my tummy, I hate my legs, does my bum	<i>What is it like to hear daughter ‘hate’ body?</i>
<i>Role: protector, supporter</i>	245	look big in this and <u>I tell her big bums are in fashion now, so you don’t need to worry about that</u>	<i>Proactively trying to support/counteract daughter’s feelings about her body through new narrative about body representations</i>
	246	(laughs).	
	247	SG: I know I am asking a lot of similar questions, but when you hear her saying all this things, that	
	248	could be negative about herself [yes, uh huh], how do you feel as a mum?	
<i>Maternal hopes for child</i>	249	P: Well I <u>don’t like to hear her talking bad about herself</u> you know cause she’s a happy girl, she’s erm,	<i>‘I don’t like’ - is it more than this? ; ‘bad’ - negative associations, meaning associated with body/weight/ bad vs. good</i>
	250	she’s like 13 going on 20 [SG: yeah] she’s so mature you know in her emotions, the way she talks and she	
<i>Protector, supporter,</i>	251	writes and you know, she’s, she’s <u>got a heart of gold</u> , so <u>I try and say to her</u> you know it’s not about	<i>Trying to bring other qualities to the foreground aside from weight</i>
<i>Emotional nurturing</i>	252	<u>what you look like, it’s the person you are inside and I think she gets that [SG: mm] you know but I think</u>	<i>Supporting daughter to create new meanings associated with body weight and self esteem</i>

Emotional nurturing	253	<u>she just like to wear some of the same things as her friends do.</u>	<i>'Positives' - wanting to support, emotionally protect daughter, reframe meanings in order to allow daughter to thrive</i>
	254	SG: So you are trying to offer a different perspective?	
	255	P: Yes, yeah often just seeing herself as this... big person, and 'I'm rubbish', I try to give her the	
	256	<u>positives you know, on herself.</u>	
One-to-one connections, bond	257	SG: How do you mediate doing that in yourself?	<i>'Rare' - indicative of busy life? Although transcript highlights closeness of the bond, and shared experience, 'rare' indicates Time alone in private is not often - this seems slightly contradictory? Repetition of 'little' - short, brief? 'Catch up' 'chat' - give sense of informal nature of connection 'Girlie' - sense of being young?; 'dragged away' - wanting to be there longer? / At the mercy of others?</i>
	258	P: I just like, <u>try and sit her down</u> and ... <u>its very rare we get a moment together</u> [yeah] we just like, I	
	259	<u>could be, normally I'm like, she's got Justin Bieber blaring out in her bedroom (laughs), and I'm sitting</u>	
	260	<u>on her bed and we just have a little catch up and you know, just have a little chat which are just little</u>	
Multiple pulls on self	261	<u>girlie moments</u> before <u>I'm dragged away somewhere else</u> , you know, just to see how she's feeling and,	<i>Wanting to be available to daughter/ holding space to hear daughter / desire to support</i>
	262	you know, she wants to ask me anything and, you know, we can have a <u>little chat</u> and she might tell	
	263	me something's happened at school or you know she might say oh there was an issue about school	
	264	<u>trousers, and I got her these trousers and the school were saying that they were too tight and she said</u>	
Protector	265	<u>her friends all wear a certain sort of trousers cause there legs are skinny and she has to wear these</u>	<i>Proactive, protection, 'tiger mum' Win against school; sense of power relations Protective 'Chubby' - softer language use for 'fat'/overweight, more endearing; pause indicative of? Is it hard to say/find the word 'chubby'? Try and do what I can and help' - desire to help/support/be there</i>
	266	<u>ones they've got like lycra in [ok] cause her legs are chunky she says... and so I just wrote a letter to</u>	
	267	<u>the school you know and I said Molly has to wear these type of trousers so they have left it for now</u>	
	268	that she can wear them, but it's like another issue or <u>not fitting in sort of thing</u> , she cant wear just the	
Complex emotional initial response	269	normal trousers cause her legs <u>are... chubby</u> and obviously they don't look right in these trousers, so	<i>Physically throwing items - indicative of anger?; 'cried' 'annoyed' - indicative of complex reaction, multiple emotions</i>
	270	its for her comfort as well. [SG: mm] <u>I just try and do what I can and help her out in any way that I can for</u>	
	271	her.	
	272	SG: So going back to when you said you felt different emotions, so you felt upset and then other times	
	273	you felt more angry and annoyed. When you were feeling upset, how did that show itself?	
	274	P: <u>Through um, I've, throwing things around, or through, I think I cried as well, I was so annoyed, er, I</u>	

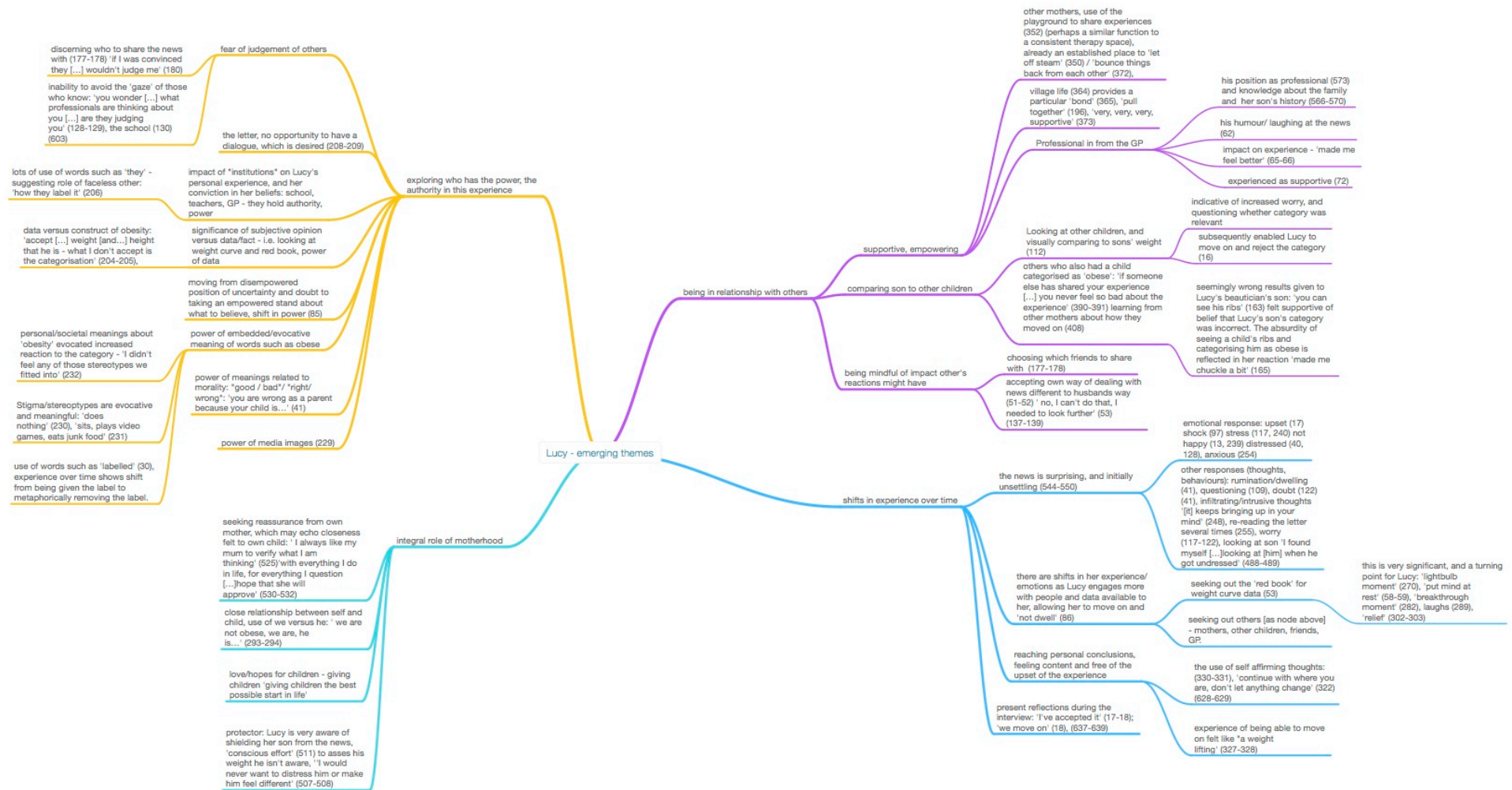
Disempowered/ overpowered	275	<u>phoned, there was a number on the sheet, and I phoned it up straight away and er, I immediately got</u>	<i>felt</i>
	276	<u>an appointment for the dietician thing as I felt that's what was asked of me, and then I cried</u>	<i>Proactive behaviour; sense of urgency/ immediacy</i>
	277	<u>afterwards cause I was so angry with, with the letter.</u>	<i>'Felt that's what was asked of me' - sense of feeling powerless; at the mercy of another's demands</i>
	278	SG: So you felt that was what was being asked.	<i>Sense of delayed reaction</i>
	279	P: And then emotions come second and then I just <u>cried with anger and annoyance</u> , you know, I	<i>Sense of complex emotions - crying and anger.</i>
	280	thought this was horrible.	<i>'Horrible' - unpleasant, dreadful, unwanted, negative</i>
	281	SG: What was the feeling like to feel something was asked of you?	
Overpowered	282	P: Just how it was put across really, it's like <u>'advised to' in other words you 'need to'</u> [need to] sort of	<i>Demanded of</i>
Judged, condemned as 'wrong'	283	thing you know, it'd be like if you didn't do it, it would be looked upon as <u>wrong</u> sort of thing	<i>'Wrong' - moral, to be judged, bad - abilities as mother in question - what is this like?</i>
	284	SG: And then after, so you made the phone call, and then after you had some tears	
	285	P: Mm hm	
	286	SG: Where you on your own at that point?	
	287	P: Um, when Molly brought the letter home it was just like me and Molly and I think her brother	
Sharing with family	288	was upstairs, and then <u>I showed my husband when he came home.</u> He felt the same as well, he felt	<i>Sharing with husband - sharing experience with another adult, possibility of support for self rather than providing support for daughter?</i>
	289	<u>annoyed you know of what it said and I phoned my mum as well and told her and she was just the</u>	<i>Shared experience with husband - what is this like? Supportive to self? Uniting? Empowering? - Impact on experience of relationship with others?</i>
	290	<u>same opinion as me really, she was annoyed and...</u>	<i>Shared opinion with own mother - reassurance? Potential role of own mother to offer support?</i>
Reassurance	291	SG: Do you remember what she said?	
	292	P: She just said oh that's <u>awful, that's disgusting</u> , I think was her words, she's not obese, she was really	<i>Awful', 'disgusting' - powerful, emotive language.</i>
	293	<u>offended by the word you know, 'she's not obese, how can they say that?'</u> you know, she's	<i>Impact of rejection of letter/label by own mother?</i>
	294	overweight but not obese, not chubby, I think Molly said one of her, her teachers daughter got a	
	295	similar letter saying her child was very overweight, and her child was just erm, like tall and big boned,	<i>'Tall', 'big boned' – seems more neutral language use. What does this indicate about embedded meaning in language related to weight?</i>

<i>Shared experience, camaraderie</i>	296	she wasn't er overweight and it upset like her teacher as well, she felt the same as what I did, we were	<i>Shared experience of upset - validating?</i> <i>Recent chat - letter was received over a year ago, and talked about recently.</i> <i>Shared experience - validating?</i> <i>Wrong' - anger at wording, 'obese' - experience becomes about wording rather than any potential health concerns</i> <i>Good' - positive, 'same' - sense of unity</i> <i>Positive impact of shared experience, verbally exploring experience with another</i> <i>Emphatic</i> <i>Alone, separated, odd one out</i> <i>Opposite of 'perfect' - my daughter is imperfect; secrecy, silence, lack of communicating, lack of relatedness, Lack of being in relationship with others regarding phenomena</i> <i>Taboo'- 'prescribed by society as improper on unacceptable', unspoken. What does this say about her experience? What does this say about the collective experience as she experiences it? 'Nobody' - Sense of absolute silence.</i> <i>Secrecy. Do her words imply she considers what others have got, and how they compare with her letter? Sense of shared shame. 'Shoved it in a book' - hidden, held between pages, captured, kept.</i> <i>Her daughter is leading the way on ownership of the letter</i>
	297	<u>having this kind of chat a couple of weeks ago.</u>	
	298	SG: You and the teacher?	
	299	P: Yeah and she felt the same way, its how it comes across,' how its worded, which I think is just	
	300	wrong.	
<i>Shared opinion, camaraderie</i>	301	SG: So how was it to be able to talk to another mother who had also experienced it?	
	302	P: It was good, yes. Someone of the <u>same opinion</u> , then you know it's not just one person feeling like	
	303	that, somebody else <u>agrees with you and you can talk it over with somebody else.</u> I think that helps,	
	304	yes.	
	305	SG: So was there a sense of feeling that you weren't on your own?	
<i>Being overweight = negative frame</i>	306	P: Yes, aha, definitely	
	307	SG: And was that in contrast to before you had spoken to her did you feel?	
	308	P: Yes, I thought well maybe <u>it's just me.</u> It's just like a one off and everyone else's got, their	
	309	daughters are <u>perfect</u> , you know. Because <u>no-one tells you what the letters say you know,</u>	
	310	beforehand.	
<i>Taboo / shame</i>	311	SG: yeah	
	312	P: Yes, it's like a <u>taboo subject</u> . No-one will say I have got a letter and my daughter was so and so.	
	313	They wont ... Nobody speaks about it.	
	314	SG: OK, so it felt taboo?	
	315	P: Yes. You wouldn't get another parent come up to you and say oh guess what my letter said. No	
<i>Secrecy; shared experience</i>	316	one spoke about it, so <u>you had no idea what anybody else had you know.</u> So just as I said it was just	
	317	between me and Molly at first and she shoved it in a book and didn't want anyone to know. She is	
<i>Hiding ourselves/shame</i>	318	quite a <u>secretive</u> sort of person and doesn't like people knowing things about her.	

<i>Secrecy, power of silence</i> <i>Power of group</i> <i>Long lasting, ripple of experience</i> <i>Distinguishing boundaries of who to share with</i>	319	SG: Do you remember what, if at all, was there an experience of being with other mothers and not	<i>despite it being addressed to her - what does this say about her experience?</i> <i>Seems she is in part led by her daughter, that the lines are blurred in terms of who has ownership of the letter. [This is markedly different to participants with younger children - mothering a twelve year old]</i> <i>She seems to experience a conflict between the known shared experience amongst her peers, and her experience of her communication (or lack) between her peers.</i> <i>Why is this 'obvious'? This seems indicative of the power of silence, and of group communication, or the consensus. It is possible that she wants to say something but feels she can't.</i> <i>The topic is unique in it's felt taboo nature</i> <i>Rumination, long term impact of experience, annoyance</i> <i>Sharing with close family, but not other mums - this may be significant in terms of camaraderie that is possible when sharing with others going through similar situations to oneself i.e. mum-to-mum.</i> <i>Is this significant in that the only professional encounter was negative?</i>
	320	knowing what they had got?	
	321	P: Yes, definitely	
	322	SG: And how did that work?	
	323	P: Well, obviously we all know that these letters have come out, and you just like, <u>nobody mentioned</u>	
	324	it to another parent. No-one mentioned the subject and it wasn't brought up in conversation, you	
	325	know, and I just. Then obviously you <u>feel like you can't talk to anybody else</u> because no-one has	
	326	mentioned it, so therefore you don't say anything. You know, it's like a taboo subject.	
	327	SG: Were you aware of the subject even though you weren't talking about it to other mothers?	
	328	P: Yeah, definitely, yeah.	
	329	SG: Would you say you were thinking about it?	
	330	P: Oh yes, definitely, yes I was thinking about it for <u>ages afterwards</u> . It was <u>annoying me that much</u> ,	
	331	but <u>obviously nobody was talking about</u> it at the school and the playground or anywhere. So you...	
	332	SG: OK. So it was on your mind, but you weren't able to talk about it to anyone?	
	333	P: Yes. Obviously to my husband, to Molly's dad, Molly and my mum and obviously the	
	334	dietician later on. That's the only people we have spoken to about it.	
	335	SG: I, I remember you mentioned something about it being in black and white and being told by the	
	336	professionals [yeah] somehow and the dietician as well [yeah], I am guessing. How do you think that, I	
	337	suppose, the formality and that relationship felt, does that makes sense?	

Overpowered by authority	338	P: Yeah, um. As I say it is just as if you are expected to do it. It is just the way it is put on you like this	<i>'Expected', impact of the language and wording of the letter is evident. Power held by the letter.</i> <i>'Have got to' - there is no option, sense of being at the mercy of another's direction.</i> <i>'Obligated' - commanded, lacking power, overpowered by the other.</i> <i>Pulled between felt demands of the letter, and wants of daughter. Sense of being in the middle, trying to mediate the situation, to make it work.</i>
Pull between different demands/	339	is what is recommended and we are like reading it and feel well <u>maybe this is what I have got to do</u>	
	340	and you feel obliged to take them up. I did make Molly an appointment for this fitness thing, but	
Wants	341	she was dead against it: 'I definitely don't want to do it'. So, <u>I even said about her brother coming along</u>	
	342	so it's not quite so it's all about her sort of thing, it's for both of them. But she just said, 'no I don't	
All powerful 'Big Brother'	343	<u>want to do it'. So I had to phone up and cancel the place because she was so dead against it and I</u>	
	344	<u>thought 'I am not going to force her into doing something she doesn't want to do'. So we didn't go to</u>	<i>'Had to' - sense of lack of choice?</i> <i>'Force' - does this echo her own experience, feeling forced to make the appointment? She is able to protect her daughter from being 'forced'</i> <i>In a way that she was not protected.</i> <i>'Hated' - powerful, emotive word.</i> <i>Surveillance - Big Brother, being watched, monitored</i> <i>Backwards and forwards' suggests a sense of continual torture? Going back to somewhere that is experienced as 'horrible'. Additionally</i> <i>Provides insight into logistical drain, and time expended.</i> <i>Language suggests clinical feel - 'monitored', 'surveyed' - or sense of being observed, which implies one need observing</i> <i>'Written down' - again, clinical feel, 'gazed' upon by others. How does this leave one feeling? Does she experience being under scrutiny</i> <i>Indicative of her views of her daughter's psychological world.</i> <i>'Managed to opt out' - sense of escaping.</i>
	345	<u>that.</u>	
	346	SG: It sounds like on the one hand you have got what feels like people telling you what to do and on	
	347	the other hand you have got your daughter who you don't want to force into doing anything.	
	348	P: Yes that's right. She absolutely <u>hated</u> the dietician experience, you know, being weighed, being	
	349	measured and having to list everything she ate for a week. It's about being <u>under surveillance</u> and it's	
	350	<u>a horrible time, this went on for about three months, the visits backwards and forwards.</u>	
	351	SG: I am interested about the use of the word surveillance. Is that how it felt?	
	352	P: Yes, like you are being <u>monitored and you know</u> . You know, just being <u>monitored and surveyed</u>	
	353	sort of thing, you know. <u>Everything you do is written down and everything you say is written down</u>	
	354	and it's not very nice. And it put Molly under pressure as well. Like it was only when we when we	
	355	moved house and they didn't have our phone number because we changed it, that we managed to	
	356	<u>opt out later on because we weren't enjoying the experience.</u>	

Appendix G – Mindmap of Emergent Themes for Lucy



Appendix H – Table of Master Themes and Constituent Themes with Representative Participant Quotes

Master theme	Constituent theme with representative quotation
<i>The Impacted Self</i>	Being shocked and surprised: experiencing the unexpected: <i>“it’s just like wow. What do you say to reading something like that?” (Val)</i>
<i>The Impacted Self</i>	Uncertainty and fragility: questioning, ruminating and worrying: <i>“I tried to not think about it, but you can’t help it [...] and then you start to question yourself” (Maria)</i>
<i>The Impacted Self</i>	Evolving and emerging: rejecting, accepting, moving on and remaining stuck: <i>“I put the letter to the back of my mind, and – I think I just forgot about it and thought ‘move on with life’” (Lucy)</i>
<i>The Disempowered Self</i>	Being judged: experiencing blame and shame: <i>“[it’s] the culmination that ‘well actually I’m a bad mum’” (Jessica)</i>
<i>The Disempowered Self</i>	Branded child, branded self: being reduced to a label: <i>“It’s like a horrible tag on you or something”. (Jemma)</i>
<i>The Disempowered Self</i>	Being controlled by ‘them’: being deprived of personal power and authority: <i>“this was totally a prison thing” (Nula)</i>
<i>The Mother Self</i>	Protecting and nurturing: being responsible for the care of your child: <i>“when people say things like I would kill for my kids, you know where they are coming from” (Anne)</i>
<i>The Mother Self</i>	Connected to your child: being biologically bonded and a role model in their development: <i>“you go from being the picture to being the frame around the picture when you become a mum” (Kate)</i>
<i>The Mother Self</i>	Navigating the complexities of motherhood: Juggling multiple ‘pulls’ and demands: <i>“you don’t get a manual as a parent” (Jessica)</i>

