

PARENTS' EXPERIENCES OF SEEKING HEALTH CARE FOR THEIR
CHILDREN WHO ARE OVERWEIGHT OR OBÈSE

By

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ABSTRACT

PARENTS' EXPERIENCES OF SEEKING HEALTH SERVICES FOR THEIR CHILDREN WHO ARE OVERWEIGHT OR OBESE

As the prevalence of childhood overweight and obesity increases, more parents will likely look to health care providers for information, support, guidance and referral to appropriate services to help them manage their children's overweight condition. Little is known about parents' experiences of having overweight children and their interactions and experiences with Canadian health care professionals. This study addresses a gap in the literature. Awareness of parental experiences is an important aspect of childhood obesity prevention and treatment.

Using interpretive description as the methodology for this study, ten parents were interviewed about their experiences of seeking health care for a child who was overweight or obese. Parents' experiences with nurses, physicians and dietitians, were reported. Interviews were audio taped, transcribed and the transcripts served as the source documents for the study. Inductive logic was used throughout the data collection and analytic process.

Findings from this study revealed that parents weighed a number of number factors before seeking professional help. They reported a high level of dissatisfaction with health care providers' services and a lack of resources and supports in the community. Parents entered consultations with doctors, dietitians and nurses with knowledge about nutrition and exercise that, for the most part, was not augmented by their encounters with health care providers. Advice tended to be simplistic and did not take into account the challenges faced by parents in enacting this advice in the context of the family. Concerns about damage to children's self esteem resulting from treatment

strategies and victimization by peers, family members and others ranked high among parental concerns. As health care experts look for ways to control the growing epidemic of childhood obesity, knowledge of parents' experiences with seeking and receiving help to manage their children's weight may provide important information to consider in the planning and delivery of nursing and other health care services.

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CHAPTER ONE: INTRODUCTION

Background

The prevalence of childhood obesity has been increasing in recent decades in Canada, the United States and worldwide (Chinn & Rona, 2001; Janssen et al., 2005; Plodkowski, 2005; Troiano & Flegal, 1998). A recent systematic review comparing estimates of the prevalence of overweight and obesity in school aged youth from 34 (primarily European) countries revealed that Canadian youth ranked fourth highest on the obesity scale with a prevalence rate of 4.1% (Janssen et al., 2005). Only Malta, the United States, Wales and Greenland rated higher. The National Longitudinal Survey of Children and Youth revealed that over one third of Canadian children aged two to 11 were overweight in 1998/99 and of these about half could be considered obese (Statistics Canada, 2002). Youth overweight and obesity rates vary within the country with the highest rates tending to be in the Atlantic Provinces. According to the 2004 Canadian Community Health Survey: Nutrition, the prevalence rate for combined overweight and obesity in two to 17 year olds in British Columbia was 28% with 7% of that representing obesity (Shields, 2005). An adolescent health survey of grade seven to 12 students in British Columbia showed that while about three quarters of youth weigh what is considered an average amount for their age, gender, and height, about half were dissatisfied with their weight (The McCreary Centre Society, 2002). About 23 % of males and 41% of females considered themselves overweight.

Obesity has been termed one of the most common metabolic and nutritional disorders in youth (Dietz, 1986). Researchers in the field of obesity and diabetes have referred to obesity as gateway disease that often leads to diabetes and cardiovascular

disease (Plodkowski, 2005). In this study obesity is conceptualized as a chronic health condition that may be associated with the risk of developing co-morbidities. Research suggests that obese children are at an increased risk of developing a number of physical ailments such as hypertension, dyslipidemia, impaired glucose tolerance and sleep apnea (Dietz, 1998). Only about one-third of adult obesity begins in childhood. However, there is evidence to suggest that obesity that begins in childhood is more severe than obesity that begins in adulthood and carries increased risk of adult disease (Dietz, 1999). Frequently, children and adolescents also endure teasing, discrimination and victimization at a rate higher than that of their leaner peers (Must & Strauss, 1999). It has become increasingly evident that children who are overweight and obese are at significant risk for physical and emotional harm as a result of their condition.

Two systematic reviews undertaken to examine the evidence for prevention and treatment interventions for obesity have concluded that there are few good quality studies (Campbell, Waters, O'Meara, Kelly, & Summerbell, 2004; Summerbell et al., 2004). Findings from these reviews suggest that reductions in sedentary behaviors, parental involvement and behavioral therapy may be beneficial; however, there is a lack of clear evidence on which to base practice. Much of the literature refers to weight loss programs involving groups receiving lifestyle interventions (dietary, physical activity and/or behavioral therapy interventions). While some programs have led to weight loss during intensive treatment, only a few studies have demonstrated a long term weight loss maintenance effect (Epstein, 1995; Epstein, Valoski, Kalarchian, & McCurley, 1995). Wooley (1995) notes that one can easily find treatment programs targeted at the same population delivering diametrically opposed advice, one urging children to attend more

carefully to diet and activity and the other urging decreased concern. The latter advice is based on the belief that it is possible to prevent obesity without encouraging weight preoccupation. Childhood weight management programs represent only one approach to treatment. Support for family-based nutrition and behavior-management programs is often lacking and access to programs may be limited (Daniels et al., 2005). Weight management advice is more commonly provided by individual health care providers or by teams of health professionals such as those in tertiary care facilities. Daniels et al. (2005) note that, with its emphasis on acute short term intervention, contemporary care delivery is often not well suited to meeting the long term needs of overweight children and their families.

While there are clinical guidelines to support the identification, evaluation and treatment of overweight and obesity in adults there are no such evidence based guidelines for children, only recommendations (National Institutes for Health, 1998). In the absence of high quality, randomized trials and observational studies, some national bodies such as the Institute of Medicine of the National Academies, have adopted a position that the best available evidence should be used rather than waiting for the best possible evidence to address reductions in obesity prevalence (Koplan, Liverman, & Kraak, 2005). The BC Healthy Living Alliance, whose membership includes the Heart and Stroke Foundation, Canadian Cancer Society, Canadian Diabetes Association, Dietitians of Canada, Public Health Association of BC and BC Pediatric Society recently released a report entitled *The Winning Legacy: A Plan for Improving the Health of British Columbians by 2010* that focused on risk factor intervention (Kruger, 2005). The report recommends increased involvement of parents in influencing children and modeling healthy diet and activity

levels as an effective intervention for obesity control. The Centers for Disease Control (CDC) recommends early treatment, involvement of the family and the institution of permanent changes in physical activity and diet in a stepwise manner. Parenting skills are considered the foundation for successful intervention. Furthermore, the CDC recommends that management of childhood obesity requires individualized recommendations that take into account the family's readiness for change, family support, financial concerns, and neighborhood characteristics including access to play areas and grocery stores (Centers for Disease Control and Prevention, 2004). Unless the family situation is fully understood by the health provider, recommendations for change may not be targeted appropriately. The rationale for viewing parenting skills as foundational to the success of intervention is presented below.

Parents are generally seen to have a profound influence on their children by promoting certain values and attitudes, by reinforcing certain behaviors and by serving as role models (Koplan et al., 2005). Families are vital components of the social environment within which children learn and practice health-related behaviors. The ecological systems theory model proposes that children and youth are being primarily influenced by the family especially in the younger years (Koplan et al., 2005). According to this model other micro-environments such as school, neighborhood, work place also have important impacts on individual and family functioning. Parenting, in turn, is influenced by economic, political, social and physical macro-environments as well as by socioeconomic status, parental goals, personal resources and child characteristics. Cultural norms are also important influences on the family (Koplan et al., 2005).

Food related parenting such as the choice of infant feeding methods, timing of the introduction of solid foods, parental modeling of eating behaviors, food restriction or pressure to eat may affect food preferences and self-regulation of intake (Ventura, Savage, May, & Birch, 2005). Food restriction by parents, that is, controlling the amount or type of food consumed by a child, may lead to a disruption of the ability to self-regulate (Fisher & Birch, 1999). Food is often categorized according to a good or bad dichotomy, with “good” foods being good for health and “bad” foods being bad for health (Rozin, Ashmore, & Markwith, 1996). Food foods are often seen as having qualities such as nutrient completeness and low caloric load. Rozin et al. (1996) suggest that people may hold what they called a dose-insensitive view about the risks that certain foods pose, i.e. if a food is harmful in large amounts, it is also harmful in small amounts. Parents, out of concern for their children may restrict access to certain foods as a means to decrease intake of “bad” foods regardless of their weight status. Maternal restriction has been shown to increase girls’ snack food intake, with higher levels of restriction predicting higher levels of snack food intake (Fisher & Birch, 1999). Parental pressure to eat certain foods, such as those that they consider to be healthy, may decrease children’s preference for the food (Ventura et al., 2005). Frequently, parents use both strategies although thinner children are more likely to be pressured to eat and overweight children tend to elicit higher levels of parental restriction (Fisher, Mitchell, Smiciklas-Wright, & Birch, 2002). Parental preferences and consumption of certain foods may also be an indication of the foods that are available for their children, influencing the foods that children are more likely to accept (Birch, 1999). Thus food modeling may lead to the development of healthful or unhealthful eating behaviors in their children.

There are numerous pressures on families that can adversely affect their ability to provide an environment conducive to healthy lifestyles (Koplan et al., 2005). The frequent need for parents to work long hours has made it more difficult to spend time in playing with and supervising children and to prepare home cooked meals. Work, which often involves multiple jobs, inflexible hours and night work, is perceived by some as representing a barrier to meeting food choice ideals (Devine, Connor, Sobal, & Bisogni, 2003). For some parents, ideals and values related to food choice and health may be balanced against other values for family closeness and nurturing and personal achievement (Devine et al., 2003). With the majority of parents in the workforce, many children are unsupervised during the interval between school dismissal and when their parents come home from work (Smith, 1997). Such unsupervised time may allow children to make unhealthy food and activity choices (Koplan et al., 2005). Economic constraints may make healthful eating and increased physical activity difficult (Devine et al., 2003). The foregoing itemization of pressures on the family that mitigate against healthy lifestyles is by no means complete but serves to illustrate the complexities and challenges faced by parents.

Parents, in their caregiver role of managing the health of their children who are overweight, are frequently frustrated by their interactions with health professionals (Edmunds, 2005). Help commonly consists of advice to eat healthily, exercise more and undergo testing (Edmunds, 2005). Many parents feel that health care professionals do not know how to address the management of childhood obesity (Edmunds, 2005). Correspondingly, a significant number of health providers have admitted to self-perceived low proficiency in the use of behavioral management strategies, guidance in

parenting techniques and addressing family conflicts when dealing with childhood overweight and obesity (Storey et al., 2002). A survey of physicians conducted by Jelalian (2003) revealed that one fourth of physicians thought that they were not at all or only slightly competent when addressing obesity, while 20% reported feeling not at all or only slightly comfortable. The combined effect of the lack of strong evidence based guidelines for the treatment of childhood obesity, the low weight loss maintenance effect, the conflicting messages sent to parents about how to address this condition and the low skill level of some health care practitioners may contribute to parents' dissatisfaction with services that they receive. Families and children frequently receive weight management advice, that in order to have any effect, must be translated into behavioral changes. These changes take place in the context of numerous personal and environmental challenges to healthy lifestyles as outlined in the foregoing discussion of pressures on the family which mitigate against healthy lifestyles. The body of literature investigating the experiences of parents in this context is limited.

In the course of my practice as a public health nurse I have repeatedly received phone calls from the public, primarily mothers, who have inquired about the availability of health care resources to help them deal with concerns about their children's excess weight. Public health nurses are not experts in the treatment of childhood overweight or obesity. O'Dea (2004) points out that health professionals and health educators involved in the prevention of child obesity need to understand the difference between treatment and prevention. The author maintains that the treatment of child obesity should only occur in a supervised clinical setting after appropriate clinical assessment. Community based professionals must refer to the appropriate professionals such as pediatricians,

general practitioner, dietitian or other clinically trained staff (O'Dea, 2004). Community dietitians generally do not provide individual counseling. Their focus is on population based education activities including support for public health nurse activities. Many of the outpatient dietary programs do not deal with childhood obesity. Outpatient dietitians may suggest contacting the pediatric tertiary care centre's endocrinology department for assistance. However, this centre does not have a specific program to address childhood obesity. Moreover, travel to the centre to obtain health care services constitutes a hardship for many parents in outlying communities.

The consensus reached at the recent Childhood Obesity Forum held in Vancouver, B.C. was that obesity assessment and treatment centers should be set up based on best practice models to help children and their families to access effective treatment, programs and counseling (Childhood Obesity Foundation, 2005). Anecdotal evidence suggests that the current system is under resourced and fragmented (Childhood Obesity Foundation, 2005). Best practice in the area of childhood obesity is evolving. Nursing research and knowledge development in this area can make a significant contribution to the determination of best practice standards.

The Family-Centered Care philosophy, adopted by many health care organizations and professionals, recognizes and promotes parents as being instrumental in the care of their children. Seeking health care consumers' input is congruent with the principles of primary health care (PHC) and the chronic care model (CCM). Both PHC and CCM are the current focus of interest by the BC Ministry of Health Services and the regional health authorities in their quest for better solutions to dealing with the problems posed by chronic conditions, including obesity (BC Health Services, 2003). As members

of the health care team, parents' perspectives need to be taken into account; perspectives relating to the quality and utility of support, identification of barriers to accessing services and the impacts on their children, their families and themselves.

The Context of Seeking Health Care for a Child's Obesity

There are a number of discourses on obesity, both in the public and private domains, that influence parents' experiences in seeking health care for a child's obesity or overweight condition. Lawrence (2003) describes three current discourses on obesity. The biological discourse posits that obesity is a health problem that can be understood and potentially cured by science. It emphasizes impersonal causes and locates causality at the molecular level (Lawrence, 2003). A second discourse is that obesity is a problem of individual behavior. This discourse views obesity as being caused by individual choice and therefore can be solved by individual choice. Within this discourse there is little role for government other than ensuring that people have good information about the products that they consume. The environmental discourse places individual choice in a larger context including environmental and policy choices. Many public health experts have adopted this lens where the primary focus is shifted away from personal responsibility and individual choice towards an examination of corporate and government practices and the role of the environment. An example of the environmental discourse is that the fast food industry's marketing practices is partially responsible for the obesity epidemic. In this view the industry is responsible for having flooded highways, schools, and malls with fast food while at the same time heavily advertising and promoting their products in the media. Lawrence notes that public health problems become amenable to

policy solutions when they can be framed in terms of involuntary risk, universal risk, environmental risk and knowingly created risk.

It is beyond the scope of this paper to examine each of these discourses in depth, however, elements can be seen at work in the definitions of obesity as outlined in the literature review, and in the current approaches to obesity treatment and prevention. As Lawrence notes, there are competing ways in which the problem of obesity is framed in the medical, pharmaceutical and public policy arenas. Increasingly, however, the literature on this topic reflects a growing understanding by different interest groups that these separate and distinct discourses cannot provide direction for finding effective solutions to the problem of childhood obesity. Treatment and prevention of childhood obesity require a multi-level approach leading to a broad range of strategies to produce an environment that supports individuals in healthy eating and physical activity (Ball & McCargar, 2003). Such an approach requires research and knowledge development from different disciplines, co-operation and the sharing of information to address this complex issue.

An understanding of childhood obesity that acknowledges the multi-causal nature of this health condition has implications for nursing research and practice. Nurses have a role in promoting healthy environments and in supporting individuals and families in their efforts to maintain and improve health. As outlined above, parents are increasingly recognized as being pivotal in influencing outcomes related to the prevention and management of childhood obesity. Gaining an understanding of factors that influence their experiences in seeking health care may assist us to find better ways to support them on both the environmental (which includes the health care system) and family level.

Problem Statement

Research in the domain of childhood obesity has focused primarily on demographics, epidemiology, etiology, diagnosis, treatment and the social impacts. Parental experiences in seeking and obtaining health services and resources for their children who are overweight have rarely been sought (Edmunds, 2005). If there is an expectation that parents manage their children's overweight condition, then we need to know what they need in terms of support or services. Gaps exist in our understanding of how parents experience seeking and receiving (or not receiving) care for their children who are overweight or obese in the publicly funded British Columbia health care system. Gaining an understanding of parents' experiences assists us in developing health services that are appropriately targeted to this group of health care consumers.

Purpose of the Study

The purpose of this qualitative study is to explore parents' experiences of seeking health care services and/or resources to assist them in managing their child's obesity and to identify contextual factors influencing those experiences. The goal is to obtain this understanding from the client's perspective, also known as the emic perspective (Morse, 1995). As health experts increasingly look for ways to control the growing epidemic of childhood obesity, knowledge of parents' experiences with seeking and receiving help to manage their children's weight may provide important information to consider in the planning and delivery of nursing and other health care services.

Research Questions

1. What are the experiences of parents seeking health services for their children who are overweight or obese?

2. What are the contextual factors influencing parents' experiences in seeking health services?

Definition of Terms

For the purposes of this study, terms are defined as follows:

OVERWEIGHT: An excess of body fat. With reference to inclusion criteria for the study, overweight was determined by parents; no measurement of weight or height was performed.

OBESITY: Obesity is classified as a chronic health condition.

PARENT: The biological or adoptive mother or father of a child.

CHRONIC HEALTH CONDITON: A medical condition which requires long term monitoring, treatment and/or care.

Assumptions

The study was founded on the assumptions that:

1. Parents in the study were knowledgeable about their child's overweight condition.
2. Parents were willing and able to communicate their experiences of seeking health care to the researcher.
3. The researcher had a commitment to enter into and understand participants' viewpoints (Streubert Speziale & Rinaldi Carpenter, 2003).

Significance of the Study

Nurses are increasingly utilizing evidence-based knowledge to support their clinical decision making and practice. Evidence-based practice as defined by Sackett, Strauss, Richardson, Rosenberg and Haynes (2000) is the integration of the best research evidence with clinical expertise and patient values. Patient values, according to these

a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient. Gaining an understanding of these preferences, concerns and expectations may lead to improved communication between health providers and patients which may, in turn, lead to better health outcomes. Skilled communication between professionals and clients involves a complex interplay between substance and process, what we communicate and how we do it (Thorne, 2002). Establishing positive relationships between parents and health professionals is likely to be a critical feature of successful child weight management (Edmunds, 2005). Description and analysis of parents' experiences in seeking health care for their children's obesity may contribute to an understanding of these relationships and services from the parent's perspective.

This study aims to fill a gap in nursing knowledge related to parental perspectives regarding health services for childhood obesity and may be of significance to public health nurses, nurse practitioners and others who work with families in similar situations. Findings from this study may enhance nurses' understanding of the issues confronting parents in their attempt to care for and seek health care for their obese children. An understanding of these issues may enable nurses to adopt more effective forms of communication and management strategies than those currently employed in helping parents manage their child's condition.

Findings may also be of significance to other health care professionals in providing them with a view of their services as seen through a parental lens. Knowledge obtained as a result of this study may lead to further research that will result in enhancement of services for children and parents.

Summary of Chapter One

The trend towards increased incidence and prevalence rates of childhood overweight and obesity has been called an epidemic by health officials and the media. Overweight and obesity are viewed as key risk indicators of preventable morbidity and mortality. Within this framework the behavioral and environmental factors that have been identified as leading to or contributing to overweight and obesity are seen as being amenable to modification. Changes in these factors are thought to lead to weight reduction or at the very least, weight maintenance which will result in risk reduction and thus decreased morbidity and mortality related to overweight. Parents look to health professionals for diagnosis and assistance with treatment of this health condition. As a frontline public health nurse I witnessed the frustration experienced by parents as they struggled to find appropriate health care resources for a child who was overweight. My interest in the experiences of these parents led to this study. The goal of this study is to gain an understanding of parents' experiences of seeking health care for a child who is overweight or obese with the hope that such understanding may contribute to improved services to parents and families. The research questions posed were: 1. What are parents' experiences of seeking health care for a child who is overweight? 2. What are the contextual factors influencing parents' experiences in seeking those services? Gaining an understanding of these factors aims to fill an identified gap in nursing knowledge that may lead to more effective communication between health care providers and parents and thus to better management.

In chapter Two a review of the literature relevant to the phenomenon of childhood obesity and parents' experiences of seeking health care for a child is overweight is

presented. Chapter Three outlines the method section, the overall plan for obtaining answers to the research questions. It includes the method, sampling procedure, data collection methods, description of the data collection tools and the method of analysis. Chapter Four presents a report of the findings resulting from the data analysis. Chapter Five presents the discussion section in which findings are related the general body of knowledge in the field and limitations are outlined. Chapter Six presents a summary of the investigation, conclusions, recommendations and suggestions for future research.

CHAPTER TWO: REVIEW OF THE LITERATURE

Overview

In this chapter literature relevant to the phenomenon of childhood obesity and parents' experiences of seeking health care for a child who is overweight is reviewed. The decision to broaden the focus of the literature review to perspectives related to the definition, etiology, diagnosis, treatment and prevention of overweight and obesity was made after a preliminary literature search showed few results describing the experiences of parents who sought health services for a child who was overweight. The rationale for broadening the focus was to provide a context for parents' experiences. Similarly, in view of the limited literature pertaining to parents' experiences in seeking health care for a child who is overweight, literature pertaining to experiences of parents in seeking health care for other chronic care conditions was reviewed.

The body of literature pertaining to adult and childhood obesity is extensive. Consequently, I had to make decisions about what studies to include in the literature review and the depth or comprehensiveness of the review in relation to the subtopics chosen. I attempted to gain an overview of the state of knowledge in these areas, identify current issues and debates within academic and practice domains and identify gaps in the knowledge. In aiming for an overview I felt that I would gain the perspective that I felt that was needed to situate the experiences of parents within the context of the health care as it is delivered in British Columbia.

The databases of CINAHL, Medline, Cochrane Database of Systematic Reviews and the internet search engine GOOGLE SCHOLAR were searched using the keywords of childhood obesity, parental help seeking, care seeking, self care and chronic care.

Reference lists of relevant articles were also reviewed. Much of the literature in this field is published in medical and dietetic journals; few articles were located in nursing journals. Research on this topic was conducted primarily in the United States, Canada, Great Britain and Australia.

The World Health Organization (WHO) situates obesity within the spectrum of malnutrition (World Health Organization, 2000). According to WHO, the determinants of malnutrition are poverty driven hunger on one end of the spectrum and development driven obesity on the other end. Obesity is emerging among all age and socioeconomic groups (World Health Organization, 2000). Malnutrition is the single most important risk factor for disease and the growing obesity epidemic (World Health Organization, 2000).

Without societal changes, a substantial and steadily rising proportion of adults will succumb to the medical complications of obesity; indeed the medical burden of obesity already threatens to overwhelm health services. The spectrum of problems seen in both developing and developed countries is having so negative an impact that obesity should be regarded as today's principal neglected public health problem. (World Health Organization, 1997)

Obesity represents a significant economic burden. In Canada it is estimated that the direct cost of obesity is estimated to be around \$1.8 billion, or 2.4% of the total health care expenditures for all diseases in Canada (Starkey, 2005). This figure does not include indirect costs which include reductions in economic productivity stemming from poorer health, absenteeism, disability, premature mortality, increased pain and suffering.

Definition of Obesity

Obesity may be defined as the condition of having an abnormally high proportion of fat or an excess of body fat (Rolland-Cachera, 1999). The Body Mass Index (BMI) is the commonly accepted index for classifying adiposity in adults and it is recommended for use with children and adolescents (Dietitians of Canada, Canadian Paediatric Society, College of Family Physicians of Canada, & Community Health Nurses Associations of Canada, 2004). The BMI is an anthropometric index of weight and height that is defined as body weight in kilograms divided by height in meters squared (Centers for Disease Control and Prevention, 2004). In adults, risk for excess body fat is assessed by using the BMI. Cut-off points define grades of overweight that have been based on the association between BMI and mortality. A BMI below 18.5 is defined as underweight, 18.5 - 24.9 is normal weight, 25.0 - 29.9 is overweight and 30.0 and above is defined as obese (Centers for Disease Control and Prevention, 2004). For children and young persons aged 2-20 years, BMI is gender and age specific (Centers for Disease Control and Prevention, 2004). Since children grow in size, anthropometric cut-offs for fatness need to be adjusted for age (Gumbiner, 2001). According to CDC criteria adopted in 1997, BMI-for-age cutoffs are as follows, 85th to 95th percentile is defined as at risk for of overweight; greater than or equal to the 95th percentile is defined as overweight (CDC, 2004). These correspond to a BMI of 25 and 30 respectively by age 18. These definitions have high specificity (diagnosing few lean children as obese) but moderate sensitivity (failing to diagnose many of the fattest children as obese) (Rolland-Cachera, 1999). The weight-for-length/weight-for stature charts remain the method of choice for assessing infants from birth to 24 months of age (Centers for Disease Control, 2004). The term

overweight rather than obese is used by the CDC to describe children and adolescents with a BMI greater than the 95th percentile of BMI-for-age (Centers for Disease Control, 2004). Researchers have used the terms at risk for overweight, overweight, obese. These terms represent varying cutoff points for weight categories. There is significant variation in the literature with regard to the BMI cutoff points that these categories represent.

While childhood obesity has been classified as a disease by American researchers it has not been classified as such in Canada (Ball & McCargar, 2003). Obesity has been called a disease in the media, pharmaceutical press releases, articles published in professional journals and in the popular press (Heshka & Allison, 2001). Other sources including authors of scholarly journals question whether obesity is appropriately called a disease (Jennings, 1986; Tremblay & Doucet, 2000). Heshka and Allison (2001) maintain that neither side has provided a definition of disease and then offered evidence that obesity does or does not fit the definition. After examining several definitions of disease offered by medical and non medical dictionaries, Heshka and Allison (2001) identified four common and recurrent components:

1. A condition of the body, its parts, organs, or systems or an alteration thereof.
2. Resulting from infection, parasites, nutritional, dietary, environmental, genetic or other causes.
3. Having a characteristic, identifiable, marked, group of symptoms or signs.
4. Deviation from normal structure or function.

Condition one is met in that an excessive accumulation of fat can be considered a condition. Condition two is met in that obesity results from various causes, i.e. genetic, environmental, dietary, etc. Condition three is a problem because other than excess

adiposity there are no other inevitable clinical or sub-clinical signs particularly in the mild and moderate category of obesity. Condition four is a problem because many obese persons suffer no impairment and do not go on to develop disease. Heshka and Allison (2001) note that one is “placed in a conceptually awkward position of declaring a disease for which for some of its victims, entails no affliction” (p.1402).

Tremblay and Doucet (2000) suggest that body fat gain cannot be perceived a priori as a pathological process. They note that adipose tissue is involved in the regulation of many physiological functions and that by inducing weight loss, body homeostasis may be disrupted resulting in an increase in hunger, a decrease in resting energy expenditure, decreased fat oxidation, decreased immunity and increased levels of stress. Several of these unintended consequences predispose an individual to weight gain.

The view that healthy weight for an individual cannot be determined by numbers on a scale, BMI calculations or body fat percentages is represented in the Health at Every Size (HAES) philosophy (Robison, 1999, 2005). It is based on the assumption that people naturally have different body shapes and sizes and they have different preferences for physical activity. Thinness is not seen as intrinsically healthy nor is fat intrinsically unhealthy. The goal is the adoption of healthier lifestyles which may or may not lead to weight loss. Tremblay and Doucet (2000) maintain that the goal in weight management should be to promote a healthy lifestyle that is compatible with a reasonable health risk profile. In adults this may or may not be below a BMI of 30. They conceptualize a healthy body weight as being seated between the risks of excess weight gain with the attendant increased risks for diabetes, elevated levels of insulin, elevated plasma lipids and high blood pressure and the threats to homeostasis outlined above.

Etiology

Overweight is a complex multifactorial chronic condition that develops from an interaction of genetics and the environment (National Institutes of Health, 1998). Obesity occurs when energy intake exceeds energy expenditure. Energy balance may be thought of in terms of a balance beam with energy intake on one side (protein, carbohydrate and fat) and energy expenditure (thermic, physical and resting) on the other side (Williams & Considine, 2001). Chronic increases in energy intake that are not countered by energy expenditure result in body weight increases (Williams & Considine, 2001).

Genetic Influences

Evidence from studies dating back 50 years points to a significant genetic influence accounting for variation in BMI. Estimates of genetic influence have ranged from 40% to 70% (Faith, Pietrobelli, Allison, & Heymsfield, 1997; Williams & Considine, 2001). Genetic abnormalities that cause the development of early onset severe obesity are rare (Beamer, 2003; National Institutes for Health, 2004). Conditions such as hypothyroidism or hypercortisolism can also cause weight gain but they do not account for typical obesity (Beamer, 2003). The exact nature of the genetic variation that contributes to more common forms of obesity is not yet fully understood (Beamer, 2003). Genetic factors are thought to explain a large part of the variation of body weight within a population in a common environment while environmental factors are thought to account for changes in obesity over time in the same population (Hoppin, 2005).

Developmental Influences

Adaptive responses to environmental conditions in gestation may produce a “thrifty phenotype” that can have a permanent effect on the metabolic profile of an

individual (Hales & Barker, 2001). The thrifty phenotype hypothesis proposes an epidemiological association between poor fetal and infant growth and the development of type 2 diabetes and the metabolic syndrome. Hales and Barker (2001) maintain that poor fetal and infant nutrition are the insult that drive the process. Poor fetal nutrition is thought to lead to poor development of beta cell mass and function, including islet of Langerhans vasculature and possibly nerve function, as well as to insulin resistance. The hypothesis proposes that fetal malnutrition sets in motion mechanisms of fetal nutritional thrift which had a differential impact on the growth of different organs with selective protection of brain growth. Altered growth is thought to permanently change the structure and function of the body. A decreased ability to secrete insulin would not pose a problem for individuals who continue to be poorly nourished and remained thin and therefore insulin sensitive. Glucose intolerance would be triggered by increased positive caloric balance resulting from increased food intake and decreased energy expenditure leading to obesity. To summarize, fetal malnutrition combined with over-nutrition during childhood may create a predisposition for metabolic syndrome, a disorder that can include abdominal obesity, high blood pressure, dyslipidemia, and elevated fasting glucose levels (Bhargava, Sachdev, & Fall, 2004; Hales & Barker, 2001; Ravelli, Van der Meulen, & Michels, 1998).

Environmental Influences

The easy availability of high caloric foods, sedentary lifestyles, decreases in physical activity and psychosocial stressors have been implicated in the rising obesity epidemic (McLellan, 2002). Causal relationships have been difficult to prove and no

single factor has been demonstrated to play a pivotal role in increasing the prevalence of obesity (Hoppin, 2005).

Screening and Diagnosis

BMI changes significantly with age. After a steady increase from birth to about one year of age BMI-for-age, begins to decline and continues to decline until it reaches its lowest point between ages four to six years (CDC, 2004; Rolland-Cachera, Deheeger, & Guillaud-Bataille, 1987). The point at which it starts to increase again is known as adiposity rebound. Whether or not the higher BMI is truly adipose tissue versus lean body mass or bone remains to be determined (Polhamus et al., 2005). An early adiposity rebound is associated with adult obesity (Whitaker, Pepe, Wright, Seidel, & Dietz, 1998). The calculated risk of adult obesity which can be attributed to early adiposity rebound is thought to be about 20% (Whitaker et al., 1998).

The BMI, a commonly used tool to screen for overweight status, is a proxy measure of body fatness. It is said to parallel changes obtained by direct measures of body fat such as underwater weighing and dual energy x-ray absorptiometry, total body potassium, and bioelectrical resistance which are often impractical to carry out (CDC, 2004; Goran, 1998). One limitation of the BMI is that it does not distinguish between weight from fat and weight from muscle or bone, nor does it identify the distribution of body fat (National Institutes for Health, 2004). The accepted standard cut-off point for determining obesity may not reflect the same risk for further health consequences in all ethnic groups (National Institutes for Health, 2004). Some studies suggest that obesity may be the result of increased height and weight at a given age which may relate to earlier maturation (Adair & Gordon-Larsen, 2001). However, Katzmarzyk (2002)

maintains that there is little evidence that the historical positive trend in the stature of children has persisted. Although routine screening for obesity is recommended by various health profession organizations, little research has been conducted to evaluate the potential benefits and harms of growth monitoring (Dietitians of Canada et al., 2004). Current recommendations are for height and weight measurements to be taken at scheduled well baby and well child health visits that frequently coincide with immunization. Optimal frequency for measuring height and weight in healthy children over age six has not been established, however annual monitoring is recommended (Dietitians of Canada et al., 2004).

In-depth assessments are required to determine if children and adolescents with a BMI for age greater than the 95th percentile are excessively fat and are at risk for health complications related to overweight. These assessments include medical history, family history, dietary assessment, physical activity assessment, and physical examination (Tanofsky-Kraff, Hayden-Wade, Cavazos, & Wilfley, 2003).

Health Impact of Childhood Obesity

Childhood obesity poses serious immediate and long term health consequences and is associated enormous health consequences and costs to society (RNAO, 2005). Childhood obesity has traditionally been viewed as an esthetic problem rather than a health risk (Ball & McCargar, 2003). Clinical evidence of disease in children is frequently absent and so the health consequences of having a high BMI for age and gender during childhood are less obvious (Tremblay & Willms, 2000). The biggest consequence of the obesity epidemic has been a significant increase in cases of type 2 diabetes mellitus (T2DM), hyperlipidemia and hypertension in obese children (Dietz,

1998; Hill & Trowbridge, 1998). Fifteen years ago type 2 diabetes accounted for less than 3% of all cases of new-onset diabetes in children and adolescents in the US, whereas today it accounts for 45% of new-onset cases (American Diabetes Association, 2000). Limitations of the current literature pertaining to T2DM are numerous. The divisions by age are inconsistent, classification of diabetes types may be inconsistent, growing awareness of T2DM may have affected prevalence rates in more recent studies, and finally if pediatric cases mirror adult experience, many may be undiagnosed (Pinhas-Hamiel & Zeitler, 2004).

The prevalence of metabolic syndrome (large waist circumference, abnormalities in levels of fasting blood sugar, triglycerides, high density lipoproteins and high blood pressure) is estimated to be about four per cent in adolescents in general and 30% in overweight adolescents (Cook, Weitzman, Auinger, Nguyen, & Dietz, 2003). In obese children the prevalence reaches up to 50% in the severely obese group (Cook et al., 2003; Weiss et al., 2004). The metabolic syndrome is a cluster of cardiovascular risk factors that frequently coincide with insulin resistance and hyperglycemia (Hunt, Resendez, Williams, Haffner, & Stern, 2004). It is a strong predictor of type 2 diabetes and is predictive of cardiovascular disease. In children there is no consensus definition for the metabolic syndrome (Cook et al., 2003). The term "metabolic syndrome" is coming under scrutiny and some question the value of drawing attention or labeling people with a presumed disease that does not stand on firm ground (Kahn, Buse, Ferrannini, & Stern, 2005). Concerns regarding the term are as numerous. Criteria are ambiguous or incomplete, rationale for thresholds are not well defined, insulin resistance as the unifying etiology is uncertain, the cardiovascular disease risk associated with the

syndrome appears to be no greater than the sum of its parts, there is no clear basis for including or excluding other CVD risk factors and the medical value of diagnosing the syndrome is unclear (Kahn et al., 2005).

Freedman et al. (1999) found that approximately 60% of five to 10 year olds with a BMI for age values of 95 and above had at least one biochemical or clinical risk factor for cardiovascular disease and 20% had two or more risk factors. The risks associated with obesity in adulthood include elevated risks for heart disease, diabetes, cancers, gallstones, osteoarthritis, and benign prostatic hypertrophy (Colditz, 2001). Lawlor and Leon (2005), however, maintain that while there is a concern that the childhood epidemic of obesity will result in increases in the risk of cardiovascular diseases in the future, there is little direct evidence on this issue. Their study examining the association between BMI in early childhood and coronary heart disease in middle age found that there does not appear to be an increased risk in later life or more risk factors. Raitakari, Juonala, and Viikari (2005) also found that being obese in youth is not inevitably associated with carotid artery thickness and elasticity. Recent analysis of National Health And Nutrition Examination Surveys points to a significant reduction in adults in cardiovascular risk factors for all three weight categories (lean, overweight and obese) in the past 30 to 40 years (Gregg et al., 2005). Risk reductions among lean persons was somewhat less than among obese persons. In estimating deaths associated with underweight, overweight and obesity, Flegel, Graubard, Williamson and Gail (2005) found that while underweight and obesity, especially higher levels of obesity were associated with increased mortality relative to normal weight, overweight (BMI 25 to <30) was not associated with increased mortality. The authors speculate that the impact

of obesity on mortality may have decreased over time because of improvements in public health and medical care. They note that these findings are consistent with increases in life expectancy and the declining mortality rates from ischemic heart disease.

Obesity poses increased risks of respiratory infections, lowered fitness levels, sleep apnea (7% of morbidly obese) and cholecystitis (Dietz, 1998; Tremblay & Willms, 2000). Overweight children tend to be taller and have advanced bone ages and experience early maturation (Dietz, 1998). Excessive body weight during childhood is associated with becoming overweight in adulthood and with higher morbidity and mortality rates (Tanofsky-Kraff et al., 2003). Of the 15% of children aged six to twelve years of age in the United States who are obese, approximately 80% will be obese adults. Half of adults with a BMI of 40 or more had obesity in childhood. Severely obese children have been found to have a lower health-related quality of life than those who are healthy and similar to those diagnosed as having cancer (Schwimmer, Burwinkle and Varni (Schwimmer, Burwinkle, & Varni, 2003).

Psychosocial health may be affected as overweight children are often the target of discrimination and stigmatization. Self perception, measured using the Self-Perception Profile for Children, was found to be lower in at-risk for overweight and overweight children (Ball, Dru Marshal, & McCargar, 2005). Children often rank obese children as those they would least like to have as friends (Goldfield & Chrisler, 1995). Childhood overweight and obesity has been linked to feelings of anxiety, loneliness, low self-esteem, sadness, anger and fighting (National Institute for Health Care Management, 2004). In a study assessing the influence of child and parental obesity and parental psychiatric symptoms on psychological problems in obese 8-11 year olds, Epstein et al.

(1994) found that the majority of obese children showed no psychological problems.

Those with the most social problems had mothers who were more overweight and fathers who were less overweight. Children with higher scores on the anxiety/depression scale were younger with fathers who had psychological problems.

Obesity is not generally considered to be the result of an eating disorder although a subgroup of obese individuals may fit the DDSM diagnostic criteria for binge eating disorder (Faith et al., 1997). Those individuals are more likely to experience anxiety, depression, obsessive-compulsive disorder, paranoid ideation, and borderline personality disorder (Marcus, Wing, & Hopkins, 1988). A recent study examining eating disordered attitudes and behaviors of severely overweight children in treatment found that a significant minority (15%) reported losing control over eating in the past month (Levine, Ringham, Kalarchian, Wisniewski, & Marcus, 2006). Braet and Van Strien (1997) found that obese children are especially vulnerable to emotional overeating (overeating in response to emotions) and external eating (eating in response to food-related stimuli, regardless of the internal states of hunger and satiety.) Oliver and Wardle (1999) found that stress among young adults changes intake patterns towards more snacks and food choices towards more energy dense foods. The concept of an "obese eating style", which includes overeating in response to emotional arousal, over-responsiveness to external food cues, and eating too fast has fallen out of favor in recent years since studies comparing eating behavior in obese and normal weight adults produced inconsistent results (Wardle, Guthrie, Sanderson, & Rapoport, 2001). It was hypothesized that that obese people overeat in response to emotional arousal and eat too fast thereby outpacing sensations of satiety. Wardle et al. (2001) note that as evidence has accumulated that

obesity is a strongly heritable condition, the emphasis in research has shifted from psychology to biology.

The current state of knowledge with regard to the health impact of childhood overweight and obesity is limited. Until recently the focus of research has been on obesity in adults. The use of a proxy measure of body fat (BMI) is problematic because it does not directly measure the substance under investigation, leaving room for error that can impact the reliability of findings. BMI may not be measuring what it is intended measure. As the debate about the merits of using the metabolic syndrome to identify children at risk of developing disease highlights, there is much that is not known about children's normal metabolic and physiological processes. The lack of agreement about what constitutes normal lab value ranges for health risk indicators such as cholesterol in children makes comparison between studies difficult and the results questionable if there is no sound basis for using a given benchmark. The adult experience shows that despite the rising rate of obesity, cardiac risk factors are decreasing. Mark (2005) notes that studies evaluating risks of obesity usually assess weight at a single point in time rather than throughout life. In children, younger age of onset of obesity may result in a longer duration of obesity which may increase mortality. Furthermore, it is difficult to draw conclusions about the degree of individual risk for morbidity at a given age and weight status from epidemiological studies. For example, it is not possible to tell which child will "grow out" of his or her overweight and which will go on to become overweight adolescents and adults. While research has demonstrated the existence of health risks related to obesity in children, much of the morbidity attached to those risks is thought to manifest in adulthood.

And finally, the findings pertaining to lowered self esteem and diminished psychological health in some children who are overweight may be related more to the social construction of obesity as a form deviance than to the weight itself. Desirable or acceptable weights are a reflection of the culture in which individuals live (Garner, 1995). In the Western culture, obesity is viewed as a bodily abnormality and a deviance that should be corrected (Harjunen, 2005). It is part of a discourse that views slimness as an indicator of personal self control and obesity as the embodiment of the opposite, a lack of self control and personal failure. Thinness is also associated with being healthy and attractive. In contrast, body fat is seen as a sign of poor health, inefficiency and lack of personal will (Harjunen, 2005). Brink (1994) in Harjunen (2005) notes that people are stigmatized for both their appearance and for what is assumed to be their moral weakness.

Parental Recognition of Children's Weight Status

For parents to become involved in childhood obesity prevention and treatment, they need to recognize when their children are becoming overweight and be concerned about the consequences. Some parents do not recognize that their child is overweight or obese, others do not believe that obesity is a health problem. Among the factors related to this lack of recognition are low education levels, maternal obesity, ethnicity and cultural norms. Baughcum, et al. (2000) conducted a study using closed survey questions and anthropometric measures to determine what factors are associated with mothers' failure to perceive when their preschool children are overweight. Their findings indicate that obesity was more common in mothers with less education and their children. Nearly all of the obese mothers (95%) regarded themselves as overweight, however, the majority of

mothers (79%) failed to recognize that their children were overweight. Low maternal education, maternal obesity, age, smoking, the child's age, race and gender were all associated with a failure to perceive their children as overweight. Another study looking at parents' perceptions about their child's weight using a visual analogue scale found that only 10.5% of parents of overweight children perceived their child's weight accurately compared with 59.4% of other parents (Etelson, Brand, Patrick, & Shirali, 2003). The parents did not differ with regard to their level of concern about excess weight as a health risk or in their knowledge of health eating. Cultural differences in the acceptance of a large body may also play a role in parents' lack of perception of health risk (Young-Hyman, Herman, Scott, & Schlundt, 2000). A study examining the effect of cultural norms on parental perceptions found that 36% of Hispanic parents of obese children between the ages of 2 and 5 years did not perceive them as overweight (Myers & Vargas, 2000). In a study of African American care giver perception of children's obesity related health risk only 44% perceived the child's weight to be a potential problem. Parents and caregivers from three Wisconsin Native American tribes recognized only 15.1% of overweight children (Adams, Quinn, & Prince, 2005).

None of the studies cited above was designed to look at the reasons for parental misperception. The literature addressing this question suggests that there are a number of reasons why some parents may not identify their children as obese or see obesity as a problem requiring intervention. Obesity may be only one of many challenges that they are presented with in the course of raising their children. Some parents may think that childhood obesity is a relatively benign condition that ranks lower in priority as compared to seemingly more urgent problems such as drug and alcohol use, violence, and

precocious sex (Moore, 2004). A lack of knowledge may lead some parents to believe that young children grow out of being overweight or that increased weight represents good health and parental competence (Boughcum, Burklow, Deeks, Powers, & Whitaker, 1998). If parents are not experiencing health or social difficulties due to their own obesity, they may not intervene to prevent their child's obesity (Boughcum et al., 1998). Jain, Sherman and Chamberlin (2001) found that mothers felt that standardized growth charts did not define healthy weight. Physical activity and a good appetite were more important to the mothers as indicators of good health. They referred to their child's size as being solid, thick or strong rather than overweight. Only if they were inactive, lazy or were teased about their weight did the mothers consider them overweight.

Most of the studies examining parental perceptions and attitudes related to obesity represented the mother's point of view. Fathers' voices were not heard. Participants were frequently drawn from lower socioeconomic groups. Mothers attending nutrition clinics or programs targeted at low income households often formed the sample or participant group as did ethnic minorities. Nevertheless, findings from these studies have application in clinical practice if health care professionals hope to find common ground with parents when they are addressing the issue of childhood obesity. As Jain et al. (2001) note, health professionals cannot assume that defining overweight according to growth charts has meaning for all mothers. Recognition of an actual or potential health risk is only one step in seeking health care. Parental readiness to make changes may also affect whether they seek help or implement recommended lifestyle changes.

Parental Readiness to Make Changes for Overweight Children

Little is known about parental readiness to make behavior changes to help their children lose weight. Health care providers may raise the subject without knowing whether a parent recognizes that a child is overweight or whether a parent is ready to make behavior changes. The Transtheoretical Model or Stages of Change Model has become one of the most influential theoretical models within health psychology (Greene et al., 1999). It is a model that describes a sequence of cognitive and behavioral steps in successful behavior change and has been used to design interventions for a wide range of health behaviors including eating and exercise (Hunt & Hillsdon, 1996b; Kristal, Glanz, Curry, & Patterson, 1999; Prochaska & Velicer, 1997). The stages are: *precontemplation*, no recognition of need for or interest in change, *contemplation*, recognition of need for and intent to change; *preparation*, planning for change; *action*, adopting new behavior; and *maintenance*, ongoing practice of a new behavior (Kristal et al., 1999). The model consists of three dimensions: the temporal dimension (the stages of change), the dependent variable dimension including behavior, decisional balance and self efficacy or temptation and the independent variable dimension or processes of change (Greene et al., 1999). Rhee, De Lago, Arscott-Mills, Mehta and Krysko Davis (2005) used the Transtheoretical Model to examine the relationship among socio-demographic factors, parental perceptions and a parent's readiness to make lifestyle changes for his or her overweight or at-risk-for-overweight child. Most parents were black or Latino, had a high school degree or less and received public assistance. Approximately half of the parents viewed themselves as overweight. Thirty eight percent of parents were in the preparation/action stage, 17% were in the contemplation stage and

44% were in the pre-contemplation stage. Factors associated with being in the preparation/action stage were having an overweight or older child (eight years or older), believing that their own weight or child's weight was above average and perceiving that their child's weight was a health problem. Parents of overweight children as compared with parents of at risk for overweight had an odds ratio of 4.54 for being in the preparation/action stage versus the pre-contemplation stage. By assessing a parent's stage of readiness for change, health care providers may be better able to individualize care and suggest stage appropriate strategies for change.

The design of the study (using a self administered survey) provided parents with limited opportunity for sharing reasons for why they might not be in the preparatory or action stage of the model. All parents in the sample received public assistance, a factor that may well have limited their choices with regard to affordability and availability of nutritious food, access to recreational activities and safe play environments for their children. Access to weight management programs and health services may also have been limited. The addition of a qualitative component aimed at capturing the contextual factors that influence parents' readiness and / or abilities to make changes would have provided valuable information in linking stage of change to environmental influences. A strength of the study was the high participation rate (83% n= 155), however, the recruitment method may have placed undue pressure on parents to participate. They were approached in the waiting room just before a doctor's visit. Some may have feared negative repercussions if they declined to participate. Further research utilizing the Transtheoretical Model with different parent sample characteristics may add to the knowledge base required by health care practitioners to help parents move through the

stages of change. Greene et al. (1999) note that of the three dimensions, the least investigated relates to the process of change.

Treatment

Treatment approaches to weight loss have included pharmacotherapy, behavior modification, physical activity, diet and surgery (Wadden, 1999). The basis of therapy in the management of child and adolescent obesity remains modification of eating and activity (Hill & Trowbridge, 1998; Jonides, Buschbacher, & Barlow, 2002; Tanofsky-Kraff et al., 2003). It is postulated that the value of including exercise in the treatment protocols may not relate to short term improvements but to the long term behaviors which could influence long term outcomes (Canadian Association of Pediatric Health Centres, Paediatric Chairs of Canada, & Canadian Institutes of Health Research, 2004). In their review of interventions for treating obesity in children, Summerbell et al. (2004) found that no direct conclusions can be drawn with regard to effectiveness of treatment which included dietary, physical activity and behavioral therapy based on the 18 research studies that met their criteria. Most studies were small, drawn from homogenous, motivated groups in hospital settings. Seven other systematic reviews which included data from at least 44 studies examining overall treatment showed evidence of benefit of treatment leading the Canadian Association of Paediatric Health Centers (CAPHC), the Paediatric Chairs of Canada (PCC) and the Canadian Institutes of Health Research (CHIR) to strongly recommend that treatment be advised for obese children. They note that treatment confers significantly increased chance of improvement or resolution of obesity (Canadian Association of Pediatric Health Centres et al., 2004).

A review of 11 school based programs found that those focusing on younger children were more successful than those focusing on adolescents (Storey, 1999). There may be a number of reasons for this finding. Children may require less self motivation than adults to take up and maintain behaviors required for weight loss since it is the parents who regulate access to the quantity and quality of foods (Epstein et al., 1995). Younger children may also have less ingrained dietary and physical activity habits than adolescents and adults. Children tend to be more physically active than adults which may assist with weight maintenance. Nevertheless, challenges to treatment are numerous and can include failure to self-monitor, motivation, sabotage within the family, multiple caregivers, time constraints, poor quality school lunches and festive occasions (Tanofsky-Kraff et al., 2003). Other barriers can include low educational level of parents and low income that can influence an adult's real and perceived ability to carry out behavior changes (Haas et al., 2003).

In adults, weight loss maintenance has been difficult to achieve on a consistent basis (Catanese, Hyder, & Foreyt, 2003). With some notable exceptions, most people regain most if not all of their lost weight within five years (Haddock, Poston, Dill, Foreyt, & Ericsson, 2002). Tanofsky-Kraff et al. (2003) note that promising long-term weight loss obtained from comprehensive behavioral treatments for childhood obesity are in contrast to the generally disappointing results from adult weight control interventions. However there are few studies documenting long term weight loss.

In comparison to medical, educational, school-based and individual behavioral treatments, family based behavioral treatment programs have been the most studied intervention in pediatric obesity (Tanofsky-Kraff et al., 2003). Behavioral approaches

can include family therapy, cognitive-behavioral treatment, problem solving, parenting skills, training in self monitoring, in addition to education related to diet and exercise. In addition to weight loss, improved blood pressure, physical fitness, body fat mass, cholesterol triglycerides, lipoprotein levels, insulin and fasting glucose levels have been obtained (Gutin, Cucuzzo, Islam, Smith, & Stachura, 1996; Haddock et al., 2002). Two types of family based programs are described in the literature. Golan, Weizman, Apter and Fainaru (1998) note that most family based programs involve children who are obese and their parents, that is, both children and parents act as agents of change in implementing strategies aimed at weight loss or maintenance. Golan et al. compared the efficacy of a family based approach in which the parents served as the exclusive agents of change with that of the conventional approach in which children served as the agent of change. In this model, children who were overweight in the experimental group were not the primary targets of intervention which consisted of support and educational group sessions for both parents. Results were found to be comparable to some of the family based programs in which both children and parents were the agents of change. The mothers took on the responsibility of acting as the main agent of change. The authors noted that many parents claimed that their spouses did not take enough responsibility, reflecting a power struggle between parents regarding the limits of responsibility for change in the home.

Epstein (1995) notes that the first generation of treatments (behavioral, inclusion of parents, lifestyle or aerobic exercise programs) were associated with weight loss of about 15% during the six month in-treatment period with significant differences in maintained weight control over ten years. A 20% weight loss in 30% of children over ten

years was reported (Epstein, 1996). Epstein indicates that while family-based obesity treatment provides interventions for parents and children, children benefit more from treatment. One such program, *Shapedown*, has incorporated features shown to be associated with weight management success. This 10 week program, run by a physician, dietitian and clinical counselor and supported by public funding has been offered several times in Vancouver. Participants, including children and parents meet once a week for two hours. It is aimed at treating the whole family and makes it clear to prospective participants that if parents do not want to eat healthily and exercise then *Shapedown* is not right for the child. Program components include assessment, nutrition and diet information, problem solving, assertive and emotionally expressive communication and parenting skills that include limit setting and nurturing techniques. Cognitive therapy, stress management techniques and body image therapies are also used. The whole child is addressed rather than just the obesity. Three evaluations of the program have pointed to favorable outcomes using changes in BMI, nutrition knowledge, body image, and diet habits as indicators (Melin, Slinkard, & Irwin, 1987; Vancouver Coastal Health Authority, 2005). Strengths of these studies are inclusion of indicators that are congruent with healthy lifestyle choices not just weight loss. Studies were randomized and controlled. Changes in BMI were modest (it should be noted that *Shapedown* is not promoted as a diet or exercise program). The dropout rate in one group was 36%. Test groups were small and one study encountered difficulty in finding a sufficient number of controls. The longest follow up time was 15 months.

CDC recommendations for treatment goals for overweight adults and children have changed from achieving normal or ideal weight to attaining healthy eating and

physical activity habits (Centers for Disease Control and Prevention, 2004). The Centers for Disease Control recommends that for children aged two to seven in the at risk for overweight category, weight maintenance is the goal. In the absence of complications, weight maintenance is also the goal for this age group of overweight children, whereas weight loss is indicated in the presence of complications in overweight children. For ages seven years and older, weight maintenance is indicated for the at risk for overweight group with no complications, while weight loss is indicated in the presence of complications in this category and in the overweight category.

Research about practices of pediatric health care providers when they deal with obesity is sparse (Barlow & Dietz, 2002). A recent survey showed that 37.7% of parents of overweight children and overweight older children had been told by a health care professional that they were overweight. An increasing trend by age group was observed in the percentage of the of the overall sample told that they were overweight (17.4% for ages 2-5 years, 32.6% for ages 6-11 years , 39.6% for ages 12-15 years and 51.6% for ages 16-19 years) (MMWR, 2005).

A self administered survey of Canadian dietitians specializing in pediatric practice was used to generate descriptive data on the assessment techniques and the philosophies and protocols of their programs (Wray & Levy-Milne, 2002). Several approaches were cited: the healthful lifestyle approach, the size acceptance/trust paradigm and the Vitality approach. The latter two approaches fall under the umbrella of the healthful lifestyle approach which goes beyond the dieting and caloric restriction approach to weight management used in the past. The Vitality approach consists of shifting focus away from negative to positive thinking about how to achieve and maintain healthy weights

(Dietitians of Canada, 1995). It focuses on eating well, being active on a daily basis and feeling good about oneself. The eating well component emphasizes a lifetime eating pattern based on the Canada Food Guide. No foods are considered 'good' or 'bad'. Vitality aims to take a more holistic approach by going beyond weight control, calorie restricted diets and prescriptive exercise regimes (Health Canada, 2002). The size acceptance/trust paradigm stems from an understanding that some children are genetically predisposed to being fat and that it is normal for some children to be fat (Hodges, 2003). Satter (1996) asserts that supporting the internal regulation of a child's food intake will lead towards a weight that is appropriate for that child. According to this paradigm, the socio-emotional environment mediated by the family as well as the nutritional and physical environments are important elements to examine in the etiology of obesity. She maintains that by identifying and resolving underlying causes for dysregulation, children can return to an internal regulation of energy balance. Parental feeding practices that ignore or override a child's behavioral cues related to hunger and satiety are thought to play an important part in the dysregulation of internal processes. Of the 164 respondents, 65 reported that they provide an intervention program to youth. Findings showed that most respondents (42) used the healthful lifestyle approach via one on one consultation, included parents and collaborated with two or more health professionals in the treatment of overweight children. Eighteen respondents used the size acceptance/trust paradigm approach. The three main methods used for assessment and monitoring were growth charts, percent ideal body weight and BMI. Twelve respondents did not define or assess overweight in their clients. Thirteen respondents who reported that they used a specific diet plan as part of the intervention also noted that they use the

Vitality approach in which a specific diet plan is contraindicated. Also, some dietitians who indicated that they were using the size acceptance approach offered more specific recommendations. Responses point to a discrepancy between espoused philosophical orientation and practice. The article offered no explanation for this discrepancy.

Dietitians may have responded to pressure from clients to provide a more structured (weight loss diet) approach than the healthful lifestyles approach offered. The majority of their clients were girls aged seven to 18, an interesting finding in view of the results of the *National Longitudinal Survey of Youth* which found more boys than girls to be overweight and obese. The study suffered from a low response rate (164 out of 298). No documentation of the non-response bias (that is, differences between the characteristics of participants and those who refused to participate in the study (Polit & Hungler, 1999)) was offered. Most survey questions were closed ended. The instrument format, that is the use of closed questions, may have resulted in some respondents not feeling comfortable with response alternatives leading to errors of measurement. Intervention outcomes were not addressed by the survey.

Health Care Practitioner Perspectives

Focus groups and individual interviews were conducted with twelve nurses and seven dietitians involved in the Special Supplemental Nutrition Program for Women Infants, and Children (WIC) to examine health care professionals' perceptions about the challenges that exist in preventing and managing childhood obesity (Chamberlin, Sherman, Jain, Powers, & Whittaker, 2002). WIC provides supplemental foods, nutrition education and health care referrals to low-income mothers and children considered at nutritional risk in the U. S. Almost half of all infants and one fourth of 1-4 year olds are

enrolled in the program. Nurses and dietitians perceived mothers as being in a “survival mode” while navigating their complex and ever-changing social circumstances. They felt that the stressful and unpredictable lives of these mothers interfered with implementation of the nutritional advice received from WIC staff. Competing demands often required immediate action and that contributed to the chaos and low levels of control in their lives. Modifying family dietary patterns competed with more urgent concerns related to housing, transportation, employment and personal relationships. They reported that mothers use food as a coping mechanism and as a parenting tool. Health care providers felt that foods were used to calm, reward and emotionally nurture their children. They felt that mothers used food to control their children’s behavior by rewarding them for good behavior with high sugar, low nutrient snacks. They also felt that mothers had difficulty setting limits with their children around food and allowing children to exercise too much control over decision making in their diets. Health care professionals were fearful of offending mothers and would only talk indirectly about weight. They felt constrained by having to adhere to protocols that did not permit them to address issues other than nutritional counseling. Time constraints were also cited as limiting their effectiveness. Finally, staff felt that mothers often receive conflicting advice from WIC staff, physicians and other family members. They felt that their credibility and effectiveness were undermined when they provided information not corroborated by other health care professionals. They saw a need to develop collaborations with primary health care providers and community agencies that affect childhood obesity.

Some health practitioners admit to low proficiency in the use of behavioral management strategies, guidance in parenting techniques and addressing family conflicts

in the management of childhood overweight (Storey et al., 2002). A survey of attitudes and practices related to the treatment of pediatric obesity in primary care revealed that one fourth of physicians surveyed think that they are not at all or only slightly comfortable in this regard (Jelalian et al., 2003). Another survey examining attitudes, barriers, skills and training needs among health care professionals found that 32 % of pediatric nurse practitioners (PDPs) reported a low proficiency level in the assessment of the degree of overweight, 30.2% reported a low proficiency in addressing family conflicts and 22.3% reported low proficiency in assessment of the degree of overweight (Storey et al., 2002). Female pediatricians surveyed in another study were less likely to cite treatment futility than their male counterparts and were more likely to be concerned about precipitating an eating disorder. Pediatricians and nurse practitioners with six or more years of practice were more likely to want additional training (Storey et al., 2002). Registered dietitians (RDs) perceived fewer barriers to treatment and were more confident in their assessment and behavioral management skills. The study was limited by a low response rate (RDs 27%, n=444; pediatricians 19%, n=202), PDPs 33%, n=293) which limits the ability to generalize findings. Strengths of the study were the inclusion of three professional groups, sampling from a large geographic area of the U.S. and the use of a comprehensive assessment tool.

Numerous challenges remain to building a sound evidence base for treatment of childhood overweight and obesity. Wide variation in the kind of treatment interventions, length of programs, duration of treatment, parental involvement, age of children, ongoing support, outcome indicators, length of follow-up, size of samples, and mix of professionals delivering programs make comparisons difficult. Focus on weight loss as a

short term outcome may miss long term benefits of diet and activity modifications that result in weight maintenance as recommended by the CDC. The high cost of conducting large, quality studies has been an impediment in furthering the knowledge base. While professional publications have been increasing in number (from 1982-92 there were 3887 citations; in 2003 alone there were 791) the quality of studies remains a problem (Canadian Association of Pediatric Health Centres et al., 2004). Furthermore, few studies have examined the role of nurses in the management of this health concern. Nurse practitioners are included in some studies but the role of the public health nurse, pediatric nurse or bedside nurse has not been adequately examined. Much of the research on this topic has been conducted in countries outside Canada which have different health care systems possibly affecting applicability of finding to this country. On a positive note reports such as those examining the evidence for addressing childhood obesity compiled by the CAPHC, the PCC and CIHR do provide some direction for practitioners, researchers and policy makers. As the problem of childhood obesity is starting to gain recognition at higher levels of government there is hope that more funds will be allocated for evaluation of various programs and treatment modalities.

Parental Experiences in Seeking Health Care for an Overweight Child

Only one study was found that examined parental experiences in seeking health care for an overweight child. Grounded theory methods were used to analyze the content of interviews with parents of 40 children who had concerns about their child's weight. Interviews included topics such as the child's weight history from pregnancy, family weight history, self-help strategies and social interactions including experiences when seeking professional help. Thirty interviews were conducted with mothers and ten with

both parents present. The Standardized Shapes of Children was used as a tool in conversation with parents. This tool depicts a series of drawings of children of both sexes ranging from significantly underweight to obese with one being underweight and seven being obese. The author's findings indicated that when a child reached approximately shape six, corresponding to the 85th percentile in the 1990 BMI charts, parents started to question an underlying medical cause. When medical advice was sought responses ranged from helpful, unaware of how to help, dismissive and negative. Parental perception was that health professionals did not know how to address the issue of childhood weight management. Interactions with health professionals included general practitioners, pediatricians, dietitians and school nurse. Where a weight problem was acknowledged, there was a tendency to blame the parent and see the weight as an individual responsibility.

There is insufficient evidence to draw conclusions about the experiences of parents in seeking health care for children who are overweight. The study cited above was small in size, it was carried out in Britain which has a different health care system from that of Canada and participants were drawn from a small geographical area. All three factors limited generalizability of findings. Insufficient detail was provided in the article to allow the reader to gain an in depth understanding of the experiences. It is unclear whether the lack of depth resulted from the design of the study or the necessity to condense description of the study and its findings for the article. The inclusion of both parents and representation of several health professions were among the strengths of study. Few nurses appeared to be represented. There is clearly a gap in the knowledge

about how parents are experiencing seeking health care for their children who are overweight.

Prevention of Obesity

Successful prevention of obesity may be defined as the maintenance of normal weight status in children over time (Canadian Association of Pediatric Health Centres et al., 2004). A recent summary of systematically reviewed literature (cited as a “review of reviews” by its authors) of obesity prevention and treatment concluded that there is currently no systematically reviewed evidence to support a specific approach to obesity prevention through childhood (Canadian Association of Pediatric Health Centres et al., 2004). The characteristics of the interventions were highly variable between studies. For example the review conducted by Campbell et al. (2004) cited interventions that included educational, health promotion, psychological/family/behavioral therapy/counseling management. Topics included diet and nutrition, exercise and physical activity, lifestyle and social support involving children themselves with or without family members. The majority of studies were school based with some having components in the family or community setting. Virtually all interventions included physical activity and diet components and delivery was multifaceted in most. Information was often accompanied by changes in scheduled physical activity and the foods available within the school. Examples of physical activity interventions included dance oriented physical activities at school targeting 10-13 year olds and 15 minutes of walking plus 20 minutes of aerobic exercise targeting kindergarten age children. Strategies to reduce sedentary behaviors included 30-50 minute lessons delivered by teachers aimed at reducing television videotape and video game use in elementary school children. Outcome measures were

commonly expressed as changes in BMI, change in percent overweight and change in skin fold measurement or change in obesity prevalence. Recommendations included follow up assessment of sufficient duration, adequately powered studies, using obesity prevalence as critical outcome measurement. When tracking the status of a group of children it is preferable to use prevalence rates rather than BMI since group mean BMI data cannot distinguish between those children who are already overweight and gaining further weight and “normal” weight children who have become overweight.

Limitations of the evidence pertaining to the studies included in the review were identified by the authors. There are few high quality studies of obesity prevention due to challenges faced by researchers related to cost, program delivery, long term follow up and outcome measurement. As a result single high quality studies may not be replicated to confirm or refute findings. Craig and Smyth (2002) note that even where we do have robust evidence we need to be careful about to whom it applies. Evidence from studies undertaken with a specific population sub-sample may be inappropriately extrapolated to other population subgroups.

In early childhood, parental obesity is the best predictor of the child’s risk for obesity whereas after six years of age or older the child’s own weight is a stronger predictor of future risk (Whitaker, Wright, Pepe, Seidel, & Dietz, 1997). Determining which children are at risk for future obesity allows for more intense preventative measures and counseling (Hoppin, 2005). Further research is needed in this area.

National, provincial and state health authorities in collaboration with professional organizations are developing practice guidelines for the prevention of overweight in children. The Registered Nurses’ Association of Ontario has published a nursing practice

guideline based on the available evidence entitled *Primary Prevention of Childhood Obesity*. Its aim is to support evidence-based practice and excellence in services that nurses provide (Registered Nurses Association of Ontario, 2005). The authors emphasize that the guidelines should not be applied in a “cookbook” fashion but used as a tool to assist in decision making for individualized client care and to ensure that appropriate structures and supports are in place to provide the best possible care. The College of Registered Nurses of British Columbia does not have such guidelines at present. In British Columbia, the Provincial Health Services Authority (PHSA) has published a summary of Better Practices for the Prevention of Overweight and Obesity and Maintenance of Healthy Weights for Children (Provincial Health Services Authority, 2005). Long-term interventions with repeated exposures are recommended. Coordinated, multi-component, multi-focal interventions are thought to have the greatest likelihood of success. These include comprehensive school health programs, community organization based programs, family based behavioral treatment, education and support for expectant and new mothers, family food policies, family policies toward children’s regular physical activity, and food security (Provincial Health Services Authority, 2005).

Risk reduction and prevention strategies for overweight and obesity are challenging due to the multi-causal etiology of the condition, low compliance, competition for prevention of other illnesses, calls for additional evidence, economic priorities and information overload of those targeted (Allander & Lindahl, 1997; Bloomgarden, 2004).

Other Influences

O'Dea (2004) notes that there are many examples of well-intentioned health messages being misconstrued or misinterpreted by the public. She cites the uptake of dieting and slimming among girls and young women as an example of health messages gone wrong. Disturbed eating behaviors accompanied by laxative use, vomiting, and binge eating may result in an increased risk for obesity in adolescent girls (Stice, Cameron, Killen, Hayward, & Taylor, 1999). Some studies suggest that children who attempt to lose weight in elementary school may increase their dieting by middle school and are at greater risk for eating disorders later on (Calam & Waller, 1999).

Summary of Etiology, Identification Treatment and Prevention Literature

The current state of knowledge with regard to the etiology, identification, treatment and prevention of childhood overweight does not appear to rest on a sound evidence base at this time. Not only is there a lack of evidence on which to base practice but evidence is often conflicting. Poor outcomes as measured by initial and sustained weight loss have led many health practitioners to develop a cynical attitude towards the management of overweight. As outlined above, some evidence points to health professionals' knowledge and skill deficit with regard to management of childhood overweight. Parental experiences in seeking health care for a child who is overweight have been largely overlooked as a topic of research. If their role as integral members of the health care team in the management of childhood overweight is to be recognized and supported, then information is required about how they are experiencing the process of seeking help. We need to understand the nature of the challenges that arise from the context that they encounter along the way in order to determine what supports are

needed. A further literature review was undertaken to identify relevant concepts and research issues pertaining to parental care for a child with a chronic condition.

Parental Experiences of Seeking Health Care for a Child with a Chronic Condition

Parents in their role as caregivers for a child with a chronic condition must deal with a number of management responsibilities and activities that involve both direct and indirect care (Sullivan-Bolyai, Sadler, Knafl, Gilliss, & Ahmann, 2003). Direct care refers to activities that are necessary for the day to day management of the illness whereas indirect care refers to activities that support the daily management (Schoenfelder, Swanson, Specht, Maas, & Johnson, 2000). The term “informal caregiver” is a term often used in the literature to describe those who provide care for a family member (McGarry & Arthur, 2001). McGarry and Arthur (2001) note that informal caring relationships are vulnerable because of the number of factors involved including the health of the care recipient, the health of the caregiver, the pre-existing relationship between the caregiver and care recipient and availability of resources.

Caregiving Tasks

The literature related to adult caregiving for family members identifies four major responsibilities. These are managing the illness, identifying and accessing community resources, maintaining the family unit and maintaining the “self” (Sullivan-Bolyai et al., 2003). Similarly, in caring for their children, parents are faced with responsibilities and tasks in adapting to their child’s chronic illness or disability. Canam (1993) has outlined eight parental adaptive tasks in the day to day management of the chronic health condition. These tasks focus on the commonalities that parents experience in caring for children with a disability or illness and may be used as an organizing

framework for the assessments and interventions when working with parents. The health care provider's role is to assist parents in knowledge and skill development in their endeavor to fulfill task requirements. These tasks include accepting the child's condition, managing the child's condition on a day to day basis, meeting the child's normal development needs, meeting the developmental needs of other family members, coping with ongoing stress and periodic crises, assisting family members to manage their feelings, educating others about the child's condition and establishing a support system.

Sullivan-Bolyai, Knafl, Sadler and Gillis (2004) offer a detailed list of parent/caregiver responsibilities associated with the day to day management of raising a child who has a chronic condition. Responsibilities include identifying, accessing and coordinating resources. This includes taking initiative in seeking resources, casting a wide net, using advice judiciously, weeding out erroneous, inaccurate or inadequate advice, determining which providers are most accessible, helpful and knowledgeable.

Historically, parental participation in care was promoted as a means of reducing adverse effects of hospitalization on sick children. It has evolved from the provision of basic care to the provision of clinical procedures once only performed by health professionals (Pike, 1989).

Experiences of Parental Caregivers with Health Professionals

Numerous studies have looked at the experiences of parents in caring for a child with a progressive or chronic illness. Many of those experiences relate to information needs and the establishment of partnerships with health care professionals. A discussion of parents' experiences in relation to information needs and forming partnerships follows.

Information Needs. Rahi et al. (2005) investigated the health services experiences and needs of parents in the period (12 to 18 months) following a new diagnosis of ophthalmic disorders in their children. The authors concluded that health services for families of children with visual impairment need to take into account that informational and other needs vary by a number of different factors including whether the parent is a primary caregiver or not, the parent's ethnicity as well as by the severity and complexity of the child's visual loss. The primary caregiver, usually the mother, who is generally responsible for accessing and using services, had greater information needs even when the father attended all of the appointments. Parents and professionals may not be aware of each others expectations and assumptions of the degree of involvement that is expected and have different or conflicting expectations of parental roles (Trollvik & Severinsson, 2004). Fisher (2001) conducted a review of the needs of parents with chronically sick children. Studies included in the review indicated that parents are frequently dissatisfied with the information that they receive (Cohen, 1993; Gravelle, 1997). They often feel that they are given insufficient and inaccurate information (Diehl, Moffitt, & Wade, 1991). Some parents who encounter difficulties in obtaining information turn to other sources such as other parents, support groups and libraries (Gravelle, 1997). The degree to which parents' need for information and support are satisfied factor into whether interactions were deemed positive (Rahi, Manaras, Tuomainen, & Lewando Hundt, 2005). Parents of children with less severe disorders may be more satisfied with care (Rahi et al., 2005). Satisfaction may vary with whether a child is faced with a single condition or whether the condition is part of a complex of impairments. Also important was care for the parent as well as the child (Espezel, 2001).

Dealing with the bureaucracy was a source of frustration for parents whenever the child's health status changed and new services were required.

Need for Rapport and Partnership. An important coping strategy in addressing these tasks and responsibilities is to form positive relationships with the health care team so that they may be utilized as sources of information for the management of the child's condition (Canam, 1993). Once a resource has been identified and chosen, parents need to negotiate a collaborative partnership with health care personnel (Canam, 1993; Kirk, 2001; Sullivan-Bolyai et al., 2003). Gravelle (1997) probed experiences of parents with children in the complex chronic phase of a life threatening illness to further knowledge related to how parents manage their child's illness. Dealing with the changing nature of their child's condition, necessitated dealing with and forming relationships with many different health care providers. Experiences with the health care system varied.

Individual service providers were identified as being especially helpful and generally parents stated that enough services existed to meet the needs of the child.

The degree of nurses' knowledge level about the child's health condition and about the child as a person was found to be conducive to establishing rapport (Espezel, 2001).

Barriers to establishing rapport can occur when a nurse has an insensitive approach and where environmental factors were not conducive to facilitating interaction. Parents often reported that they were not consulted or respected for their expertise (Hayes & McElheran, 2002; Trollvik & Severinsson, 2004). According to Trollvik and Severinsson (2004), parents felt that care planners and providers need to have a real world understanding of childhood chronicity, its impact and consequences and sufficient knowledge a child's health issue to ask pertinent questions, listen for and hear parental

expertise. The need for individualization and expanded assessments of family was emphasized. Parents felt that neither their competence nor their assessment skills were trusted by health care professionals, leading ultimately to a lack of trust in these professionals. Fisher (2001) notes that most parents want to be regarded as partners in the care of their children. Where this partnership was is not satisfactory, parents may become vigilant and assertive (Diehl et al., 1991).

As the chronic care literature review cited above demonstrates, parents look to health providers for respect, co-operation, understanding, information, planning, and individualization of care to assist them in managing a child's chronic condition. While there are commonalities in the ways in which parents take up and carry out their responsibilities in managing their child's health condition, the nature and severity of the condition are important variables in how parents experience the care giving role, their information needs and possibly their relationships with care providers. The differences between the health conditions under investigation in the chronic care studies cited above and the predominantly symptom free condition of overweight or obesity are significant. Parents in the first instance are often dealing with a child's physical limitations, threats to current and future independence and even threats to the child's survival. This contrasts with the task of parents who may have children who are deemed to be at risk for morbidity and premature mortality at some future date. These differences may have implications for the kind of support received and how it is experienced by parents of overweight children.

Summary of the Literature

I have reviewed relevant theoretical and research literature for the purposes of this study. Health authorities have labeled the childhood obesity as an epidemic that has dire consequences for public health in terms of morbidity, mortality and health care costs. A variety of approaches have been utilized in the treatment of childhood obesity with interventions directed solely at children who are overweight, parents only, parents and children who are overweight and the whole family unit. While the solutions to childhood overweight appear deceptively simple, that is, restriction of caloric intake and increased activity, they have proven difficult to implement and sustain. Many parents with overweight children have dealt with or are in the process of dealing with their own weight concerns, most often unsuccessfully. Parents are expected to manage a chronic condition whose etiology has genetic, behavioral, social, cultural and psychological influences, many of which are not well understood and which may not be under their direct control. While multi-factoral influences on etiology are recognized, treatment remains focused on the individual child or the family. Parents find themselves dealing with a chronic health condition for which solid evidence of effective treatment and the means of delivering treatment is lacking. Moreover, health care professionals may not have the knowledge and skills required to provide the assistance that they need. Parents' experiences in seeking and obtaining health care for a child who is overweight are largely unknown. This knowledge deficit constitutes a gap in our understanding of the management of this condition and merits further research. Parents are acknowledged to have a profound influence on the health of their children. Involvement of parents in interventions to change the dietary and physical activity behaviors of their overweight

children has been shown to contribute to success in weight loss and long term maintenance. Research in the field of childhood obesity has focused on the inputs of weight management, that is, on different types of interventions delivered by individuals or teams of health care professionals. Comparatively little research has been conducted about the experiences of parents who are the main agents of change in implementing strategies designed to lead to weight loss or maintenance particularly when the child is at a young age. Their experiences of accessing health care services on behalf of their children and enacting the advice that professionals provide, is likely to influence the outcome of interest, that is, the child's weight status. By gaining insight into the nature of these experiences, we may be able to enhance or modify interventions and identify the kind of support that parents need to succeed in their role as change agents.

The review of parents' experiences of seeking health care for their children with chronic health conditions revealed the use of a variety of qualitative approaches to explore the subject matter. It provided direction and support for the methodology chosen for the study for which this review was undertaken. The themes identified, such as not having information needs met, variability of informational needs by parents, the need to establish rapport with health care professionals and the common tasks that parents of children with a chronic condition need to perform, illuminated the issues which confront parents in similar situations. They provided direction for the questions that were used to elicit information from parents about their experiences in seeking health care for a child who is overweight.

With this review I have endeavored to explore, to some extent, what is known about childhood obesity and parental experiences of seeking health care for a child with a

chronic health condition and to provide a critical analysis of this knowledge. This existing knowledge comprised the analytic framework referred to by Thorne et al. (1997), which forms the platform on which an interpretive descriptive study may be built. The analytic framework represents knowledge constructed by formal research, clinical and personal knowledge. The broad focus of the literature review permitted me to locate the experiences of parents in seeking health care for a child who is overweight in the context of the family and health care system.

CHAPTER THREE: METHODOLOGY

The methodology chosen for this study is the qualitative approach of interpretive description developed by Thorne, Reimer Kirkham and MacDonald-Eames (1997). The term methodology as used in this context reflects the philosophic framework that is employed. Qualitative research approaches grew out of constructivist philosophy (Caelli, Ray, & Mill, 2003). Within this position humans construct knowledge out of their subjective engagement with objects in the world. The key axioms of naturalistic inquiry provide the underpinnings of interpretive description (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). These axioms include: a belief in multiple realities, that reality is complex, contextual and constructed; the inquirer and the object of the inquiry influence one another; theory emerges from, and/or is grounded in data (Guba & Lincoln, 1985). The term methods is used to refer to the tools, techniques and procedures employed in gathering evidence (Caelli et al., 2003).

Areas of inquiry where human subjectivity and interpretation are involved are best addressed by qualitative approaches such as interpretive description that take into account the meanings that people attach to their experiences (Charmaz, 2004; Streubert Speziale & Rinaldi Carpenter, 2003). Qualitative approaches are well suited to gaining a better understanding of a phenomenon or social setting and are particularly suited to areas of nursing that have not been well conceptualized. Public health practitioners and researchers need multiple approaches to understanding problems and developing effective interventions for health conditions (such as obesity) that have numerous contributing causes (Ulin, Robinson, & Tolley, 2005). In the majority of cases, obesity, whether in adults or children is largely determined by behavior which is, in turn,

influenced by a range of individual, social, economic and cultural factors (Hunt & Hillsdon, 1996a). Qualitative methods can help to explain social and contextual influences on the ways decisions are reached or services are accessed (Ulin et al., 2005).

Interpretive description acknowledges the constructed and contextual nature of human experience while at the same time allowing for shared realities. Thorne et al. (2004) note that interpretive description methodology is a grounded approach to articulating patterns and themes emerging in relation to clinical phenomena. It is non-categorical, an alternative to approaches such as phenomenology, ethnography and grounded theory. Thorne et al. argue that the latter are not entirely adequate for nursing research because they are grounded in non-nursing disciplines. Sandelowski (2000) defines a categorical approach as one that uses methods that already exist and a non-categorical alternative as an approach that uses a method that already exists but is relatively unacknowledged.

A qualitative approach was selected because it was the appropriate choice to answer the research questions which were: 1. What are the experiences of parents in seeking health services for their children who are overweight or obese? 2. What are the contextual factors influencing parent experiences in seeking health care for their children who are overweight or obese? An interpretive descriptive approach was chosen because it meets the applied practice needs of nursing. Sandelowski (2000) maintains that qualitative descriptive studies offer a comprehensive summary of an event in the everyday language or terms of those events.

Within this research paradigm, the data being sought are in-depth accounts containing detailed descriptions of participants' experience. These accounts are obtained

from individuals who have first-hand experience with the phenomena of interest (Streubert Speziale & Rinaldi Carpenter, 2003). Consequently, a “good” informant is one who was willing and able to articulate her experiences in sufficient detail to reveal facts and illuminate meanings. Participants are involved as “co-researchers” in the sense that the study relies on their co-operation (Reinharz, 1983) as cited in (Koch, 2006). The interactions between the participants and researcher are reciprocal, decisions about the interview setting, interview time, length of interview are negotiable. Participants decide what information to share (Streubert Speziale & Rinaldi Carpenter, 2003).

The products of this methodology ought to have application potential, that is, the potential to inform clinical reasoning. Nursing is an applied science, therefore knowledge that is generated from this approach should provide what Thorne et al. (2004) describe as “a backdrop” for assessment, planning and intervention strategies.

Sampling Procedure and Participant Characteristics

Relatively small samples may be used within the tradition of interpretive description to access meaningful experiential knowledge (Thorne et al., 2004). Participants for this study represented a convenience sample of parents who have experiences of seeking health care for a child who is overweight. Snowball sampling, a type of convenience sampling in which referrals for potential participants are made by those already in the sample, was also employed (Polit & Hungler, 1999). Parents who resided in the Lower Mainland of British Columbia and who were able to communicate verbally and read English were eligible. These parents who had children with other health conditions were excluded because the issues or problems facing parents are different if the child has another chronic condition and obesity. Moreover, these parents

may already be receiving additional obesity related services that would not be available if the child was only overweight or obese.

Research participants were primary caregiver biological parents with children between the ages of five and 18 who had identified their children as being overweight or obese and who had made some attempt to deal with managing this condition. As Sandelowski (1995a) notes, people enter qualitative studies by virtue of having personal knowledge of some event or experience that they are able and willing to communicate. The definition of primary caregiver parent was the parent who is most likely to identify the need for and seek health information or health care for his or her children. The rationale for choosing this parent was that she or he can provide the depth of data that was being sought to enable the researcher to enter into the experiences of the informant.

A wide age range of children was selected based on literature pointing to the difficulty of obtaining participants for some studies in this field (Edmunds, 2005). This strategy was aimed at maximizing the probability of obtaining 10 participants who were able to provide the kind of information being sought. There is evidence for three critical periods for body weight development: prenatal, childhood and adolescence (Barker, 1999). This study aims to capture the experiences of parents with children in the child and adolescent developmental stages. Moreover, during adolescence, obesity is much more likely to persist than obesity that occurs in children at younger ages (Dietz, 1999). Age 18 was chosen as the upper limit because after that this age, it is likely that parents have less and less influence and control over management of the condition.

Participant Recruitment

Once ethical approval was received from the University of British Columbia and Fraser Health Authority, participants were recruited into the study by a variety of different means. An information poster (Appendix A) was designed and distributed via email to health unit personnel and hospital outpatient dietitians in the Fraser North and Fraser East Health Regions. A short presentation outlining the purpose of the study was made to a group of fifteen public health nurses at a staff meeting. An appeal was made at that time for assistance with recruitment. If a nurse felt comfortable about informing a client about the study and the client was interested in participating, she was requested to have the client contact me or get permission for me to contact the client. The office staff of family practitioners, pediatricians, walk-in clinics and a maternity clinic in the Maple Ridge and Pitt Meadows area was approached with a request to pass the study information on to physicians and midwives and to display the poster in the office waiting areas. Approval for the display of the posters was obtained from the appropriate health authority representative, physicians and midwives. One walk in clinic refused to display the poster citing office policy as the reason for refusal. Posters were distributed to community centers and libraries in Maple Ridge and Pitt Meadows, and placed on bulletin boards in two shopping malls. A poster and participant information letter was provided to the Vancouver Coastal Health community nutritionist involved in the Shapedown Program, a 10 week program for overweight adolescents and their parents. This program targets changes in nutrition and activity for the whole family. The poster proved useful in situations where a participant wanted to give printed information about

A one day advertisement was taken out in The Tri-City News serving populations in the Coquitlam, Port Coquitlam and Port Moody areas of the Lower Mainland inviting prospective participants to contact the researcher if they were interested in receiving more information about the study. A short article was submitted and appeared in *Infocus*, a monthly Fraser Health Authority newsletter published in electronic and print versions. Information about the study, including the poster, was sent via an e-mail distribution list of the members of the Lower Mainland Diabetes Educator Section of the Canadian Diabetes Association. The membership is comprised of nurses, dietitians, nutritionists, pharmacists and others.

A summary of recruitment sources may be found in Table 3.1.

Table 3.1. Summary of Recruitment Sources

<i>Recruitment Source</i>	<i>Number of participants</i>	<i>Geographic Location</i>
Diabetes Educator Section e-mail distribution list	1	Vancouver, B. C.
Public health nurse referral	3	Maple Ridge, B. C.
Information poster displayed at health unit, drug store, and physician's office	3	Abbotsford (1), Maple Ridge, B. C. (2)
Regional health authority newsletter (<i>Infocus</i>)	1	Maple Ridge, B. C.
Social contact at educational workshop	1	New Westminster, B. C.
Participant	1	Maple Ridge, B. C.
Total	10	

Efforts were also made to include participants from the aboriginal community because of the high rates of obesity in that community and to ensure representation from diverse communities. The researcher contacted the community health worker of the Katzie First Nations Band in Pitt Meadows, British Columbia with the request to display the information poster and refer any clients who may be interested in participating. The public health nurse whose area of responsibility includes the Katzie Reserve was also provided with information about the study.

Once a referral or self-referral was received, telephone contact was followed up by a mailed or e-mailed information letter (Appendix B) outlining the voluntary nature of participation, addressing confidentiality, rights of the participants and anticipated time commitments. After a parent agreed to participate, an interview was scheduled. Two participant consent forms (Appendix C) were signed before the start of the interview. One copy was provided to the participant and the second copy was retained by the researcher and filed with other study records.

Setting

Three interviews took place in families' homes in Vancouver, New Westminster and Abbotsford. Most parents choose not to be interviewed in their own homes. Some indicated that they did not want the focus child (the child who was overweight) in question to know about or overhear the interview. Others did not want their spouse to overhear the conversation. Those parents found it preferable to meet with the researcher at the local health unit where a private office was available for the interview process (six

parents) or at the home the researcher (one parent). Participants resided in Vancouver, New Westminster, Maple Ridge, Mission and Abbotsford, British Columbia.

Data Collection

The participants were the primary sources of data for this study and the investigator the primary instrument. Primary data was collected through audio taped face to face interviews with 10 parents (all mothers) representing 10 families and 11 focus children. An interview guide, developed with the assistance of the faculty thesis supervisor, was used to direct the interview (Appendix D). Questions were designed to allow the participant to describe their experiences in seeking health care for a child who is overweight. Permission was obtained from each parent for future telephone contact for the purposes of clarification or expansion of information provided during the interview.

Field notes were completed after the interview to capture information not obtained on the voice recording. These notes served as important additions to data analysis because they functioned to support important points made by the participant and facilitated appropriate emphasis on emerging themes during analysis (Streubert Speziale & Rinaldi Carpenter, 2003). For example, participants' wish for privacy and their choice not to have other family members present during the interview was later correlated with themes relating to secrecy and the lack of open discussion about the child's weight condition in some families. Data collection and analysis occurred concurrently. As Sandelowski (1995b) notes, qualitative researchers emphasize the simultaneity, iterativeness and emergent nature of the research process.

Prior to each interview at the health unit or in my home, I offered tea or coffee and asked whether the participant was comfortable and ready to proceed. The majority of

interviews lasted about one hour but there was flexibility with regard to their length. I was sensitive to the needs of the participant by attending to nonverbal cues that could indicate fatigue, unwillingness to continue, or emotional distress. For example, when a participant requested that the tape recorder be shut off so that she could collect her thoughts, I complied with her wishes. When a participant became tearful, I attended to her non-verbal and verbal signals to determine whether I should proceed with the interview. Although an interview guide was used, I conducted the interview as a guided conversation and provided the participant with an opportunity to communicate what was relevant and important to her. I ended each conversation by asking the participant whether there was anything else that she wished to add to ensure that the topic had been explored in enough depth.

Data Preparation

Interviews were tape recorded with the permission of the participants and transcribed verbatim by a transcriptionist. The transcripts became the raw data that were subject to analysis (Sandelowski, 1995b). Transcriptions were checked by the researcher for accuracy.

Data Analysis

An interpretive descriptive methodology, a grounded approach to articulating patterns and themes in relation to clinical phenomena, was used to provide direction for this qualitative study (Thorne et al., 1997). Basic cognitive processes inherent in qualitative data analysis, that is comprehending, synthesizing, theorizing and recontextualizing were applied to this data set (Morse, 1994). In what follows I delineate how each of these was undertaken in the study.

A critical review of the state of current knowledge (outlined in Chapter Two) provided the basis for the analytic framework and formed the foundation for comprehending (Morse, 1994; Thorne et al., 2004). This framework was only a starting point and modifications were made as necessary during the analytic process (Thorne et al., 2004). Comprehension was reached when enough data were obtained to write a detailed, coherent and rich description of parent's experiences (Morse, 1994). The analytic process began while data were being gathered. It continued during the interviews while listening to participants' accounts of their experiences and while proofing transcripts against the audiotape to ensure accuracy (Sandelowski, 1995b). Accuracy of the transcripts is important in order to capture the nuances of participants' stories. Transcripts were read several times to gain an in-depth understanding of the content. For example, on the first and second readings of one participant's transcripts, I missed the significance of her interaction with nurses at the tertiary care center. Its significance lay not only in the nature of the communication but also because there were so few references to nurses throughout the interviews. Coding was used in the margins of transcripts to help sort the data. Text was tagged, labeled and combined into categories according to common themes. I looked for implied meanings, cultural values and metaphorical references (Morse, 1994). For example, when mothers described the lack of support from family members or health care providers, I used probing questions to elicit a response that would reveal what this meant to the participant. Cultural values were identified from participants' descriptions of their actions and feelings. The embarrassment expressed by one mother about her daughter's overweight appearance suggested that she had subscribed to the normative ideal appearance set for the female

body in this culture. Two mothers made metaphorical references to waves, likening their efforts at weight management to the characteristics of waves. At times their efforts were determined and focused, representing the peak of the wave; at other times they were not, representing the trough. Themes such as family influences on participants' ability to enact advice, the fears about accessing health care services and feelings of guilt were explored.

Synthesis involved merging several experiences to describe a typical pattern of behavior or response as described by participants (Morse, 1994). The range and variation of experiences were identified as were the commonalities and differences among participants' experiences. While most parents were dissatisfied with the quality of services by health professionals, one felt supported by her physician in her efforts to manage her child's weight. In examining the reasons why this might be the case, the significance of the alignment between participants' perception of the presenting problem and that of the health care professionals was identified. Data was removed from the particular instance and abstracted, or, as Morse would say, "sifted" leaving only the common but important features (p. 31). This process assists in the cognitive processes of synthesis and interpretation. Sandelowski (2000) notes that qualitative descriptive studies do not require highly abstract rendering of the data.

In the theorizing phase of analysis, inductive analytic approaches were used to move beyond description to interpretation. Thorne, Reimer Kirkham and O-Flynn-Magee (2004) note that "the mechanics of interpretation.... depend far less on coding sorting and organizing than they do on the process of intellectual inquiry" (p. 4). An interpretation of parents' experiences was provided showing how the thematic areas relate to one another

(Ulin et al., 2005). Using interpretive description I described what parents said about their experiences in seeking health care for a child who is overweight and then interpreted those experiences in light of the literature. In the process of recontextualization, the study findings were placed in the context of established knowledge to identify findings that support existing knowledge and identify new contributions (Morse, 1994).

Researcher's Role

Interpretive description is influenced by social constructivism. In this paradigm, the researcher plays a central role in interaction with the participants and in the collection, analysis and interpretation of the data. The knower and known are interactive, constructing knowledge during the process of inquiry (Guba & Lincoln, 1985). Streubert Speziale and Rinaldi Carpenter (2003) note that all research is conducted with a subjective bias. The researcher needs to account for the influence of bias upon the research findings (Thorne et al., 1997). In this study I endeavored to remain aware of the influences inherent in a nursing perspective in researching an area in which services are delivered by health professionals from a number of different disciplines such as dietetics, medicine, psychiatry as well as nursing. My own experiences of having had a child who was overweight have sensitized me to some of the issues under investigation in this study. I have acknowledged and examined my personal experiences while remaining open to participants' experiences during data collection, analysis and interpretation. Personal perspectives have been made explicit through the use of a reflective journal. The fact that I am female may have influenced the nature and depth of information shared with me by the participants (all female) by virtue of that shared bond. As a member of the nursing profession, which is generally held in high regard by the public, I may have

been privileged with information deemed to be of a sensitive nature by parents. Such information is vital in understanding parent's perspectives and in identifying variables that are complex, interwoven and difficult to measure.

Scientific Rigor

The proposed research procedures are congruent with the qualitative paradigm. The research questions which seek to examine experiences embedded in the social and behavioral realms are appropriately explored by qualitative methods. Part of scientific rigor is ensuring collection of credible data. A number of measures to ensure quality were incorporated into this study. Validity and relevance were addressed in a number of ways.

Confirmability

A clear audit trail was left by documenting, from the beginning of the research project through to its conclusion, the thought processes, hypotheses, analytical schemes and abstractions that were employed to reach conclusions. The purpose of an audit trail is to provide a recording of activities that others can follow to demonstrate how the research process generated the data (Streubert Speziale & Rinaldi Carpenter, 2003). A clear exposition of methods of data collection and analysis is provided (Mays & Pope, 2000). When necessary, a phone call to the participant was made when clarification or elaboration was required on reading the transcripts.

Credibility

An effort was made to ensure that a wide range of different perspectives was incorporated into the study (Mays & Pope, 2000). The large geographic area from which participants were drawn made it more likely that differing perspectives of urban,

suburban and rural residents might be represented. The viewpoints of any given group of individuals were not represented as the sole truth about the experiences of parents.

Prolonged engagement with the subject matter increased the probability of credibility of the findings (Streubert Speziale & Rinaldi Carpenter, 2003). Each audio interview tape was listened to at least once during proofreading and transcripts were read numerous times to engage with the subject matter prior to the start of coding, sorting or creation of linkages.

Evidence of reflexivity, that is, sensitivity to the ways in which the researcher and the research process may have shaped the collected data is documented (Mays & Pope, 2000). I demonstrated evidence of reflexivity during data collection by not leading the conversation and following up on comments to decrease researcher bias. The data was collected from participants over the course of one interview. Consequently, the window of opportunity for the development of a trusting relationship between participants and I was very narrow. Due to the nature of the topic, which is deemed by many as sensitive, I felt that it was important to establish a sense of trust and an environment of safety for those individuals sharing their stories with me. It appeared to me that all of the participants welcomed the opportunity to speak about their experiences, a feeling that was confirmed by the feedback (described in Chapter 4) that I received at the end of several interviews. I did not have to “work hard” to elicit the information that I was seeking. The willingness of one participant to travel 44 kilometers to meet with me, indicated that she felt that it was worthwhile for her to participate in this process. Another sign that participants felt secure during the interview process was the nature of

the information that they shared, that is, details about their personal and family life that, at times, revealed their own and family members' vulnerabilities and shortcomings.

A number of participants offered unsolicited comments at the end of the interviews about how they experienced the interview process. One mother exclaimed in surprise, "Are we done? No way! We're not done are we?" When asked if she had anything else to add, she indicated that she didn't "think so but it was very pleasant." Another stated that it was a "therapy session, getting to talk about it." A third participant commented that it was, "really nice that somebody is looking at it [parent's experiences]." After I thanked her for participating in the interview another mother stated, "Well I actually have a little bit of value out of this as well, because it's made me realize some of the things that I need to do and so I thank you for that." It should be noted that no suggestions were made to this or any other participant about what she could or should have done with respect to managing her child's weight. Receiving this feedback was helpful to me because it confirmed that parents saw value in being consulted and in being able to talk about issues that were of concern to them. It was also an indication that for those individuals who made the comments, the interview experience had been a positive one.

The effect of my personal characteristics such as age, sex, professional status, and social and professional distance between researcher and participant have been considered and made explicit.

Attention was given to negative cases, those elements that appear to contradict the emerging themes and explanations. An effort was made to account for all data.

Credibility will be enhanced if the findings of this study pass the “thoughtful clinician test”, that is where those with expert knowledge of the phenomenon find that the claims confirm clinical hunches, are plausible and illuminate new relationships and understandings (Thorne et al., 2004). In this case, those with expert knowledge are the parents not clinicians.

Relevance

Sufficiently detailed information has been provided to allow the reader to determine whether or not the findings might apply in similar settings (transferability). No claim with regard to generalizability has been made. As Lincoln and Guba (1985) note the determination of fit or transferability rests with potential users of the findings. Guidance was sought from the chairperson of the thesis committee to ensure that the fit between the data and the emergent themes was an appropriate one.

Ethical Considerations

Issues related to the emergent nature of qualitative research methods such as ongoing negotiation of consent, sampling and ethical concerns relating to vulnerability of participants were addressed. Due to the inexperience of the researcher in qualitative methods, this study was carried out under supervision of faculty members at the University of British Columbia. Prior to conducting this research study ethical approval was obtained from the University of British Columbia’s Behavioural Research Ethics Board and the director of research from Fraser Health Authority. Rights of the participants were protected by:

- Providing participants with an information letter describing the study purpose, potential risks, benefits and expectations

- Describing the measures taken to protect the confidentiality of participants including data security:

1. sharing of audio taped interviews and transcripts only with members of the thesis committee and a transcriptionist
2. storage of transcribed interviews in a locked file cabinet
3. transcribed interviews will be kept for five years then shredded
4. computer files will be password protected
5. tapes will be kept for five years then demagnetized to ensure anonymity and floppy discs will be destroyed
6. participant names will not appear on any written reports

- Describing any potential risks – no known risks in this study
- Obtaining informed written consent from participants
- Advising participants of their right to have the interview stopped at any time and have the tape erased.

Limitations

The researcher is a member of the health care profession and the regional health authority (Fraser Health). Parents may have had some reservations or concerns about sharing negative experiences with a representative of the authority, especially if they were still utilizing services provided by the health region. Those parents who are comfortable in answering open ended questions and interacting with someone who is not well known to them may have been more likely to consent to participate in the research (self-selection). Those who are not as articulate or who are socially less adept may not consider participating in the research. Yet these very characteristics may

influence the nature of their experiences within the health care system in a way that may be important to describe and interpret.

While qualitative sampling does not need to meet the criteria of representativeness, the data should be of sufficient depth and breadth so as to make description and analysis possible. Field and Morse (1985) note that the quality of the research project relies heavily on the researcher's ability to obtain information and on perseverance and sensitivity. The researcher's interviewing experience is limited, which can potentially limit the findings of the study. The researcher's time is a limiting factor in terms of the number of informants interviewed and the amount of data collected.

The participants in this study were female, white, English speaking, and came from a middle class background. Inclusion of fathers, persons of different cultural, ethnic and socio-economic backgrounds would have strengthened the study by including a broader range of perspectives. The population in the Lower Mainland of British Columbia is diverse and includes individuals and groups from many parts of the world, some of which may not subscribe to the dominant Western values that privilege thinness over more substantial body weights and forms. It would have been beneficial to access members from these groups.

The size of the sample is a limiting factor in that the full range of experiences of parents seeking health care for a child who is overweight may not have been identified. Although significant thought, time and energy were invested in recruiting participants, the recruitment methods chosen yielded only ten participants. Time constraints on my part were also a limiting factor in determining the length of time available for participant recruitment.

The study relied on self-reported data. There may have been a social desirability response bias, that is, a tendency of some respondents to distort their responses to present a favorable image of herself (Polit & Hungler, 1999).

Summary of Methodology

In this chapter I provided a description of and the rationale for my choice of using interpretive description as the methodology for this study. I described the methods used, how the data was analyzed, the precautions taken to ensure ethical treatment of participants and how scientific rigor was addressed. In Chapter Six I will outline the findings from this study.

CHAPTER FOUR: FINDINGS

Introduction

This study focuses on the personal experiences of ten individual parents drawn from the population of parents who are seeking help in the identification and management of a child's overweight condition. Although I was open to hearing perspectives from mothers and fathers, in the end only mothers volunteered to participate in the study. There is no suggestion that the experiences of these parents are representative of the greater population of parents. Parents' experiences are embedded in particular contexts that vary across time, place and space. Nevertheless, as Frank (2004) notes the value in examining subjective experiences is in "...making ordinary people vivid by depicting them at their decisive moments of conflict and self-doubt; connecting what counts as stakes in their games with the stakes in other people's games; and most difficult but ultimately most important, realizing what truth needs to be told" (p.40).

Parents generously shared information about their own actions in seeking health care for a child who is overweight as well as the responses that they received from health care providers. They readily talked about their personal strengths and shortcomings in interfacing with the health care community and in managing their child's condition within the context of family and their social environment. And finally, they critiqued the services that they received and identified resources and services that they felt would have helped them to better support their families and their child. A detailed description of the parents is presented below.

The findings are discussed by themes that were identified from the accounts provided by parents. These themes pertain to the help seeking trajectory, accessing

health care, and parental management of the condition. After identifying a child's overweight condition, parents engaged in a process of reflection on the possible causes, often attributing the excess weight gain to their own parenting practices or family history. They tried to influence their child's diet and activity patterns in ways that they hoped would result in a slowing of the rate of gain or the normalization of the weight status. When their efforts did not yield the desired results, they considered turning to health care professionals including family physicians, dietitians, public health nursing services and tertiary care services for assistance with managing their child's weight. Parents weighed their fears or concerns about engaging or reengaging with health professionals against anticipated benefits of accessing health services during the process of deciding to seek help. Different conceptualizations of the presenting problem (excess weight) between health care professionals and parents contributed to the high level of dissatisfaction with services expressed by parents. Concerns about damage to children's self esteem resulting from treatment strategies and victimization by peers family members and others ranked high among parental concerns. From the health professionals' perspective, it was the presence or absence of health problems commonly associated with overweight that often determined whether and how long follow up took place. Parents received simplistic advice that did not take into account the complexities of weight management in the context of the family setting. Consequently, they dealt with these complexities largely without the benefit of professional help by using a variety of management strategies that emphasized varying degrees of parental control of the child's environment and self control in the child. Parental expectations of help from health care professionals were generally not met and their children remained overweight.

Description of Participants

In this study ten biological mothers shared their experiences of seeking health care for a child who is overweight. Of these ten, three mothers volunteered to participate in the study as a result of having seen the information posters displayed at the health unit in Maple Ridge, a doctor's office in Maple Ridge, and a drugstore in Abbotsford. Four public health nurses initiated a total of three referrals. All four met the study inclusion criteria; three consented to participate, one declined citing lack of time. One participant responded to information about the study sent out to members of the Lower Mainland Diabetes Educator Section of the Canadian Diabetes Association via their email distribution list. Another participant had read the article about the study in the Fraser Health Authority newsletter *InFocus* and felt that she had relevant experiences that she was willing to share. One mother heard about the study during a social gathering that was part of an educational workshop and expressed an interest in participating. And finally, another mother was referred by a friend who had expressed interest in participating but whose daughter did not meet the age criteria. Participants resided in Vancouver, New Westminster, Maple Ridge, Mission, and Abbotsford, British Columbia. Of the ten participants nine lived within the Fraser Health Authority while one resided within the Vancouver Coastal Health Region.

Study participants were Caucasian, English speaking women. Although information such as age, marital status, occupation and employment status was not sought as part of the study design, a number of parents shared this information. Two parents indicated that they were not working outside of the home at the time of the interviews, the remainder made reference to some form of work outside of the home. Occupational

categories included teacher, respiratory technician, clerical support, administrative assistant and nurses. Although efforts were made to sample from the Aboriginal and immigrant communities, participants from these communities are not represented in the study.

In the course of the interviews, six women identified themselves as being overweight; two identified their husband as being overweight. Participants were not asked whether they considered themselves overweight. Several women reported having attended Weight Watchers International, a consumer organization offering a program of group support and information about diet, exercise and other lifestyle strategies leading to weight loss.

The children for whom services were sought had no other diagnosed health concerns. Four of the children were boys seven were girls. One young adult, the sibling of a child who was the focus of interest for the purposes of this study, was included in the study and is listed in Table 4.1, the summary of selected participant and child characteristics, even though she was older than the upper age limit for the study. The rationale for including her was that the experiences of the mother in seeking health care for the older sibling strongly influenced her approach with the younger sibling. Furthermore, in relating her experiences with health care providers, the mother often made no distinction between the two children. After initial attempts to clarify which child she was referring to I felt that, in the interests of getting at the experiences themselves, I would not interrupt her train of thought. One child had been diagnosed with dyslipidemia but had been discharged from care for some time prior to the interviews. At the time of the interviews, all children were between ages of nine and

Table 4. 1. Summary of Selected Participant and Child Characteristics

<i>Parent</i>	<i>Parent ID Self or Spouse as Having Weight Concerns/Struggles</i>	<i>Sex of Child</i>	<i>Age in Years at Weight Problem ID</i>	<i>Current Age in Years</i>	<i>Health Professionals Consulted (Publicly Funded Unless Otherwise Stated)</i>	<i>Diagnosed Health Condition Related to Weight</i>	<i>Sibling ID With Weight Issues</i>	<i>Sibling ID With Health Concern</i>
1	Yes	F	8 – 9	11	None outside family	None	No	No
2	Yes	M	5	14	GP	None	Yes	No
		F	5	20	Dietitian * Endocrinologist* Nurse* GP	None	Yes	No
3	Yes	F	4	17	Nutritionist GP	None	Yes	No
4	No	F	13	18	Health Unit GPs (3) Psychologist	None	No	Diabetes Asthma
5	Yes	F	5	9	GP	None	Yes	Hearing Loss
6	Yes	F	7	17	Nutritionist GP Endocrinologist* Dietitian* Gynecologist Psychologist	Dyslipidemia Advanced Bone Age, Early Maturation	No	Anorexia
7	No	F	6-7	12	GP Pediatrician (socially)	None	No ? under-weight	OCD
8	Yes	M	11	13	GP	None	No	No
9	Yes	M	2 1/2	9	GP Pediatrician Endocrinologist* Dietitian* Dietitian-counselor (private)	None	No	No
10	No	M	4-5	8	Dietitian	None	No	No

Note. * Seen at tertiary care center. ID = identified, M = male, F = female, GP = general practitioner, OCD = obsessive compulsive disorder

eighteen and were attending elementary, secondary or post secondary schools; one child was home schooled. All except one child were still living at home. One was an only child, all others had siblings. Three parents reported having another child who was overweight. The parents reported experiences of interacting with family physicians, pediatricians, endocrinologist, dietitians, psychologist, gynecologist and nurses in the process of seeking health care for a child who was overweight. Consultations took place in clinical settings such as a physician's office, a tertiary care pediatric center and a health unit. One participant used her social and professional connections with physicians in the management of her child's condition in addition to consulting with her family physician.

Although all parents were given the option of being interviewed in their own homes, only three chose to do so. Six parents indicated a preference for being interviewed at the Maple Ridge Health Unit citing convenience and privacy as the reason for their choice. One chose the researcher's home without offering a specific reason. Partners or fathers of the children were notably absent from both the interview and the interview setting despite the willingness of the researcher to conduct interviews at a time convenient to participants including evenings and weekends. In some instances, this absence appears to have been intentionally structured by the mothers to ensure a greater degree of privacy. Perhaps they could speak more freely about family dynamics related to the child's overweight condition than if the partner were present. Some of their comments in this regard are outlined in the body of this chapter. One mother, interviewed at the health unit, confided prior to the start of the interview that she had informed her husband

that she was going to be interviewed on a topic related to children's health, not mentioning that the topic was specific to her own experiences related to seeking care for a child who is overweight. She indicated that she could not take any chance, no matter how remote, that he would share this information even unintentionally with their daughter. She expressed a fear that if her daughter found out that her mother was discussing her weight with anyone, even the researcher, a health care provider, she would feel betrayed. The actions taken by the participants in structuring elements of the interview process in the ways outlined above foreshadowed the themes that emerged from the interviews.

Although written and verbal information was provided to prospective participants about the purposes of the study prior to the interview, the first participant revealed within the first ten minutes of our conversation that she had not sought health care services for her child. My initial reaction was to terminate the interview since I felt that she did not possess the information that I needed. As she continued speaking about her experiences of managing her child's weight, I decided to proceed with the interview because it became clear to me that her reasons for not seeking health care were relevant. I began to see the experiences of parents from a broader perspective and started to look at influential antecedents to seeking health care. The inclusion of this participant in the study was discussed with and approved by the committee supervisor.

Quotations are identified to demonstrate that all participants had a voice and were represented in the findings but some of the short quotations are not identified by participant number. To protect the identity of the children, their names, when cited in quotations, were not stated but replaced with the word *child* and bracketed. Participants

were not specifically asked about the weight of their children; most did not routinely weigh their children or monitor weight or degree of overweight based on weighing. Several participants did make reference to current measures of weight or estimations of the degree of overweight and those are included in the findings where relevant.

Help Seeking Trajectory

All the flowers of all the tomorrows are in the seeds of today. (Chinese Proverb)

Consultation with health care providers about a child's weight was typically preceded by a period varying from months to years during which parents identified a concern, tried to find an explanation for its cause, adopted a wait and see attitude or took measures to address the problem. The pathway leading from problem identification to consultation with health professionals to utilizing advice or support was not always linear. The process involved not only an assessment of the nature of the problem and of how to deal with it, but a retracing of steps to identify what factors might have led to the weight gain. The process also entailed looking into the future to assess the costs to the child if she remained overweight and the likelihood of her losing the weight without intervention. The major landmarks along this pathway are outlined below.

Identifying a Weight Concern

Parental concern about a child's weight crystallized at ages two and a half to 13. Appearance in relation to peers, how the child fit into clothes and behavior was often the trigger for concern rather than anthropometric measures such as weight, or use of a height and weight growth chart, BMI or BMI for age chart.

I think that it was the way that she was fitting in her clothes and her coming to me saying I'm hungry and sometimes I'd be able to see this isn't hunger. That this is something else that you want some of my attention for. (1)

Body fat distribution patterns that differed from the perceived norm triggered concern for a number of parents. One participant noted:

It was just really last year that he started to get more around his middle. My husband and I weren't really comfortable with that. The minute he started to get a tummy, his dad started getting really uptight about it.... I stress about it because I see my husband stressing about it. (9)

Another child sustained a knee injury which restricted his mobility. He subsequently developed "rolls" and "male breasts" which made him a target for teasing by other children. His mother was less concerned about the appearance of breasts than the social consequences for her son.

Often the mother first identified that a child was overweight and subsequently sought confirmation from her partner and others in the family. The significance and meaning that was attached to a child's overweight condition varied, "... there was a lot of conflict and people's [other moms'] opinions on whether you should just ignore it and pretend it doesn't exist and she's just going to grow out of it." Another mother, referring to her husband's perception of his daughter's increasing weight, stated, "I don't think that he would have identified it as a problem, I think that he would have identified it as the same way that a parent who has a child that has big ears. I don't think that he would have, he would have just accepted the way she was."

The weight status of other members within the extended family influenced how a child's weight was perceived. Having a morbidly obese brother-in law, sister-in-law and mother-in-law sensitized one participant to the likelihood of an increased risk of overweight for her own children. This mother witnessed the struggles of these family members who reportedly weighed between 300 and 450 pounds as they underwent "stomach stapling surgery," experienced wound dehiscence and the "mouth jaw thing."

Although she recognized that her own children were at risk for obesity, paradoxically, this family's history had the effect of increasing the threshold for the weight at which she became concerned:

She was never a skinny Minnie, as I say, and because of our history we knew that, um, we were never going to have small skinny children and that wasn't a problem so nobody had ever really mentioned anything although she was probably at the high end and possibly a little bit obese, but nothing that I was concerned about until she was about thirteen, then she started. (4)

Parental Strategies to Manage Child's Weight

After identification of a child's overweight status, parents typically utilized a variety of strategies in trying to manage the child's condition prior to seeking help from health care professionals. Those parents who had been members of Weight Watchers International were already familiar with the principles of what is commonly termed as healthy eating. Most other participants were also aware of the importance of balancing sedentary activities with activities which required greater energy expenditure. They were aware that limiting access to "junk food" and providing healthy food choices were recommended approaches to weight management, indicating the source of this knowledge was in the public domain.

Strategies aimed at dealing with the weight problem included acting as a role model by making healthy food choices and exercising. One parent related:

I do remember talking to her [participant's mother] later on and I can't remember was it initially or not and she felt that the best weapon against this issue with [child] was that [child] follow my lead. And that was the most important thing. And I remember thinking that yes, she's right. And about four years ago I did join Weight Watchers and lost 40 pounds. And I was feeling like wow if I can do this and you know [child] is aware of the fact that I was weighing in once a week and this stuff. (1)

The same parent reported later regaining the weight. Her experiences paralleled those of a number of other mothers. The difficulty encountered in sustaining the behaviors needed for weight maintenance proved problematic in their efforts to serve as role model for their children. The frustration about the effort that it took to maintain weight loss was described by one mother who indicated that her Weight Watchers leader had suggested that she be written up in the Weight Watchers magazine because "I had to eat so little and I had to exercise so much to maintain my weight and that's something that I you know, I can do that because I'm quite disciplined, but I think to expect that from a child" Even this parent regained a significant amount of the weight that she had lost.

In some instances friends were consulted about the management of the child's weight. This led to advice such as not to "make a big deal" out of the weight gain or referral to books such as those written by nutritionist Ellen Satter on the topic of good infant and child feeding practices.

Once a child's overweight condition was identified, parents generally looked back in time to identify factors that might have been responsible for what they considered to be excessive weight gain. Attributing causation was important in their attempts to understand and modify their own and their children's behavior.

Attribution of Cause of Overweight

Participants frequently looked to their own parenting behavior and family circumstances as possible causes of, or contributors to, their child's weight. Having four children in rapid succession was thought by one mother to limit the amount of time that they, as a family, had spent in physical activities outside the home. She also reflected on the effect of having praised her daughter for finishing everything on her plate, concluding

that she would do things differently now. Another parent wondered if, as a baby, the child had been fed too much. A third mother stated:

I remember having to make her eat something because she'd leave the table when she was three and four and five years old. She would hardly eat, so she was a little, tiny bird. That was a mistake, I think now I look back on it to force a child to eat when they're not hungry. And you learn, live and learn. (6)

These examples point to a commonly held view that some children need to be rewarded, coaxed or forced to eat, that their signals of food refusal or satiety cannot be trusted and must be overridden. Actions taken by parents to encourage a child to eat when she does not want to eat are consistent with the control paradigm described by Satter (1996) as outlined in Chapter Two. The last quote clearly shows that the mother is reevaluating her previous actions from a stance consistent with the trust model or paradigm which assumes that children will eat the amount of food that they need (Satter, 1996). In the course of informing herself about the causes of obesity some of the assumptions and beliefs on which her parenting style was based were discarded and replaced with the belief that it is the parent's role to provide nutritious meals and it is up to the child as to whether or how much to eat. At times this approach conflicted with other expert advice to ensure that children eat breakfast regardless of whether or not they are hungry. Several parents recounted that they insisted that their children have breakfast, seeming not to be aware of the contradiction between encouraging their child to attend to internal signals of hunger and satiety and forcing them to eat when they did not want to.

One mother identified a number of steps that she had taken that, in her opinion, should have prevented her child from becoming overweight. These steps included staying home when the children were young, breastfeeding, and providing homemade baby food to her infant. Even mother-daughter outings during which food was the focus were seen,

in retrospect, as having contributed to excessive weight gain. Overly rigorous parenting standards were thought to contribute to the problem. "I don't know, how much really, contributed to this rigorous parenting standard that we set out to have, a standard that was hard for us to maintain." This participant did not elaborate on what that standard might have consisted of or specifically how it contributed to overweight. Eating meals outside the home, especially fast food, was identified as being a contributor to weight gain.

The ease with which their children gained weight was attributed by several mothers to a family history of overweight, including their own. Seven of the ten parents made reference to their own or to their partner's overweight condition. One mother, whose son started to rapidly gain weight at age two and half referred to her husband's weight several times throughout the interview. Although she did not explicitly state that that family history was a contributing factor to her son's weight gain, the juxtaposition of statements made about her son and her husband point to a correlation. She describes them as follows:

He's [her son, now aged 9] five foot five, he's 180 pounds, he wears size ten shoes and his hands, they're like hams. He's as strong as an ox, he can lift me up and swing me up like I'm a puppet. So, he's a big strong guy. Dad is six feet tall and almost three hundred pounds. (9)

One participant stated that, "I would be considered an overweight person for sure. Sometimes I feel, what's the word for it? Sort of helpless. I can't even help myself, how am I going to help her?" She saw a relationship between her own weight and that of her daughter and seemed to think that getting her own weight under control was a prerequisite for helping her daughter. Not having succeeded at this in the past she did not have confidence in her ability to help her daughter manage her weight. That belief could have been challenged by knowledge of studies that have shown that family

based weight management programs often have greater success in helping children to lose weight than the parent participants.

Specific traits and behaviors of the child were identified by one mother as having contributed to excessive food intake:

She's an oral person. She always had something in her mouth. She sucked her thumb until she was five and she still is passionate about food and I constantly catch her putting pens in her mouth. I think there was something about who she was as a little girl that she was very eager to please and happy to finish her food.
(1)

Not all parents saw an obvious reason for weight gain especially when they compared the amount of food eaten by their child to that of other children who showed no evidence of overweight or if they served healthy food to the whole family and only one child had weight concerns.

Factors Influencing Decision to Seek Professional Help

The decision to seek professional help was made in the wake of unsuccessful attempts to manage on their own or when the child's weight gain increased beyond a parent's comfort threshold. None of the parents indicated that a health care provider had raised the subject of weight concern prior to their own identification of the problem. The decision to seek out, engage with and remain engaged with health care providers involved the consideration and evaluation of a number of factors as outlined below.

Fear of damage to a child's self esteem ranked as mothers' main concern, on par or even higher than concerns about medical consequences of overweight. Most parents reported that their children had been singled out for negative attention or teasing by other children as a result of their weight. Even when the teasing came from a friend, one mother felt that it had an impact on her self esteem and body image, "She had a little

friend that called her Goliath and herself David so she [laughing] really saw herself as different than other kids.” She came home crying from kindergarten one day because she was called fat. From her mother’s perspective the child was “a little bit more round than other kids”, yet she was called fat at school. These experiences correspond with research findings that children develop body ideals early in life. Children as young as kindergarten age have a tendency to negatively stereotype the obese and adopt a lean body as their ideal suggesting that have started to adopt the dominant culture’s views of good and bad body shapes (Harrison, 2000).

Speaking first generally then more specifically about her daughter, one mother articulated her concerns as follows:

If you don’t have personal value, you don’t, you don’t feel worthy of anything, you don’t feel worthy of love and you don’t feel worthy of a good job, you don’t feel worthy of taking care of yourself and I think if you don’t have a good self image and I don’t think that most girls do, so I’m not saying that [child] is the only one, um the core of your being is rotten and there’s nothing to build on, you have to have the core solid and then, then everything can flourish. (7)

The imagery evoked by this analogy is powerful. Her choice of words in describing what it means to not value the self conveys the importance of the issue and the dangers that she perceives lay in store for her daughter if that sense of personal value is threatened. Her comments also reflect a belief that most girls do not have a good self image, which makes them more vulnerable to negative influences.

She followed this by saying:

I think on a visit later or on a personal basis we [physician and mother] spoke about [child] and about her weight but also about her [daughter’s] body image problem that, to me, was more important than how much she weighed. That, that’s adjustable but the image you carry on for such a long time and that’s what really hurt [child] more than her weight. (7)

This mother felt that she could help her daughter maintain a sense of personal value and did so in a number of ways such as encouraging friendships with other girls who were heavier and who had a strong sense of self.

Several participants made reference to buying clothing for or influencing their children's choice of clothing so that what they wore deemphasized their problematic body shapes and sizes. The aim was to preempt negative comments from their peers:

I encourage her to buy, pick out clothes that she likes but I try and sort of, sort of point out the options just not be as revealing of her body size so that she's not put in the predicament where somebody might say something to her that would have an impact on her body. It's not an easy task because you've got to keep your feelings apart and removed from it and that's my biggest fear is, is creating a body image for her that she's going to develop a real over-eating problem and it's, it's really frustrating. (5)

This mother tried to steer her daughter away from a two piece bathing suit in which the child felt comfortable towards a one piece bathing suit that covered more of her body. Since her daughter apparently was not aware that exposing more of her body could draw negative attention, she wanted to know why she couldn't have a two piece like her friends. Her mother was put into the difficult position of trying to answer her question without drawing attention to her weight. A truthful answer might alert her child to the fact that her body was not acceptable and needed to be camouflaged in order not to draw negative attention from others. Mothers wanted to protect their children from the hurtful comments of others by drawing attention away from their bulk, yet the very act of protection can signal to their children that they are, in some way, defective and the defect needs to be hidden. Parents were trying to cope with what they considered to be a social environment that stigmatizes their children thereby putting them at risk for damage to their self image.

Perceived threats to the child's self esteem came not only from other children, but family members, and health providers. Husbands, in particular were seen at times to be insensitive and thus potentially damaging in their comments to their children:

I feel like I'm having to, um, be the mediator between the two of them now and protecting, be a voice for [child] because he's so young and I, you know try to make, help my husband to see that, you know, maybe some of the comments he makes are not fair and not helpful. (10)

Another mother stated:

I always say because he's a man he doesn't he's not as tactful as he should be and he, he loves her to pieces and he would never want to hurt at all or to demean, but sometimes, I mean I'm surprised by how candid he can be, that's a better word for it, he's really candid and not very tactful and that's not, you know, not good for a young girl who's going through, you know negative body image. (7)

Mothers frequently spoke of the need to act as intermediaries or buffers between family members, health providers and the child to protect him or her from hurtful comments or behavior. Such comments or behavior were interpreted by mothers as threats to the child's self esteem. While mothers generally intervened by pointing out that comments were not appropriate, more often than not, there was a price that had to be paid for coming to the child's defense. That price was often a temporary disruption of relationships between family members:

My sister is very insensitive towards [child's] weight and will say anything in front of [child] and I find that very, I get quite angry. My sister and I have actually had quite a few arguments outright because of it because I don't, I find it hurtful what she does to [child] and me. (6)

One mother, while feeling compelled to step in on behalf of her child, at the same time questioned whether her intervention was actually exacerbating the problem:

If he [child's father] makes a comment about what he is eating or make comments about his weight, um, and then I, if I didn't react to his comments would [child]

just, would it roll off [child] more, more so than when I get involved with saying, you know, don't talk like that or, you know, that's not a nice thing to say because then I do make more of an issue of it. (10)

The uncertainty about the correct course of action and the negative consequences of intervening added to the level of tension felt by the mothers and affected family dynamics. One mother described the rift between her and her parents over their behavior and expectations of her child, "they would want her to have everything [food] but then at the same time there would be that judgment that would come with it. So that was hard." None of the parents reported having discussions about managing family conflicts with their care providers.

Several parents had concerns that consulting a health provider could be damaging to the child by drawing attention to the child's overweight status. One parent wondered:

Maybe going to see the dietitian and doing that stuff with her has damaged her psychologically and her mother is telling her she's fat so she's got to go see the doctor. I don't know, maybe I've messed up and done that too, but I don't know what she, what she really thinks, because she doesn't, she's not a talker, she doesn't say a lot. (6)

The concern about damaging a child psychologically placed mothers in a double bind. If they did not mention the weight and did not seek health care and their child remained overweight or continued to gain weight, they felt that they were at risk for psychological damage from comments made by their peers and/or family members. If they did speak openly about it and sought assistance with weight management from health care providers, then that too could be construed by the child as a message that something was wrong with him and thus hurt him psychologically. In the example just cited, the parent also had to deal with the added burden of not knowing how her child felt about the

actions that she had taken to address the problem. This uncertainty weighed heavily upon her.

Not all parents agreed about the importance of seeking help and the kind of help to obtain. In the example cited above in which the boy developed a "tummy", the father who was very athletic was more concerned about the weight, frequently criticizing his son's appearance. Her husband's negative, hurtful behavior towards their son constituted more of a problem for the mother than his weight. She identified counseling as a solution to this problem, but had no immediate plans to address the issue. Arranging for counseling would necessitate gaining her husband's co-operation to participate in this process and possibly involve a confrontation, something that she may not have been prepared to do at this point. She was more concerned about the decrease in her son's energy level which she thought might be related to the family's vegetarian diet. While living in another community, she had enjoyed a good relationship with a physician who was also a vegetarian. She was reluctant to broach the subject of the decreased energy level and the increased weight with the new physician who was not vegetarian, and was considering returning to her former physician, "because at least I know she would understand what the issues are." Although she had calculated the child's BMI and determined that he was overweight, she appeared to be unconvinced that it constituted a problem necessitating action. When asked about how she would go about resolving her concerns she replied, "I would start with the medical system and I don't know if I'd buy into that whole BMI thing. That would be the first thing that probably a physician would look at...." Her statements, regarding being vegetarian and calculating the BMI, point to an underlying concern about the importance of alignment between her values and beliefs

and those of the health care providers. She appeared to feel vulnerable to being challenged on both accounts. At the time of the interview, she remained ambivalent about taking action even though she was aware that the results of a hemoglobin test could allay some of her concerns regarding the decrease in her son's energy level. If the test result showed a low hemoglobin level, then she felt that she might have to forego the vegetarian diet, something that she was reluctant to do. She had not been raised in a vegetarian household and appeared to have underlying concerns/guilt about exposing her son to the potentially detrimental health effects of a vegetarian diet. Addressing all four issues, that is, her husband's behavior, seeing a new physician, contemplating a change in diet and making changes to manage her son's weight may have been too much to deal with in the context of a busy life that included work, childcare and numerous leisure activities.

Another parent described the continuing effects of negative "baggage" from her prior experiences with physicians. She recounted having to engage in a lengthy battle to have her older son's profound hearing loss diagnosed and treated. The memory of having her concerns dismissed by health professionals was still painfully fresh. She indicated that, "I guess maybe I had that baggage that still hangs on with me so to go there and see my daughter.... It was hard very hard to go in there and say I think my daughter is overweight and I need help and there's a problem."

Similarly, a parent whose older child had been assessed by an endocrinologist and nutritionist chose not to pursue this avenue with the younger child because she felt that these professionals were not able to give her any information that she did not already possess. Referral to a pediatric tertiary care center had not resulted in weight loss or

maintenance for her child. This mother estimated that the second child was about fifty pounds overweight. While she was clearly worried about his weight status and its implications in terms of risks to physical, social, emotional and psychological well being she felt that there was no point in pursuing the same avenue that she had for her older child.

One parent's decision to seek her family doctor's help was precipitated by an encounter with a physician at a walk in clinic which essentially shamed her into taking action:

I'll never forget it where they basically said your daughter is overweight and that's it. It's not like, you know, can we come along side of you and give you some advice or, you know, it was just very much like she was labeled as a fat child.... My daughter went home and she just cried up in her room for two hours because he made some comment too that, you know, there's a risk of diabetes and everything. This is at the clinic and we were there for something else, not even any relationship with my daughter and he chews us out. (2)

The manner in which the subject of a child's weight is broached by the health care provider was important to parents. The lack of sensitivity shown by the physician in the walk in clinic combined with no offer of help in resolving the problem that had just been identified left the parent upset, hurt, and feeling vulnerable. It also left her daughter feeling fearful and shamed.

One parent stated that her own physician would be able to be of assistance in referring her to a dietitian. Although she felt a dietitian would be helpful, she had not accessed this service because of the perceived threat to the child's self-esteem in dealing with professionals with whom she has no relationship.

We rarely go see the GP and I have rarely taken [child]. [Child] might have been in to see the doctor, her doctor when she was less than five years old, so you know, it's kind of ridiculous but this you know is the kind of relationship that she

doesn't have with her doctor, it doesn't really exist as a relationship. He didn't seem like the natural person for her to talk to. (1)

This parent alluded to the role of her own struggles with weight management as a reason for not looking outside the family for help, "First of all, I've to deal with my life. And probably there's some, something in that, in there too and that might explain why I didn't look anywhere else." The threshold for seeking help outside of the family had not been reached.

Even when there was a clear reason for an increase in weight such as decreased activity due to an injury, parents often had concerns about other underlying physical or metabolic condition such as a thyroid abnormality. Diabetes was frequently cited as a concern. One parent worried, "He never had the drinking water and the ketone breath, you know. We know what to look for, but certainly that was one of the reasons we went to the doctor was to make sure." Another mother shared her concerns about her son's increasing size with her sister, a physician, during an out of town family visit. On the advice of her sister she requested and received referral to a pediatrician.

Table 4.2 outlines factors taken into account by parents when determining whether and when to deal with weight concerns and access health services.

In summary, once visual cues alerted parents to a child's increasing size, they deliberated about the course of action to take to address a condition that they saw as posing a threat to the child's well being. Participants claimed to possess some knowledge about healthy lifestyles prior to interacting with health care providers. When they encountered barriers to applying their knowledge and no longer felt capable of helping the child reduce or maintain weight, they considered accessing health care services. For a number of parents, turning to a health care professional for advice, support or referral was

not a decision that was made lightly. The decision to engage, remain engaged or re-engage with health professionals to manage their child's overweight condition was made after weighing a number of concerns or fears and incentives.

Table 4.2. Fear – Incentive Considerations in Engaging with Health Professionals

<i>Fears</i>	<i>Incentives</i>
<ul style="list-style-type: none"> • Parent and /or child's relationship with health provider not well established • Fear of precipitating an eating disorder by drawing attention to weight • Fear of inflicting emotional damage on child by drawing attention to weight • Shame or embarrassment regarding inability to manage own weight • Fear of labeling of child and / or self • Fear of straining relationship with child and or losing trust • Having concerns about child's weight discounted • Fear of having to defend dietary practices 	<ul style="list-style-type: none"> • Rule out medical causes of overweight • Address medical/physical condition • Expectation of getting support/help with information related to diet, exercise, behavioral strategies, referral to other resources • Hope of resolving weight problem

Accessing Health Services

Knowing is not enough; we must apply. Willing is not enough we must do.
(Goethe)

Most commonly, the family physician was the health provider contacted by parents to discuss their concerns about their child's weight. Depending on results of the physician's assessment, advice was given, lab tests were ordered and referral was made in three cases to a tertiary pediatric care. Such referrals led to assessment by nurses,

dietitians, endocrinologists, and in some cases psychologists. A public health unit was contacted by several parents in their search for services and programs. A dietitian-counselor in private practice specializing in adult weight management services was consulted by one parent. Parents' experiences with these health professionals are described below.

Types of Health Services Accessed

Family Physician Services. With one exception, parents' concerns that their child was overweight were validated by family physicians. Assessments tended to be brief, consisting of visual appraisal of the child's weight status and frequently did not include weighing or calculating the BMI for age or laboratory work even when it was requested by the parent. When family practitioners acknowledged a weight concern, advice appeared to be based on the provider's assumptions about the assessment of the causes of the child's overweight condition. Advice fell into two major categories: management of diet and/or physical activity. Dietary advice included eating less, eating healthy, not putting the child on a diet, watching portions, not letting the child go to McDonald's. Recommendations to increase activity included keeping kids moving, not too much television time, and finding activities that the child loves. One mother recounted:

The advice that I got from him to begin with really was more, you know, she'll grow out of it and as long as you keep her active and don't make a big deal out of it and try to keep junk food out of the house, just very basic type of advice that you would get from anyone.

Differing approaches were utilized by health care professionals when addressing an identified weight concern with parents and children. One mother reported a physician's use of fear tactics to encourage behavior change:

[He] would suggest dire consequences. Your toes are going to fall off. You know, try anything. Horrible things that she pretty much figured out that its not going to happen and this wasn't a real thing. (4)

This mother recognized that her daughter most likely could not relate to health risks that may manifest three or four decades later. As she noted, "Yes maybe, she could develop diabetes and that, there were twenty steps in between."

Some advice provided by physicians ran counter to be beliefs and values of the parent.

My own doctor said to me, you're just going to have to tell him that, you know, the refrigerator door is closed after this point. I remember my doctor saying to me, though, is put all their plates out on the counter and put on what they can eat and then put it out. (2)

A mother whose nine year old daughter is wearing size 9 women's clothing related:

I did go to the doctor and the doctor said there were no concerns, I was overreacting. She was very healthy. I asked if we could get tested for thyroid because my mum has a history of thyroid problem and my mum also developed adult diabetes so I asked her if we could be tested for thyroid and diabetes to ensure that wasn't a concern. He told me that there were no concerns and that we didn't need to follow that step and just to keep her active. (5)

Although the most commonly physician identified causes of overweight in these children were poor dietary habits and sedentary lifestyle, other contributors were identified as well. One mother related her experience with a new physician who on the first visit, "talked about weight and she suggested that weight sometimes is a symptom of mother/daughter conflict and that [child] was struggling because I became successful so that was what [child] and I took away." She indicated that her daughter liked that, "Lets blame mum, then I'll be thin." The same mother related that although two physicians had diagnosed her daughter's overweight condition, neither had followed through with a plan of action to treat the problem. She repeatedly stated that physicians admitted lacking

knowledge about community programs or resources to which her child could be referred. She took from these encounters that it was her responsibility to identify and locate services that could help her family manage the child's weight.

Two mothers were told to look to their own weight. According to one mother:

He told me that rather than look at my daughter's weight, that I should probably look at my own weight and consider that first. I should focus my energies on, rather than disturbing her cells because he just kept saying to me she's a healthy girl and there's nothing wrong with her body or her body size and I'm putting my worries in the wrong direction. (5)

While this mother acknowledged that she could stand to lose weight, she felt "frustrated" that the physician was trying to divert the discussion away from her concerns about her child's weight to her own weight. One adolescent reported to her mother that as she was talking to her physician about her weight loss, the physician abruptly changed the topic and focused her attention on a skin lesion that she thought might be suspicious.

According to the mother, her daughter was very upset especially once the lesion was determined to be inconsequential. She felt that she had been deliberately cut off by the physician and, in the process, had caused her a great deal of anxiety. Her mother predicted that this incident would have long term consequences in that she would never be as trusting in a physician again.

Length and frequency of consultations ranged from one five minute session to several brief discussions often in conjunction with consultation for other health issues. Two parents commented on the limited time spent addressing the issue. One stated that the physician was "out the door" signaling the end of the meeting while the other concluded, "You're just stuck with your doctor...they are too busy." Parents did not speculate on the reasons for the limited time spent by physicians in assessment and

follow-up of weight related issues. Inadequate reimbursement for assessment and counseling may have been a contributing factor.

Weight issues were not always the primary focus of visits to health care providers. One parent had ongoing concerns about her daughter's bedwetting, a problem that lasted until she was ten years old. The bedwetting took priority over the weight concerns, perhaps because of the immediacy of the impact on the daily lives of both parent and child.

Tertiary Care. Family physicians acted as gatekeepers to services offered by pediatricians, endocrinologists, dietitians and psychologists. In one instance, abnormal cholesterol laboratory test results triggered a referral to a tertiary pediatric facility. Another child was referred to tertiary care because he was overweight, very tall for his age and had a large bone structure, which taken together, raised concerns about a medical condition. In another instance, a parent's request for referral to specialist services was denied by the family physician because he deemed it unnecessary.

Some parents felt that referral to a tertiary care facility would ensure a more thorough assessment of any underlying medical causes than the family physician was able or willing to provide. Children referred to such a facility did receive extensive assessments including a history taken by a nurse, a physical examination by an endocrinologist, laboratory testing, nutritional assessment and in one case psychological assessment. Conditions assessed and / or monitored included early maturation, advanced bone age and dyslipidemia. One child who had experienced early maturation was admitted and treated for excessive bleeding during one of her periods. Treatment entailed

taking hormone therapy to stop her periods for a year, which, according to her mother, further exacerbated her obesity.

In reflecting on her experiences with the nurses at the pediatric care center, one mother observed that they just did the height, weight and heart rate. "They were friendly-ish, they were good, not terribly helpful." She explained the lack of helpfulness in the following way, "I honestly think that unless you have this experience, I think it's very difficult to put yourself in the shoes of these people [parents]." Most health care consumers do not have an expectation that providers have experienced the same health problems for which they are being consulted. Her comments suggest that the experience of trying to manage childhood obesity has unique features that are not well understood by others, including health care professionals. This mother suspected that her occupation as a nurse affected how she was perceived by the nurses, "I wonder sometimes if perhaps I was a bit intimidating to the nurses because, maybe because of my questioning. They were there to do their job and not really probe too much below the surface." If they had not been intimidated, would they have engaged with her on a deeper level? Or were their interactions with her limited by the narrow role assigned to them by the organization? The mother's experiences with other staff members were similar, "It always stayed very superficial, sort of looking at numbers and charts.... I thought they were kind but it was just you know, just scratching at the surface."

Dietitian/Nutritionist Services. Health unit dietitians were accessed by two parents. One parent had a brief conversation about ensuring nutritional balance on a vegetarian diet. As a result of this phone conversation she also received printed information including a vegetarian food guide. It does not appear that she discussed her

husband's concern about her child's weight with the nutritionist. The parent alluded to the difficulty of using the information "on a day by day basis" because she is not the main cook and her children have a number of foods that they do not like eating. She indicates "I'm trying not to make it a huge issue, my husband is doing enough of that for both of us, so yeah, but that part is hard for me." The contact with the dietitian was made at the suggestion of her sister-in-law.

Keeping a food diary, as recommended by one nutritionist, was a task that one parent found difficult to do. "We kept a food diary but that only lasted as long as you're interested. It's not that I wasn't interested but it was a lot of work and not a lot of results." This parent reported that her child's "eating behaviors were not that much different than the other two." The same parent indicated, "We had our first nutritionist consultation and it was basically the five food groups."

After receiving no new information from a dietitian seen over a period of time, one parent terminated the consults that were part of follow up at the pediatric tertiary care center:

I didn't want to see the dietitian anymore because it was so repetitive as I mentioned, I wouldn't feel it was necessary so, uh, the last couple of years I felt we weren't getting anywhere with her weight and I couldn't see how they could help her with her weight. It was going to have to be a home issue and that didn't work either. (6)

After making brief contact with a nutritionist at her place of work, one mother did not pursue this resource because she did not feel comfortable with the individual's response to her on the first meeting. She indicated that she had felt judged.

Meeting with a dietitian/counselor in private practice proved to be a disappointing experience for one mother. She met with her at the recommendation of a friend who had

been struggling with weight issues and who had benefited from consulting with her. As it turned out, the dietitian/counselor had little expertise in dealing with issues related to childhood obesity and after two visits the mother determined that she had little to offer her in terms of advice or strategies that she had not already used.

Public Health Nursing Services. Public health services were accessed or considered by three parents. One parent received referral to a community dietitian in a neighboring community. Another noted that the school nurse, also a public health nurse, was diligent about posting health information on a public bulletin board within the school. The parent felt that if information about weight management resources was available, it would have been posted. Since she saw no such information she concluded that there was none. A third parent obtained the Canada Food Guide through public health services but accessed no other PHN services once the children were of school age. She related:

I just felt that when I had my kids, there was a lot of support until they get to kindergarten, you know what I mean. Like honestly, like I would phone sometimes, like, um, I felt comfortable, you know when our kids were little to phone you guys up and if my kids had a reaction like to a shot or just anything, it was in a comfortable place but when your kids start school and there really isn't after that. (4)

The same mother indicated that:

My doctor never said that there would be any help through public health so I just assumed not. I just didn't think that there was anything other than that I picked up Canada Food Guide a few times and plunked it on my fridge, and said to the kids, you know, you should have a look at this. (4)

Referral to a dietitian in private practice was provided by the family doctor for this parent but the family lacked the financial means to follow through.

Parents made decisions about the appropriateness of including or excluding their child in consultations with family physicians and dietitians. Some felt that it was not appropriate to have their child present because it would signal that was something wrong with him. This in turn, was perceived to have a potentially negative impact on self esteem. For other parents, having the child present during the visit and having her receive reinforcing messages about diet and activity from professionals was seen to be beneficial.

In summary, family physician and dietitian services were those most frequently accessed by parents. Limited time appears to have been spent by family physicians in assessment, planning and follow-up of weight concerns. Nursing services were rarely mentioned except in passing. While nurses were involved in the history taking as part of the assessment process at the pediatric tertiary care center, parents offered few comments about them or their contribution to the management of the child's weight. Participants did not report delays or difficulty in accessing family physicians. Cost was cited as a barrier to accessing private practice nutritional services in one instance. While two participants telephoned or saw a health unit dietitian, another who was very interested in those services was not informed of this option. This constituted unequal access to dietary services. Some of the reported dissatisfaction with encounters with physicians revolved around whether overweight or obesity constituted a health problem and whose responsibility it was to address it. Overall, it does not appear that the health system was working to meet the needs of the participants.

Differing Perspectives Regarding the Nature of the Problem of Obesity

Parents were faced with a number of views held by their children, family members, and health care providers with regard to what kind of problem overweight and obesity was and what should be done about it. Some parents initially perceived the child's increasing weight as an esthetic issue, however, over time it evolved into a concern about potential health risks. One parent acknowledged, "It was mostly aesthetics but it started to get to the health issue because as I've gotten older and I know more myself, I was deep down inside wondering how far it would go."

One mother described the divide between her own concerns and those of the nursing, medical and dietary staff in the following way:

I was maybe looking more for, I was like, what do I do with this, what do I, how do I make this better? How can I make this better? And they were kind of looking for physical problems. (9)

Her information needs centered on practical management strategies like how "to teach him how to make good food choices without coming across as being the one in control." Her experience points not only to a communication gap between parent and staff but also to fundamentally differing perspectives regarding the nature of the problem. The staff, in the absence of co-morbidities, considered the child as healthy, although they continued to monitor him over a prolonged period of time. The parent's concerns about the ability of her son to realize his full potential appeared to reflect an understanding of health as more than the absence of disease. "I worry about the long term effects, like how this is going to affect him when he's twenty, how it's going to affect him when he's thirty or forty." These worries were based on her understanding of the physical, social and emotional risks of being overweight in the context of a fat phobic society.

While parents were generally pleased with the thoroughness of assessment at the tertiary care facility, they felt that monitoring and treatment were focused on the secondary effects of obesity, rather than the obesity per se. A mother observed, "They sort of let the weight go, you know. The cholesterol was the big issue and they kind of let the weight issue go." Once cholesterol levels had normalized, the child was discharged with no plans for follow up even though the weight concerns remained unchanged from the parent's perspective.

Evaluation of Services Received and Recommendations

One participant expressed ambivalence about the value of services received at the pediatric tertiary care center. After showing staff the completed food diary and activity record, she received validation that she was doing everything that she could to support her child. This feedback was a source relief for her on the one hand because it reflected well on her parenting skills. At the same time, her child remained "obese" and she felt frustrated that staff could provide no further suggestions or advice to address the problem:

It didn't seem that there was anybody that would take the time and say, you know, like to, to sit down and say okay, now this is, you what you need to do to help your kids to lose weight because everything that I did like the food diary and everything else they would just look at it and they would say, you know we don't see a problem here and then would just send me on my way. (2)

This frustration was echoed by most participants who felt that they did not receive any advice that actually lead to the resolution of the weight problem:

I would love to say that the physician's visit was like wonderful and phenomenal, these things happened. None of the visits really made that much difference, I mean things were laid out to me and they were things that I already knew. It was very simplistic, it was like, if you eat less, you will lose weight. (3)

The lack of specific information and helpful strategies to manage the child's condition was commonly cited as a source of frustration. One parent stated, "I think that you have to go out of the health care system and just do something yourself." Another parent commented:

I don't agree that there is a health care team of which a patient and the physicians and the nurses and the dietitians are part of. I believe that in fact for many chronic conditions such as obesity many patients become the leader and all of the others are consultants. And there are helpful consultants and there are non helpful consultants. And the helpful consultants are the ones who actually give you something. (4)

She continued:

You have to go ferret it out yourself and once you find it you have to hen peck or threaten or twist somebody's arm to refer them and then once you've gone through all that, often you have to pay for it. And then you almost have to hand deliver it over to the program and hope that the waiting list isn't a gazillion miles long where the kid will roll right through the cut off date. And after you've done all that you have to really pray that the funding isn't cut off because that's the only program and you've done all this work to get to that one program. There isn't anything else. (4)

Those comments reflected her personal experience of having found an adolescent weight management program which was cancelled by the time that all of the requirements had been met. The program was part of a University of British Columbia research study that incorporated dietary, counseling, exercise and social components in its approach. According to this mother, it was the only weight management program that she had found after what she deemed to be a thorough search. She had found a pamphlet advertising the program while attending a concert at a boy's school.

Only one parent had positive comments about the support received from her physician. These related to feeling supported in her efforts to focus on her daughter's body image and self esteem rather than weight loss. The physicians' approach and her

own were compatible with her belief systems and her understanding of the risks and benefits of weight loss. She appeared to have accepted that weight loss was unlikely and that the process of attaining weight loss could result in negative consequences for her child's physical and emotional health.

Parents offered numerous suggestions for the kind of services and resources that would have been helpful to them in their goal of managing their child's weight. Routine monitoring of a child's height and weight beyond age three was recommended by one mother who could not understand the lack of weight screening by the medical community in the face of what she considered to be significant and pervasive media attention to the health implications of childhood obesity. Several parents suggested groups for parents and children and were specific in outlining the components that would be useful. While support was seen as beneficial and necessary, parents also felt that they had information needs that could be met by talks or lectures provided by those with expertise. An opportunity for children to engage in physical activities during these sessions was also recommended. Several parents indicated that they would welcome a Weight Watchers program for children if it were offered.

More readily available, user friendly information about where to turn for services and resources related to the management of childhood overweight was recommended by one parent who felt that perhaps, despite her diligent efforts, there were resources that she was missing. She queried:

How come there isn't more step by step ready information available, at a person's fingertips whether they advertise it in magazines, in the newspapers, on TV, on the radio... or have a 1-800-number where people can call and just get initial information so they know the next step? (5)

She hoped for information that would lead her to the resources, individuals or groups that would give specific direction in helping her to manage her child's weight in a manner that did not end up hurting her.

The reasons for parental dissatisfaction are summarized in Table 4.3.

Table 4.3. Parental Dissatisfactions with Services Received

1. Information received from health care providers did not add to their existing knowledge base.
 2. Not having concern about their child's weight taken seriously.
 3. Professionals not spending enough time to address parents' concerns.
 4. Experiencing difficulty in enacting simplistic advice.
 5. Not receiving the kind of support needed.
 6. Feeling blamed for causing or perpetuating their child's overweight condition.
 7. Professionals' advice not leading to the parent's desired outcome i.e. the child losing weight.
 8. Lack of anticipatory guidance before the weight became a concern.
 9. Not knowing where to turn when health care professionals did not provide the information and supports needed.
 10. Inadequate depth of communication between parents and health care providers to identify and address concerns.
 11. Lack of weight maintenance or weight loss goals.
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Expectations of Help

Expectations of the kind of advice or services available to parents, children and families varied. Some had been uncertain about what to expect from health care providers. Some felt that physicians should be aware of treatment options and of community resources such as support groups, and groups such Weight Watchers and be able to refer them to these resources. Most parents looked for assistance to help their children to lose weight. One parent wanted a “game plan” spanning two to three years leading to successful weight loss drawn up after consultation with the parents, the child, a dietitian and other health professionals.

Qualities, skills and attitudes that parents felt were important for HCP to possess included: the ability and willingness to listen, to be encouraging, respecting of privacy, to be interested in having a relationship with the child and parents, to have a good personality, to be positive, to want to help, to help the child to feel good and to be a kid person. Several parents emphasized the importance of the last quality, that of being able to connect with children and young people in a manner and on a level that is appropriate for their age. One parent noted that “If you’re not going to do it and do it well, don’t bother.” A key expectation was for the provider to help the parent implement what she already knew.

Parental Management of Child's Overweight

Therefore you must always keep in mind that a path is only a path; if you feel you should not follow it, you must not stay with it under any conditions... Does this path have a heart? If it does, the path is good; if it doesn't it is of no use. Both paths lead nowhere; but one has a heart, the other doesn't. One makes for a joyful journey; as long as you follow it you are at one with it. The other will make you curse your life. One makes you strong. The other weakens you. (Don Juan, from the teachings of Dona Juan: A Yaqui Way of Knowledge by Carlos Casteneda)

Consultation with health providers was often followed by a lengthy period during which parents managed the child's weight to the best of their abilities. Management involved dealing with their own and others' emotions, reconciling differing perspectives about the nature and potential risks of the child's overweight condition, choosing management strategies and dealing with numerous challenges that arose from the individual characteristics of the child, family dynamics, and social situations.

Dealing with Emotions

Shame. While most participants expressed concern about threats to the child's self esteem as outlined above, one mother was candid about her own feelings of shame engendered by her daughter's appearance. She described a time when she spent \$150 on a one piece bathing suit for her daughter who wanted a "tankini" for a grade six outing to a water slide:

I thought to myself, how am I going to let this kid wear a two piece bathing suit? This is just going to be ridiculous. I think of the shame of her being overweight because I wonder if I was ashamed too and then that would make me feel even worse. And then I would feel bad for her and then I would feel ashamed because I let her eat. (3)

Another talked about her daughter's stage performances. On the one hand she saw it as a sign of self confidence that she was able to put herself in the public eye, but on the other hand the mother felt very uncomfortable when the daughter chose the role of an

unattractive heavy character and people in the audience laughed. She suspected that they might not only be laughing with her but also at her.

Anger. Some mothers admitted to anger with their children when they chose not to follow the eating plan or follow through on commitments such as attending a gym membership that the parents had paid for.

I was at home with her and was kind of watching stuff. I mean we're doing crazy stuff like putting elastics on the cookie cupboard so that she's not going in and you go through waves of being angry at her and being, you know, it really affects your relationship. (4)

One mother also expressed anger at the influence of the media:

Then you get angry.... People are more than what they look like, it's the inside that should count. We keep getting told that the inside is the part that should count, what people are like on the inside, yet everything in the media and everything out there comes to us. And it's the outside really counts, it doesn't matter about the inside. You know, magazines, shows. You don't really see shows on TV regarding children that are chubby except for when they're a caricature kind of person like Fat Albert. (3)

Her anger stemmed from a fear that the power of the media would prevail over her efforts to nurture self acceptance in her daughter. Both of these sources of anger reflect the lack of control that parents have over many of the processes that influence their children's weight gain and weight loss.

Guilt. The gap between what a participant felt she should be doing and what she was actually doing to manage her child's condition sometimes resulted in feelings of guilt. Mothers themselves were not always consistent in meeting the healthy eating standards that they had set for themselves and the family. The time pressures created by work, taking children to activities and numerous other commitments sometimes led them to fast food restaurants even when they felt committed to healthy eating practices. At times this led to feelings of guilt and shame.

Guilt, overwhelming guilt, because I felt guilty by not implementing it, you know, if I couldn't do it. And then I would feel very guilty even thinking that I should be trying to change her in any way. She's a child, she'll develop how she develops and I feel guilty thinking that way because well, what about her health. I'm allowing her to eat whatever she wants. (3)

Her sense guilt was compounded by of the intersection of two conflicting beliefs. She held one belief that she should take certain measures to control her daughter's weight while at the same time believing that she did not have the right to change her. The first belief was congruent with her view that, as a parent, she had a duty to ensure the health of her daughter. The second belief was congruent with her belief in the autonomy and basic rights of children. Without resolving this conundrum, whichever course of action she chose would result in feelings of guilt. She goes on to state:

It was terrible, because you want to nurture your child and you want everything for your children what they want for themselves and it was like a torturing kind of role to try and you know, get her to do without or you would try and avoid situations where there could be temptations but, you know you're trying to live your life at the same time, so that part of it was really hard. I would get angry, I would think, this isn't right, I mean you know you would never expect a child that has an impediment of some kind, you wouldn't sort of blame it on them. (3)

When asked about the impact of trying to control her child's weight another participant responded "I would have to say, for me personally, there is guilt, like, what did I do wrong as a parent? Where along the line did I ...?" She acknowledged her feelings of guilt but could not identify or locate the actions that led to those feelings. In her eyes, the evidence that she had done something "wrong" was visible in the overweight body her child. Her sense of guilt was literally embodied in her child.

At times mothers felt "tortured" by denying and depriving their children of certain foods and had difficulty in maintaining consistency in their approach to weight management. They sometimes had mixed feelings about the food choices made by their

children when away from home. They understood the need of children to fit in with their peers which included trips to the convenience store to buy junk food, yet were angered by their lack of compliance.

Choice of Management Strategies: Parental Control vs. Self Control

Parents continued to use their own management strategies if no new information or resources were provided by health professionals or if advice contradicted their values. General advice provided by physicians and dietitians was interpreted in the context of their own families. Their efforts centered on structuring the family environment to decrease access to “junk food”, make healthy foods available and increase physical activity. Additionally, expectations were placed on the child to make “healthy choices.” The degree of parental control exerted over the child in an effort to gain compliance varied considerably from family to family. In one family the mother monitored her 18 year old daughter closely. She relates:

Well you see, there's no real managing on your own as such in my house [laughter]. No, no, no, we have a nice democracy outside the doors, a nice dictatorship inside the doors. She gets to weigh out her own portions, she gets to write in her own book, she goes off to the meetings [Weight Watchers] by herself.... I make the meals so she gets to choose portions a little bit but she doesn't get to do other things. I pack her lunch, so you know, she is managing much of it by herself, but she gets a strong home team advantage.... She at one point wanted not to have breakfast. No, that's not an option in my house, you eat.
(4)

In this family, evidence of lack of compliance was followed by consequences such as confiscation of the daughter's debit card and Starbucks card to prevent spending on fast foods. “We have to take it away and like her jailor, look at receipts and make sure that she hasn't eaten any chocolate bars or whatever.” Confrontations ensued and ended with the daughter in tears at times. This mother was very assertive in getting her child the

physical activity that she felt was required. She did so by misrepresenting the child's age to meet admission requirements for a floor hockey:

I lied through my teeth and told them that she was sixteen and she enjoyed the floor hockey and the woman said to me when I took her in because they're all women of about... anywhere from 20 to 50, she looked at me and she said she's sixteen? And I said yes. She was about fourteen and a half and she said, can you prove it? And I said you bet, I can [laughing] and I guess I looked ... so cranky that she was too afraid to ask me again. (4)

One mother, after following recommendations to take her 12 year old daughter to Weight Watchers with her, concluded:

It was just totally inappropriate, totally. I mean she was in tears afterwards, you know. She was in this room with these fifty year old women who she had nothing in common with at all, so it actually made her feel even more isolated, like she was the only person in the world. (3)

The assessment that the Weight Watcher's environment is not targeted at adolescents or young adults was echoed by another participant who stated, "And two weeks later I sent her to Weight Watchers so now she is going to Weight Watchers. She goes with 50 year old women, so there were no young people at all, she hates it."

Parents reported that for some children, their weight represented an esthetic problem or no problem at all. If the child did not perceive the weight to be a problem, the mother found it difficult to enlist his co-operation to make the kind of lifestyle changes she thought were necessary. As one parent noted, "It's a matter of self-discipline, but it's hard to exert your self-discipline on someone else." This statement is key to an understanding of the challenges faced by mothers in the management of their child's condition. Control over the processes that led to weight outcomes was only partially in their hands. Self-control on the part of the child was something that, by definition, could not be imposed by anyone else; it had to come from within. As one mother of an older

teen observed, none of her efforts to help her daughter were effective until she decided to take control and make changes herself.

Most parents fell into the middle of the parental control – self-control approach continuum and tried to provide children with as much choice as possible while trying to structure the home environment in ways that would support healthier food choices and increased activity levels. For some parents structuring the environment meant the elimination of “junk food” and “treats”. Within this environment children were encouraged to make “healthy choices” which, in effect, were not real choices. Their real choices were often exercised away from home or when other family members exercised their perceived right to bring “unhealthy” foods into the home. For most mothers, teaching children to make healthy choices was a priority. The challenge, as expressed by one of the participants in a quote cited above, was how to accomplish this without appearing coercive or controlling.

Family Dynamics

The seeds of mothers’ frustrations found fertile ground in the family setting. Typically mothers assumed responsibility for dealing with their children’s weight condition often without the full co-operation of their partners or extended family members. This resulted in mixed messages being sent to their child when the father took the family out for fast food while the mother was at work, or when he brought “junk food” into the home against his wife’s wishes. Women sometimes felt undermined by husbands and other family members in their efforts to ensure that their children had a healthy diet. One mother spoke of her need to “train” her husband to make better choices about what and when to eat so that he could act as a role model. When health care

providers suggested that healthy eating and activity behaviors be adopted by the whole family, they may not have been aware of the intensity of resistance to change put up by some family members and the amount of energy required to implement the recommended changes when only one parent is invested in or committed to the process. Eating habits were embedded within the established patterns of family life. The role of the woman as cook was clearly established in most of the families and when she was at work her partner often chose not to provide healthy food for the children. One participant reported working three twelve hour shifts per week and whenever it was her husband's responsibility to provide meals for the children he would choose fast food meals, a choice that his wife "despised". It appears that if she wanted her children to eat in a healthy manner on a regular basis her only option would have been to ensure that pre-cooked meals were available during her absence. Her husband's actions in providing fast food for his children suggests a lack of buy-in and or / commitment to the principles of healthy eating, something that his wife considered an important component in the management of their child's weight.

Sometimes the food centered cultural traditions of extended family members clashed with participants' views of healthy eating. One woman, in speaking of her visits with her mother, states:

I tried to say let's not make dinner and the snacks the main event, let's go for a walk. Let's go for a swim, let that be the main event and the other stuff becomes secondary.... Instead of being something fun, it ends up being a power struggle always. She's a really good person and I love her dearly but it becomes a big issue. (9)

When they did go for a walk, her mother brought along a large bag of food including treats, eggs, cheese and the like to eat during the outing. Although she had tried to talk to

her mother, she had not been successful in changing her behavior. This participant was frustrated by these encounters and needed help to find a way of maintaining a good relationship with her mother while at the same time ensuring that her son received consistent messages about what foods were appropriate on an everyday basis as opposed to those that were treats and reserved for special occasions

One mother reported that communication was hampered by the presence of her husband during the interviews with the endocrinologist:

My husband came with us every time we went to the endocrinologist. He'd take the day off work and at the time I appreciated it. However, looking back now I think it was very much a control thing on his part and he was saying for his sake he's always going to be there and what's the big, what's the issue, what's the problem? I never really felt free to ask questions because he's quite sensitive about his weight and he doesn't do anything about it and so in turn, maybe overly sensitive for [child]. Like why are you asking me these questions? (9)

The parent is dealing with barriers to communication arising from within the family and from her interaction with health professionals. Her roles as nurse, wife, mother and advocate intersect as she responds to the challenge of advocating for her son while maintaining a productive working relationship with staff. She does not appear to have the freedom to express her needs either to staff or her husband.

Several parents talked about the sensitive nature of obesity and held the view that talking about it or naming it in front of their child would be detrimental to their emotional or psychological health. A mother indicated, "I didn't want (child) to be aware that I was seeking help from other people...." If the management of the condition could not be freely discussed in the presence of the child, then strategies and actions to address it were covert. One parent stated:

We put her in swim club, we had her swimming five days a week where she was swimming laps constantly, she's playing soccer once a week, she's in dance class

twice a week, anything that's going to burn calories. We took all the sedate activities out and tried to put things in that were sporting activities and still she's gaining weight.... I don't say it to her but I keep thinking like push, push, push. (5)

All participants encouraged their children to increase their physical activity levels

For some family members excess weight represented a barrier to finding an appropriate mate. One participant's recalled:

My mother-in-law sometimes would look at [child] and she'd start crying and she would be, she's a very, um how can I put it, when I say non- educated. I don't mean like school although she probably went to grade three but like she would sit in the corner and say things to me like who's ever going to marry that poor girl. It was awful, you know, and then I would, I would just be so angry at my mother-in-law. How could she think such a thing and then, at the same time, it would sort of play on me and sort of think well, why am I not seeing this. This must be a really big problem, you know. That here was that sort of force. (3)

Challenges to Implementing Professional Advice

Lack of specific guidelines or advice for the dietary management of a child's weight led to frustration, confusion and anger on the part of mothers. They sought, often unsuccessfully, to deal with the everyday challenges that arose from trying to implement simple advice in complex settings. Some parents were informed that it was inappropriate to put a child on a diet. There are several medical definitions of the word diet: 1. Food and drink in general. 2. A prescribed course of eating and drinking in which the amount and kind of food, as well as the times at which it is to be taken are regulated for therapeutic purposes and 3. Reduction in caloric intake to lose weight (The Houghton Mifflin Co., 2002). Although most parents did not report having discussions with care providers about the definition of the word diet, it appears that that the implied definition was that of reduced caloric intake to lose weight. One mother recounts:

I even asked for a diet that I could put her on like what kind of calorie count I should be putting her on and I was told that if I restrict the amount of calories she

eats because she is a growing child, then I'm going to counter act what her body is supposed to be doing. So I don't know what to do anymore. (5)

The same parent, on seeing the child become increasingly heavy despite being very active, felt compelled to go against the doctor's advice:

I've cut her diet down to basically nothing and I'm afraid that I've maybe slowed her metabolism down so that her body, I don't know, I don't understand all of that part of it so, it's just been really frustrating. (5)

This parent had a need for information that was not filled by the family doctor or the other sources of information that she had turned to for advice. One parent whose daughter is 5 feet tall and weighs 185 pounds recalled:

They didn't believe in children dieting at [the tertiary care center]. That was a big issue and they really stressed for me not to diet her but to watch her portions, and make sure she had food from the different food groups and such but there was no, they just wanted her not to gain any more weight. And I remember one doctor saying we don't want you to lose weight but we don't want you to gain anymore but she was still growing, so I found that frustrating. How do you, stop a child from gaining weight when they're still growing?

The actions that were required to meet this weight management goal were not clear to this mother. The advice to provide healthy food, encourage healthy choices, watch portions and encourage more active living was not specific enough for her to translate into action. Given that appetite and feelings of hunger can vary for any number reasons throughout the day and in the course of a week, it can be extremely difficult for a parent to determine what portion of food is reasonable at any given time. Several parents indicated that their overweight child did not eat more than other children in the family who were not only slim but "skinny." How to effect dietary changes when the parent felt that the diet was already healthy and portions were reasonable?

One parent was faced with the challenge of meeting the needs of one child who was overweight and another child who had "a bout of anorexia at ten." For her, anorexia

was not a theoretical possibility but something that had manifested in her own home. She felt that if she did not handle this challenge correctly, the overweight child might become anorexic and the younger daughter might experience a relapse. Yet what was the “correct” course of action? She could only guess at what it might be. She stated:

I feel like I’m walking on pins and needles with her sometimes with that, because I don’t want to trick her into starving herself or I don’t want to say, you know, that doesn’t look good on you because your tummy is hanging over and stuff like that. (6)

Some mothers’ efforts to increase physical activity were focused on enrolling their child in activities such as soccer, dance, floor hockey and swimming, all of which had associated entrance or program fees. Costs of these activities had to be weighed against other family expenses such those arising from a sibling’s health condition. Other less structured and free activities that parents encouraged were biking, going for walks, and participating in the dog-walking program at the SPCA. About half of the parents commented on the difficulty of trying to increase their child’s activity level when, temperamentally, they were inclined to be more interested in sedentary pursuits. As one mother noted, “When he’s doing kilometer club at school he’s more apt to walk than he is to run. He just doesn’t enjoy it, he complains about it.” Another mother described her child as “slow paced, not energetic”. To counter these sedentary tendencies, one family offered a monetary incentive to their daughter, a dollar for every lap completed during the runs that were part of the grade four physical education programs. Her mother commented, “That was a big incentive for her and she made some money that winter and gained some self esteem.” Moments before, the mother had indicated:

My mom made it [the participant’s weight] into a major issue and she bribed and controlled me and reminded me about it if I were to take a second helping and I felt I was on my own because she didn’t do that with my other sisters and she

would do it in front of the rest of the family. So I felt that I was put on the spot and I was conscious how that made me feel and so I said to him don't do that. (1)

This participant described the sense of isolation that resulted from being treated differently from her siblings when it came to being allowed to have second helpings. The recollection of being bribed and controlled and the negative feelings evoked by these memories influenced the way that she chose to approach the management of her own daughter's weight. She wanted to shield her from the kind of negative weight management experiences that had impacted her own life. Perhaps by applying the label of incentive to increase activity vs. bribe to decrease the amount of food eaten, the mother was able to distance her own actions from those of her mother which she found hurtful.

Another mother shared a similar account:

I know for me when I hit puberty, that was when my mum started really in on me about to watch my weight and stuff like that and I took it to an extreme so I think of me, where I lost so much weight. I mean, I was, my periods stopped. I mean I was very thin, so for me I think it's a bit of baggage on my part that I'm sensitive to him hurting that way.... I worry about him being hurt by or developing a warped way of thinking about food. (10)

Both mothers used the lens of their own experience in guiding the approach to management of their children's weight. They chose not to repeat what they considered to be hurtful and/or harmful strategies used by their own mothers. Now faced with similar challenges as their parents had been faced with, they had to find new, more positive, ways to deal with their children's weight issues.

Weight Management Outcomes

All parents still considered their children as overweight at the time of the interviews. One mother, whose 17 year old daughter had a recent 50 pound weight loss in time for her high school graduation expressed concern and suspicion that the loss

resulted from unhealthy weight management practices. She had found evidence of “throwing up” in the toilet which led to a concern about bulimia as a means of weight reduction and management. Parental worry and guilt did not cease when children matured. Since there was no satisfactory resolution to the identified problem, (excess weight) fears about their children’s future continued. As the children became older, control over factors that influenced weight loss or gain shifted from the parent to child.

One parent shared:

When she was nine it was pretty much in my hands and up until she was about twelve, and then she started being out more and more and independent....I have no control whatsoever now except for what’s in my house for her to eat, but she goes out a lot and I don’t know what she eats when she’s out with her friends. I’m certainly not going to question her on it.... I worry about what she’s eating but I can’t really do anything about it, so I pretty much have to let that go. (6)

For those participants with older children, letting go was more of an intellectual exercise than a reality:

I can’t worry about it anymore. It’s not going to be a problem, just not a problem anymore, because if you can’t fix it, you can’t worry about it. You got to move on.... So if you don’t classify it as a problem, it’s not a problem. Whether or not it is, is irrelevant. [4]

As children’s level of independence increased, their ability to access food outside of the home environment increased as well. As one mother stated, “It was the in-between stuff, snack type of things, if I didn’t buy them, she would find a way to get them just like all kids do, go to the corner store.”

Another mother, the parent of a 12 year old daughter, had framed outcome goals in terms of the child’s attainment and retention of a sense of self esteem. As long as she saw evidence of self esteem, the primary goal was being met. Such evidence included

signs of good personal hygiene and grooming, choice of clothing, and forming and maintaining friendships.

Looking Back

Retrospectively, a number of parents felt that they should have been more proactive in their own efforts at management of their child's condition and/or in securing the health care that they felt that their child needed. As one mother relates:

I'm not blaming the health care system, like maybe it's me, maybe I needed to be more assertive.... Maybe I didn't push hard enough, maybe I needed to push harder with my doctor.... I look back and I go, well, should I have taken, you know, dragged all my kids to Weight Watchers or should I have done something similar to that?" (2)

Another participant stated:

I think that because I'm older I would have more of a resolve to say, okay, for example, let's say this is diabetes, there wouldn't be the option of, oh well, we're just going to go into MacDonald's. Oh, well, this weekend, we'll just forget it. Do you know what I mean? It would be a life and death thing and we would, this is the way it would go and we would just do what we had to do. I think that I would have a lot more self discipline in terms of having more backbone as a mother to say, no, this is not good for you.... I think that I, as a parent would have more backbone with that. (3)

Another mother commented, "I would have done things a little earlier, I think I waited a bit too long to start taking more of a leadership role in activities that she does".

Another participant reflected:

Probably I should be more aggressive in seeking out the information and perhaps, maybe if I utilized some of the information available through even, you know, like the health unit or like finding someone else. But I guess I just kind of expected that my doctor would be able to point me in that direction.... I guess I should probably have been more aggressive and I, in hindsight I'm wondering why I wasn't because I've become, learned to be a very strong advocate for my older son and I'm not sure why I haven't implemented that as strongly as I should have for my daughter. (5)

Although these parents tended to blame themselves for not being proactive enough in securing the help that they felt their children needed, the question prompted by their statements is, why should they need to fight or be more aggressive in securing health services for this health condition as compared to other childhood conditions? As outlined above, some parents stated that physicians did not know of other resources to which the child or parent could be referred or did not know how to deal with the problem. If, in fact, their perceptions are correct, the problem may lie with how services for the treatment of childhood obesity are organized and the importance that they are accorded within the health care system. The brief consultations that most parents had with health care providers may not have been the best way to address the information and support needs of parents or their children. Childhood obesity has come to the fore as a public health concern only in the past few years and health care institutions are only now starting to consider ways of addressing this condition. If a parent had greater awareness of how her individual efforts to manage her child's obesity are impacted by a health care system that is only now starting to mobilize resources to address the problem, she might be less inclined to shoulder the blame for her child's continued overweight status.

Some parents concluded that their low key approach was not effective in reaching the desired goal of weight loss for their children. A number of participants had been told either not to make a "big deal" of the management of the overweight condition or had been told that there was no problem to begin with. As a result, some may not have been as consistent or focused in the management of this condition as they might have been if their child had a disease such as diabetes. Even slow weight loss requires a significant decrease in caloric intake for children who are still growing (Daniels et al., 2005).

Literature pertaining to successful long term weight maintenance in adults and children has demonstrated that attention to diet and activity has to be a top priority in the daily lives of those individuals. The intensity of effort required to achieve these goals requires extraordinary commitment. If weight loss is the agreed upon goal by the health care practitioner, the parent and the child (where appropriate), then parents need to understand the level of commitment required to meet this goal and have access to the support that will enable them to meet this goal.

In summary, the process of enacting the advice offered by health care professionals proved to be complex and was constrained by numerous factors arising from within and outside of the family setting. The path referred to by Casteneda was such that mothers did not find their journey to be a joyful one and they did not appear to be at one with it. They experienced conflicting values when it came to management of their child's weight. The heart wanted to nurture and to support their child's sense of self worth. Mothers wanted to maintain good relationships with their children yet sometimes encountered resistance and conflict within the family in their efforts to enact the advice that was given. They were acutely aware of the stigma attached to overweight and tried to protect their children from it's effects but, at times, found evidence of it in their own families and in themselves. Mothers grappled with feelings of guilt about not doing a better job of managing their children's weight yet they did not have complete control over the processes that led to their child's weight loss, maintenance or gain. In some families, the issue of the child's weight seemed to be an "elephant in the room", something that family members were aware of but could not openly address for fear of damaging a child's self-esteem. Several parents noted that they did not know how much

their child weighed because they felt that weighing might contribute to a negative sense of self esteem and lead to an obsession with daily fluctuations in weight.

Most participants were clearly not satisfied with the level of support offered by the health care system. Their anger and frustration was palpable. Media messages and their own research reinforced their concerns about the health risks posed by childhood obesity but when they looked for assistance to manage those risks they found little of value beyond what they already knew. Advice tended to be generic and not individualized to take into account their particular set of circumstances and challenges. For lack of an alternative, some turned to programs that they knew to be age inappropriate.

Summary of Findings

The decision to seek health services for a child who was overweight was made by parents on a non-urgent basis, after efforts were made to address the concern on their own. Some were advised by family, friends and health providers not to worry, that their child would “grow out of it.” No one, however, could guarantee that this would happen. If they adopted a wait and see stance, some felt that they would miss a crucial window of opportunity to help their child. Nine of the ten participants felt that action was needed to address a problem that they identified as being a health and/or an esthetic concern with significant social consequences. They felt a deep sense of responsibility to take steps that would ensure that their child could grow up to have the same experiences and opportunities in their personal, social and work lives that others had without being targeted or singled out because of their weight. Concerns about damage to self-esteem ranked high and mothers often tried to prevent or mitigate the effects of others’ actions or

words that might pose a threat to their child's self-esteem. All of the mothers appeared to feel that they and their partners held great power to harm their child. They felt less powerful in their ability to help their children meet weight loss goals.

Parents identified a number of negative outcomes resulting from consultations with health providers about their child's weight. They experienced having their concerns dismissed, having their child labeled as fat, having attention drawn to their own weight and feeling blamed for letting the child gain weight. In addition to these experiences, some participants feared that by consulting with a health provider the child would feel that there was something wrong with him and that would lead to a loss of self esteem. Some were also concerned about the possibility of precipitating eating disorders by using weight management strategies. These risks were balanced by the hope that the child would be assessed for medical causes of overweight, receive treatment for any secondary conditions related to overweight and receive treatment for any diagnosed condition. Mothers also hoped to obtain support or advice which would lead to the resolution of the weight problem.

With some exceptions mothers reported an absence or lack of clarity about goals and plans to address the weight concerns. Where goals were set, parents felt that they had not received sufficient direction in how to meet them. Advice was described as simplistic and most participants felt that the advice received did not add to what they already knew. In several instances when a child showed no signs or symptoms other than excess weight, he was deemed to be healthy by the physician. Where the primary parental concern was about threats to the child's self esteem, this assurance of health did

nothing to address the concerns regarding the negative social consequences that the child experienced as a result of being viewed as overweight in a society that values thinness.

Mothers took the lead role in trying to structure the home environment to encourage healthy eating and physical activity. Not all family members were supportive of these efforts and efforts were not always consistent. Several mothers talked about feeling guilt and shame in relation to their child's weight. Shame, because of the child's appearance and guilt, about not being consistent with management strategies. They faced numerous challenges in trying to motivate children who were not interested in healthy eating and who were temperamentally not inclined towards sports or physical activity. These challenges were not addressed by the advice that they received from health providers. Mothers identified a number of resources that would be helpful to them including groups providing support and educational opportunities, Weight Watchers for children and well publicized, easy access to information.

CHAPTER 5: DISCUSSION OF THE FINDINGS

Introduction

In this chapter I present a discussion of selected findings from the study in relation to the current literature. The decision about which findings to present was influenced by their relevance to nursing practice, research and education. As Thorne et al. (1997) note, "the researcher determines what constitutes data, which data arise to relevance, how the final conceptualizations portraying those data will be structured and which vehicles will be used to disseminate the findings." The literature review presented in Chapter Two influenced the choice of sample, data collection and data analysis. In placing the findings from this study into the context of the body of knowledge relating to parents' experiences of seeking health care of a child who is overweight, I have utilized the literature from that review and I have also moved beyond that review to include other relevant theoretical and research knowledge.

Parental Concerns about Self-Esteem

The findings from this study suggest that the psychological well being of children who are overweight ranks high among the concerns expressed by parents. Their concerns are well founded since the most common consequences of childhood and adolescent obesity are psychological (Dietz, 1998). However, according to a study examining fat-teasing in children, about half of the children did not report these experiences (Hill & Waterston, 2002). Hill (2006) notes that a significant proportion of obese children appear protected from or are resistant to the psychological consequences of their obesity. The implication for health care professionals is that while there certainly are adverse psychological consequences of childhood and adolescent obesity, we should not expect

psychological distress in every obese child. When it is present its cause may or may not be related to the child's weight status. Miller and Downey (1999) in Hill (2006) found a small but robust correlation between overweight and self-esteem that increased with age and was significantly stronger in females than males. Hill notes that low self-esteem is probably a minor contributor to obesity and obesity is only one of several influences on self esteem. Age, gender and victimization experiences are some of the determinants of self-esteem and their impact is often competence specific.

Self-esteem has been conceptualized in various ways. It can be described as a generalized feeling about the self that is more or less positive (Emler, 2001). It has also been related to a perceived sense of self confidence, that is, a personal evaluation of competence in areas that are deemed personally and culturally important. Another perspective is one that self esteem is based on judgments that we imagine others to make of us. Depending on the domain that is measured a child may demonstrate high self esteem in one area such as in scholastic achievement and low self-esteem in another area such as physical appearance or athletic ability (Hill, 2006). It may be helpful for parents and health care providers to understand self-esteem is not just one construct, that it has a number of dimensions.

Ironically, weight specific parental over-concern may place a child at higher risk of experiencing psychosocial problems and unhealthy behaviors (Mellin, Neumark-Stanzier, Storey, Ireland, & Resnick, 2002). In examining the relationship between the level of parental monitoring and the probability of extreme dieting behavior, Melin et al. (2002) found a curvilinear relationship between these two variables. A moderate amount of parental monitoring was associated with the lowest frequency of extreme dieting

behaviors and extreme levels (high and low) were associated with the highest frequency of dieting behaviors among overweight girls. Among boys, moderate levels of parental monitoring were associated with the highest rates of breakfast consumption, educational aspirations and the lowest rates of emotional distress among boys. Family connectedness has also been shown to have a protective effect in relation to health behaviors and psychological well being in this population (Mellin et al., 2002; Turner, Rose, & Cooper, 2005). Overall, overweight adolescents reported engaging in more unhealthy behaviors and experiencing more psychological distress than their non-overweight peers. The challenge for parents is to determine what constitutes a moderate level of monitoring and control and to maintain satisfying and developmentally appropriate relationships with their children.

The fear of precipitating an eating disorder or an unhealthy relationship with food was expressed by a number of parents. Eating disorders are classified as anorexia nervosa, bulimia nervosa and binge eating disorders. In fact, the prevalence of eating disorders is quite low. Approximately 3% of women will be affected by an eating disorder during their lifetime (Public Health Agency of Canada, 2002) Young men represent only about 10% of individuals with anorexia. They are more likely to be affected by binge eating disorder. McVey, Tweed and Blackmore (2004) found approximately 3.9% of preadolescent and young adolescent girls reported binge eating and 1.5% reported self-induced vomiting in their recent study. Fear of inducing an eating disorder may keep parents from addressing childhood obesity. The prevalence rates presented in Chapter Two for cardiovascular risk factors and insulin resistance

suggest that obese children are more likely to develop those health risks than they are to develop an eating disorder (Cook et al., 2003; Freedman et al., 1999).

Differing Perspectives

The prevailing approach used by health care providers in the management of childhood overweight and obesity which consists of advising parents that the child should eat less and exercise more, is too simplistic. Advice that the whole family should adopt a healthy lifestyle has merit but it too, is too simplistic. This approach is based on the assumption that informing family members of the benefits of healthy eating and increased activity levels will motivate them to make changes to eating habits that have been deeply entrenched in nuclear and extended family life. It appears to be based on an understanding of obesity as simply an energy imbalance that can be corrected if the individual or family follows certain guidelines. Advice is based on the principle that if less caloric energy (food) is supplied and more energy is expended (exercise) then stores of energy are used and weight reduction occurs. What this mechanistic formula fails to take into account are family, social, environmental and gendered contexts in which the individual is located.

Dissatisfaction with Services and Supports Received

The findings from this study support Edmunds' (2005) findings that overweight and obese children tend to be regarded as a homogenous group and therefore, for the most part, treatment strategies were not individualized to reflect the child's circumstance.

Insufficient Information, Direction and Inadequate Communication

Like the parents of children with other chronic conditions in the studies reviewed in Chapter Two, the parents in this study felt that they received insufficient information

to confidently manage their child's condition. Parents in Edmunds' study also received little help or support beyond the advice to eat less and exercise more. In some cases laboratory testing was carried out which, for the most part, yielded negative results; only one abnormal result was found in the present study and once that resolved, there was no further follow up for the weight. Edmunds also found that some parents felt blamed by health care professionals and that overweight was seen as an individual rather than as a societal problem. The present study goes beyond Edmund's work in probing not only the proximate causes for parents' dissatisfaction with the health care providers but the underlying cause which was a difference in the conceptualization of what obesity represented to parents and physicians. To parents, the actual or potential damage to the child's self esteem caused by being overweight was a primary concern whereas for the health care providers, especially general practitioners, the physical health of the child appeared to be the main concern. Consequently reassurance by a physician that the child was healthy, did not necessarily reassure a parent who was concerned about their child's self-esteem being damaged as a result of being victimized and/or discriminated against on the basis of his weight.

Health Care Systems Constraints

Participants relied on health care providers, principally physicians, for assessment and advice that would help them to manage their child's overweight condition. The Medical Services Plan currently allows for financial reimbursement of \$62.08 for complete physical examinations. Individual follow-up counseling appointments are reimbursed at significantly lower levels. Ainsworth and Youmans (2002) note that common barriers for individualized counseling are the lack of adequate financial

reimbursement and competing demands to address other health recommendations. With the average office visit lasting between 2 and 10 minutes, this format of service delivery for the treatment of childhood obesity may not be adequate to address the number and complexity of issues that may present during visits. If physicians are expected to fully address the concerns of parents, then clearly more time and by extension, greater reimbursement may be needed to accomplish the required counseling and education tasks. In British Columbia reimbursement for physician services is determined by the Ministry of Health. Without significant changes in the payment schedules, it is unlikely that physicians will devote more time to the management of this complex condition. The provincial government which funds the Ministry of Health will need to be convinced, as the World Health Organization is, that the rising rates of obesity threaten to overwhelm health services and represent the most neglected public health problem (World Health Organization, 2000).

The substitution of doctors by nurse practitioners has been seen as one way to address the rising costs of health care. A recent systematic review evaluating the impact of doctor-nurse substitution in primary care concluded that appropriately trained nurses can produce as high quality care as doctors and achieve as good health outcomes for patients (Laurant et al., 2006). Patient satisfaction was often higher with nurses. They tended to provide longer consultations, gave more information and recall patients more frequently and had higher rates of investigation, all factors that may contribute to positive outcomes in obesity treatment but which can have effects on the direct cost of care. No studies were found directly comparing the economic benefit of utilizing nurse practitioners as compared to physicians in the treatment of childhood obesity. The role of

nurses in the treatment of obesity will likely expand as nurse practitioners are increasingly being utilized in the Canadian health care systems. They will, no doubt, face challenges similar to those of physicians in terms of time constraints in counseling parents and their children.

Program Availability

None of the parents and children had access to the kinds of family based weight management programs that claim to have long term weight loss maintenance effects as described in the literature. It is likely that some of the dissatisfaction with health care providers' services as outlined in Table 4.3 would be addressed by comprehensive family based child and adolescent weight management programs. These programs need to be accessible to parents, have adequate funding, the appropriate mix of health professionals, provide follow-up and provide professional and peer support for parents and children. It was beyond the scope of this study to examine the reasons for the lack of access to weight management programs, that is, whether such programs simply did not exist, whether there were not enough programs to meet the need or whether health care providers lacked knowledge of their existence and therefore did not refer parents to them. The experience of several parents who were familiar with and who were part of the health care system and thus would be expected to know how to access resources, suggests that such programs were not available when they were seeking support. The 2005 Forum on Childhood Obesity noted that an inventory of treatment options in the province is necessary and that families, physicians, schools, and community based organizations know about them, suggesting that neither professionals nor parents currently have access to this information (Childhood Obesity Foundation, 2005).

Prevention vs. Treatment

Parents reported that some siblings were overweight; others were very lean. Most of the participants or their spouses were overweight to some degree. Since parents provide both the genetic and to a large degree, the environmental influences in their children's lives, it would appear that children of overweight parents are at higher risk for overweight. Therefore, the siblings who were currently at a healthy weight would be considered to be at higher risk for overweight. Although some parents reported that the lifestyle strategies suggested by health care professionals consisting of increased activity and healthy eating were aimed at the whole family, none of the parents indicated that they had been alerted to the increased risks of overweight for those children who were at a healthy weight.

While many of the primary prevention strategies and actions aimed at children who are of normal weight will benefit those who are overweight, they are likely to produce insufficient weight loss to achieve normal weight status (Koplan et al., 2005). Kumanyika and Obarzanek (2003) also point out that "although effective interventions for obesity prevention may share some similarities with those used for weight loss, the science of obesity prevention, which includes identification of those aspects that are unique to prevention compared with treatment, is only now emerging" (p. 1263). Kumanyika and Obarzanek (2003) note that there is a need to better specify the qualitative distinctions between obesity treatment and obesity prevention. Citing motivational differences noted in recruiting study participants for weight loss interventions as compared to interventions related to prevention research, there is no population clamoring for preventive interventions as there is for weight loss. The

resistance encountered by mothers from other family members, including children, when they tried to implement changes to adopt healthier lifestyles is reflection of the motivational gradient, so to speak, that existed between the parent who was motivated to make lifestyle changes and others in the family who were not. If, in fact, the treatment of obesity requires strategies that are quantitatively and qualitatively different from the prevention of obesity, then the expectation that parents and professionals may have that healthy lifestyle principles can be applied to the whole family to address both issues simultaneously may be unrealistic and lead to frustration and disappointment. The methods used for intensive treatment of obesity that are required for weight loss may be inappropriate when applied to other members of the family and the methods used for preventing overweight or obesity may not be sufficient for the degree of weight loss that is recommended or desired. The attraction of using strategies in a nonselective manner, that is, targeting the entire family, is self evident. No individual member feels singled out for special treatment that could add to the stigmatization that may already be attached to the individual who is overweight and it simplifies the process of meal planning and cooking. However, such an approach may not routinely lead to weight loss.

One parent made reference to having a child who had "a bout of anorexia" for whom being underweight may have been or is still a concern and several referred to having a very thin child. The co-existence of overweight with underweight in the same household has been referred to as the dual burden household (Doak, Adair, Bentley, Monteiro, & Popkin, 2005). The weight management challenges presented by having both under and overweight children in the same family have not been well described or explored. Management of under and overweight conditions in the same household may

pose several challenges. The first relates to accessing health services and health care providers that are able to provide expert advice about both conditions. No studies were found assessing physicians', nurses' or dietitians' abilities to deal with both concerns when present in the same family. However, as outlined in the literature review, a significant number of health care providers do not feel confident about their ability to counsel overweight individuals. Doak et al. (2005) note that from a public health perspective, overweight and obesity prevention programs need to be mindful that their target households may include underweight individuals. An intervention designed to prevent one problem may exacerbate the other. The existence of dual burden households reinforces the importance of assessing the family not just the individual. All family members' health risks need to be considered before making recommendations to significantly change the household diet. Although individuals within a family may share genetic and household environments, their lifestyle patterns related to external social, cultural and physiological factors may be sufficiently different to impact on energy density needs.

While the treatment of childhood obesity has traditionally been in the domain of dietitians and physicians, health promotion and disease prevention activities aimed at individuals, groups, communities has long been a part of nursing practice. The Registered Nurses Association of Ontario (RNAO) has taken a leadership role in providing practice, education, organization and policy recommendations to support nurses in the primary prevention of childhood obesity (Registered Nurses Association of Ontario, 2005). The RNAO recognized, as did a number of other medical and public health organizations that immediate action is required to slow or reverse the trend of

increasing childhood obesity and that while the evidence base for action was not solid, taking no action posed more risk than taking action based on limited evidence. The document outlines 17 recommendations to help guide nursing practice.

One of the parents noted that she had utilized public health nursing services when her children were young but that she did not feel that this support was available for parents with of older children. The emphasis on the 0-5 age group in the Preventive Services of Public Health may have left families of older children under serviced. The decisions that led to the prioritizing of services to the 0-5 age group were taken before the issue of childhood obesity became the pressing concern that it is today. It may be time to re-evaluate organizational priorities to take into account the growing need for information and services for parents of overweight children. The extent of involvement and the experiences of Canadian public health nurses in the prevention and treatment of childhood obesity have not been well described in the literature.

Maternal Guilt

Some participants experienced as sense of guilt when reflecting back on earlier years regarding what they might have done to cause their children's overweight condition. The conflicting feelings engendered by limiting food portions and choices and the belief that children should be free to develop without parental interference also resulted in guilt feelings in a number of participants. Some parents clearly did not feel comfortable in exercising this kind of control over their children. Parents described the conflict that they felt in trying to limit portions or restrict certain foods for the child who was overweight while feeling that the same portions or types of foods were not a problem for their other children. Attempts to limit one child's intake sometimes led to emotional

outbursts and accusations of unfairness, which parents found distressing. In contemporary families where equality and choice are often highly valued, parents may have difficulty enacting the advice of health care providers when it results in differential treatment of children based on weight status. Fielding (1957) in Coveney (2004) traces the roots of current family values and beliefs to the mid twentieth century. He describes four key elements of a new style parenting that appeared after the Second World War:

... a belief that one had to be equipped with knowledge in order to deal with children effectively, a belief that one should be affectionate and companionable towards children, a desire to produce self-regulated children and an aim to ensure the full development of child's capacities. (p. 225)

Increasingly, children's rights were recognized and enshrined in documents such the Declaration of the Rights of the Child (United Nations, 1959) and in the United Nations International Convention for the Rights of the Child (United Nations, 1990). Children now had the right to be heard and had opinions that were to be taken seriously. Children's eating habits became an important site for the encouragement of choice, self expression, and independence. Parents were required to provide foods that their children enjoyed while ensuring that they received a nutritious diet. Experts in parenting and nutrition became instrumental in determining the correct and therefore right thing to do in order to produce happy, healthy children. Consulting experts became a way of fulfilling parents' ethical responsibilities to their children. Coveney notes that the idea of children choosing foods, especially nutritious foods may be problematic and encouraging self-expression and independence in children in relationship to food comes at a price. Given a choice, children often will choose what tastes good not what is nutritious (Thomas et al., 2006). Balancing a nutritious diet, choice in eating and positive mealtime experience is a difficult task that, more often than not, falls to mothers. The tensions and conflicts that

arise from the belief in allowing children freedom of choice and while at the same time restricting portions (as their health provider may recommend) and providing food that, in many cases, they and other family members do not like, can result in feelings of inadequacy and guilt in mothers and a sense that they are not fulfilling their parental obligations. Coping with children's eating habits is often seen as a way of demonstrating the art of good parenting. In this sense, good parenting entails raising children who are self-reflecting and self-regulating by allowing them to make choices (Coveney, 2004; Satter, 1991). Without recourse to the authoritarian parenting strategies acceptable only a generation or two ago, today's parents must rely on negotiation, reasoning and persuasion to get their children to eat healthily. The centrality of the child within the modern family that values enjoyment, health and choice has placed significant demands on parents and has redefined what being a "good" parent entails.

Mothers who are trying to increase their children's fruit and vegetable intake and having only limited success, might be less likely to blame themselves if they knew that interventions that are able to increase children's consumption of fruits and vegetables to 5 per day are extremely rare (Thomas et al., 2006). Furthermore, it appears that the messages that they are trying to convey to their children such as making "healthy choices" (on the advice of health care providers), may not be as effective as they are hoping for. Thomas et al. (2006) identified six themes derived from children's views about healthy eating: they do not see it as their role to be interested in health; they do not see future health consequences as personally relevant or credible; they actively seek ways to exercise their own choice with regard to food; they value eating as a social occasion; fruit, vegetables and confectionary have very different meanings for children; they

recognize the contradiction between what adults promote in theory and what is provided in practice. For some children labeling foods as healthy was a reason for rejecting them.

Gendered Contexts and Emotional Labor

As the stories of the study participants unfolded, it became clear that their food choices were influenced by busy lifestyles and family traditions. Food represented the outward demonstrations of family members' love and affection for each other and it served as coping and comfort mechanisms in times of stress. Food choices were influenced by the gendered roles assumed by parents, which in turn determined who made the meals and who took responsibility for the management of the child's weight. Rather than being perceived as a source of support, some members of the immediate and extended families were thought to undermine the efforts of participants to create an environment conducive to healthy eating and active living.

Parents, primarily mothers, are charged with the difficult task of trying to enact advice pertaining to healthy eating and exercise while at the same time trying to circumvent numerous barriers that they encounter along the way. The work that the women in the study performed appeared to be largely invisible. In a number of cases it was not valued by spouses and actively opposed by family members. These findings support those of Mannix, Faga and McDonald (2005) who reported that participants often felt that their attempts to instill healthier lifestyle patterns in their children were impeded by the children's father. One of the participants in that study commented that their child's weight management took more of a commitment from her than from the child's father.

The nature of the work performed by mothers could be described as emotional labor, although the term tends to be used primarily in reference to the work setting (Hochschild, 1983). James (1989) defines emotional labor as the labor involved in dealing with other peoples' feelings, a core component of which is the regulation of emotions. Battista (2006) maintains that mothers are producers of emotional labor just like priests or teachers, trade unionists and others. Mothers in this study frequently managed and masked their own emotions to conform to what they deemed to be socially acceptable behavior in relation to their children, spouses and extended families. The fear of damaging their child emotionally by dealing with obesity openly made some parents behave in ways that they did not feel. An example of this is the mother who no longer believed in her daughter's ability to adhere to a healthy diet and exercise program after repeated attempts and failures but felt that she had to demonstrate support. This dissonance between how she felt and how she behaved is a key feature of emotional labor (Morris & Feldman, 1996). Parents also attempted to manage their children's feelings by taking actions that they hoped would protect them from victimization by their peers, family members and others. A number of mothers also tried to manage their expressive behavior so that their children would not sense their dissatisfaction with their weight status. And finally, mothers acted as buffers between their children and other family members to protect them from hurtful comments and actions. The cost, if any, of emotional labor in the setting of the home, is not clear. What does appear clear, though, is that a significant amount of energy is invested by mothers in the weight management process.

The Ethics of Weight Loss

Most mothers hoped that their children would lose weight as a result of measures taken to change diet and activity levels. Ebbeling, Pawlak, and Ludwig (2002) suggest that the dietary and physical prescriptions used in family-based and school-based programs might not be efficacious. Furthermore, they suggest that the adverse environmental factors overwhelm behavioral and educational techniques designed to reduce energy intake and increase physical activity. Epstein et al. (1998) observed that interventions used to treat childhood obesity have been marked by small changes and substantial relapse. In view of what has been termed a staggering failure rate, some question whether it is ethical to recommend weight loss as a medical treatment (Aphramor, 2005). Not only is the failure rate high but dieting is not without risk as outlined in Chapter Two. Parents who turn to a nurse practitioner, dietitian or physician for weight loss advice for their children in a situation where, according to CDC recommendations, it is not indicated, are faced with an ethical dilemma. Parents may believe that weight loss is the only way for their children to avoid or prevent the negative social consequences of overweight and to boost self esteem. There is some indication that success in weight loss can bring about some changes in self-representation and esteem (Hill, 2006). However, few children achieve weight loss and fewer still maintain the loss, making this goal difficult to reach.

Some participants' dissatisfaction with health care professionals may have related to differences in understanding regarding whose responsibility the weight problem was. Some physicians believe that obesity is the responsibility of the patient rather than a medical problem requiring a medical solution (Epstein & Ogden, 2005). Furthermore

they believe that obese persons want to hand responsibility for management over to the doctor, creating a conflict of expectations that is exacerbated by ineffective treatment options. The general practitioners in Epstein and Ogden's study tried to maintain relationships with patients by offering anti-obesity drugs in which they had little faith, listening to patients' problems despite having no solutions and showing an understanding of the problems associated with being overweight. It is possible that the health care providers whom the participants of this study consulted were aware of the limited utility of their advice but did not want to negatively affect the physician patient relationship by being explicit about the low success rates of existing treatment options.

Competing Conceptual Schemes of Obesity

Early in the literature review process, it became clear that there were a number of different ways of defining and conceptualizing obesity and that there were a variety of discourses on obesity. Although, with the help of my committee supervisor, I settled on defining obesity as a chronic health condition, I struggled against idea of labeling an overweight child with a disease or chronic condition label especially since there is no clearly defined point at which an individual moves from a healthy to an unhealthy state. The debate in the medical and social sciences literature whether obesity is a disease or a chronic health condition is a muted one. None of the research studies included in this literature review defined overweight and obesity in terms other than BMI categories. Much of the discussion and debate about the nature of obesity was found in articles published in journals that focus on the relationship between social science and health and philosophy and education. Although the medical discourse on obesity is the dominant one in the health literature and the media, there are other discourses that challenge the

framing of obesity as a medical condition or disease (Gard & Wright, 2001; Monaghan, 2005). These discourses challenge the scientific and philosophic premises underlying the mainstream medical understanding of obesity (Aphramor, 2005). I believe that there are a number of reasons why it is important for nurses and other health care practitioners to have an understanding of the different ways of conceptualizing obesity. Firstly, how obesity is conceptualized by policy makers, public health, nursing and the medical communities may impact on resource allocation for the prevention and treatment of this condition. For example, when drug and alcohol addiction was conceptualized as a character flaw or personal weakness, the cost of treatment was a personal responsibility. When it was reconceptualized as a disease, public funding became available for treatment services. Secondly, how an individual practitioner conceptualizes obesity may influence his or her course of action in recommending treatment for weight loss or maintenance. Thirdly, how a parent conceptualizes obesity may influence when or whether a health care is sought for a child who is overweight. Parental sensitivity to having a child labeled may delay help seeking behaviors. Fourthly, if health care practitioners and parents have different perspectives about the nature of obesity, then communication and interaction between the two parties may be adversely affected. Finally, it appears that little if any research has been conducted about the impact on a child's self concept of being diagnosed with a disease or condition that often has no symptoms other than excess fat.

Summary and Conclusion

In this chapter I have discussed the findings of the study, presented in Chapter Four, in relation to the existing body of knowledge related to the parental experiences of seeking health care for a child who is overweight. The findings represent some of the

experiences of parents before, during and after the process of interacting with health care professionals in their attempts to manage their children's overweight condition.

Participants faced numerous challenges in enacting the knowledge that they possessed prior to and after consulting with dietitians, physicians and nurses. Parental concerns about their children's self esteem were examined in light of recent findings which indicate that parental over-concern in this area may place children at higher risk of experiencing psychosocial problems. The finding related to parents' dissatisfaction with regard to the weight management information that they received was similar to findings from the chronic care literature reviewed in Chapter Two and the single study carried out by Edmunds (2005). The feelings of guilt experienced by mothers related to controlling their children's eating behaviors were analyzed and located within the tensions arising from values adopted by families after the Second World War. The work related to weight management appeared to be gender specific, that is, it was primarily the mother's responsibility. The nature of the emotional work that mothers carried out was compared to the emotional labor that employees perform when they are expected to convey and enact emotions that they may not be feeling. The ethics of recommending weight loss was discussed in view of the dismal short and long term results. The discussion of the findings has highlighted the shortcomings of the health care systems in supporting parents in their endeavors to help their children. It has also highlighted the complexities of managing children's overweight and obesity in the context of family life.

In Chapter Six, the final chapter of this thesis, I will present a summary of the study, the conclusions reached from the findings and the implications of these findings for nursing.

CHAPTER SIX: SUMMARY, CONCLUSIONS AND IMPLICATIONS

Summary of the Study

The purpose of the study was to explore parents' experiences of seeking health care services and/or resources to assist them in managing their child's obesity and to identify contextual factors influencing those experiences. The goal was to obtain this understanding from the client's perspective.

Ten parents (all mothers) who participated in this study, were interviewed once either in the health unit or in their homes. Interviews were audio recorded and transcribed verbatim. Data collection and analysis took place concurrently although the largest part of the analysis occurred after the completion of data collection. Interpretive descriptive methods were used to analyze the data.

Parents generally reported dissatisfaction with health care provider's services (primarily physicians and dietitians) and a lack of resources and supports in the community. They entered consultations with health care providers with a knowledge base about nutrition and exercise that, for the most part, was not augmented by their encounters with these providers. Information and advice was not individualized to meet the needs of the child or family. It tended to be simplistic and condensed into a "eat less, exercise more" formula. Parents' weight goals for their children were shaped, to a large extent, by the negative social bias against individuals who are overweight. These goals were not explicitly stated in terms of pounds, rather in their children's ability to form healthy peer relationships and have access to the same opportunities as any other child. Their concern about threats to their child's self esteem, mediated by a poor body image, led them to believe that weight loss would reduce those threats. Weight loss would help

them to gain entrance to a way of experiencing childhood, adolescence and adulthood like peers who were of “normal weight” and who therefore did not suffer from social sanctions. When health care providers did not agree with the weight loss goals or could not provide the means to help parents achieve them, parents felt frustrated and dissatisfied with their services. They became resigned to managing their child’s overweight condition on their own. Parents encountered obstacles to enacting the knowledge that they already possessed and the advice that was given by health care professionals. They encountered resistance within the immediate and extended family setting to instituting changes in eating and activity patterns that they hoped would result in a healthier lifestyle. Some family members undermined participants’ efforts to: consult freely with health professionals, eliminate “junk food” from the home and at family functions, to avoid fast food meals and to redirect the focus of family gatherings from food to other activities. Some participants described complex family contexts such as having one child with a history of anorexia and another child who is overweight.

What initially appeared to be a negative case, that is where a parent was satisfied with the support offered by her physician, in fact, lent support to the notion of the importance of the agreement between health care provider and parents of what treatment was realistic and desirable and what goals to pursue. Like the other participants this parent’s goal was also for her child to acquire and maintain a good body image and self esteem, but she felt that it was possible to develop this without changing her daughter’s shape through weight loss.

Conclusions

The conclusions presented below reflect my understanding of those aspects of the study findings that have relevance to nursing.

1. For most parents, the decision to seek health care services for a child who was overweight, engage with and remain engaged with health care providers was undertaken after weighing a number of negative and positive consequences that might arise from accessing health services. Fear of negative consequences included the fear of precipitating an eating disorder, fear of inflicting emotional damage on their child by drawing attention to her weight, fear of having their child or themselves labeled as fat, fear of straining their relationship with their child, fear of having their concerns discounted, shame or embarrassment regarding their inability to manage their own weight and having concerns and concerns that the relationship between the child and the health care provider was not well established.
2. Prior experience with health care providers factored into the decision about whether, when and who to turn to for assistance with managing their child's condition.
3. Some parents felt that it was appropriate to have their child present when discussing their weight concerns with health care providers, others did not and felt that all information should be channeled through them.
4. Most parents felt that the advice provided by health care providers was not beneficial in helping them to manage their child's weight because it was too simplistic and did not take into account the difficulty parents faced in trying to

enact the changes that are recommended to lead to weight loss and/or a healthy lifestyle.

5. Enacting strategies such as making changes to the family diet and encouraging increased activity levels required balancing competing needs and desires of various family members. Motivation to change was not necessarily present either in the child who was overweight or in other family members regardless of whether they were overweight or not. Tensions arose between mothers and some family members when they tried to change traditional or familiar patterns of physical activity, socializing and eating. Tensions also arose when other family members used an approach that the participants deemed as insensitive or hurtful to their child.
6. Some parents found that their attempts to change their children's weight, diet and activity patterns conflicted with their belief in the rights of children as autonomous beings. The tension between their belief in the necessity to make those changes and the doubt about their right to enact them gave rise to feelings of guilt. Mothers also experienced guilt when they were not consistent in demonstrating the kind of leadership that they felt was necessary to model healthy lifestyles.
7. Caregiving in relation to the identification, seeking, accessing and enacting weight management strategies remained, among this group of participants, primarily a gendered task. Surprisingly, only one parent made reference to the care giving burdens experienced by the unequal distribution of care giving tasks.

8. Parents and health care providers often had differing definitions of the presenting problem. For the physician, it tended to be the presence or absence of risk factors for other conditions. For the parents the absence of risk factors did not allay their concerns about risks to their child's psychological and social well being. They saw these risks as actual and potential problems that could impact their child's current mental health and limit their opportunities in the future in terms of finding life partners, social relationships, income and jobs.

The findings from this study revealed that parents actively sought help to manage their children's overweight condition but were frustrated at every turn by the lack of information and support that they received from health care professionals. Some concluded that professionals did not know how to help, others felt that they perhaps they just had not found the right program or resource. They faced ethical and moral dilemmas in trying to reconcile conflicting values while trying to manage on their own as best they could. Not only were they frustrated by the lack of support offered by professionals but the resistance to change that they encountered within their own families was emotionally draining. They offered insight and concrete suggestions about the kind of support that they were seeking. All of these findings have implications for nursing practice, education and research.

Implications for Clinical Practice

This study supports what other nursing researchers have previously concluded, that encouraging patients to lose weight is not enough (Rogge & Greenwald, 2004). Gaining an understanding of what parents experience in their attempt to find and utilize health resources can help nurses to develop sensitivity toward the frustrations that parents

are likely to be experiencing in trying to manage their child's overweight condition while balancing those needs with other family and work responsibilities. Nurses need to be aware of, respond and attend to clients' intra-family stressors and be prepared to offer support referral or advice. Helping parents to deal with their feelings of guilt, anger and frustration may assist them in moving forward with their efforts to implement and sustain healthier lifestyles.

Nurses have taken pride in their holistic approach to patient care in looking beyond the presenting symptoms or concerns and taking into account the individual's experience in the context of her environment. While nurses may not be in a position to offer solutions to all of the problems or concerns that arise from having a child who is overweight, demonstrating to parents that they understand the complexities of managing the condition will go a long way to building a trusting relationship and productive partnership between parents and nurses. Nurse practitioners and public health nurses are especially well positioned to have repeated contact with clients over time and therefore have an opportunity to provide ongoing support.

Patients or clients have increasing access to information about health topics, including obesity, from a variety of sources including but not limited to the internet, television, radio, and print media. Nurses cannot make assumptions about parents' knowledge or lack of knowledge about the topic of childhood obesity. As with every other aspect of practice, a thorough assessment of prior knowledge and knowledge deficits is indicated before giving advice. Parents need more information about strategies that can enhance the sustainability of their efforts to provide a healthy diet and increased activity levels for their focus child and for the family as a whole. Nurses need to be

aware that some parents may not be comfortable in discussing their child's weight in his/her presence and feel that all information should be channeled through them. Working respectfully with parents includes acknowledging individual preferences and accommodating them where appropriate.

Consistent with the principles of informed consent, parents need to be informed about the limited success of weight loss programs and the high rate of weight regain. As the findings from this study indicate, mothers invest considerable energy, emotional and otherwise into the management of their child's weight. They deserve to understand what the anticipated returns of their efforts are likely to be so that they can make informed decisions about treatment options. Nurses can also help parents to address their fears about the health consequences of treating obesity by providing evidence-based information about the risks of inducing an eating disorder.

Nurses need to be aware of the guidelines and recommendations for the prevention and treatment of childhood obesity so that they can determine and work within the limits of their professional scope of practice, give appropriate advice and provide anticipatory guidance that is consistent with the best evidence available.

Implications for Patient Education

Childhood obesity is difficult problem and requires a commitment on the part of health care providers, parents and children (where age appropriate) for ongoing management. Helping parents to understand, in language that they can understand, the rationale for recommended weight management goals is an important aspect of patient or client education. Investing the time to provide full explanations to parents at the

beginning of the consultation process may help to prevent miscommunication, dissatisfaction and disappointment.

The suggestions provided by participants about what they would have found helpful in their efforts to manage their child's weight indicate that they see a role for professional and peer support that can be delivered in a variety of settings through a number of different delivery vehicles. Nurses have been innovative in helping breastfeeding mothers to connect with each other and in providing breastfeeding expertise on an individual and group basis. Similar approaches could be considered to provide the kind of support that parents say they are looking for. Whatever services are developed need to include parents and children (where age appropriate) at every stage of development. Supporting initiatives by and partnering with non-health care professionals to deal with obesity at a wider community level to work towards common goals is another avenue of supporting parents.

The development of written patient educational materials that address the issue of childhood overweight and obesity would help to support and reinforce current evidence based information that nurses and other health care providers provide to parents. Such materials are readily available for most other conditions but are lacking for childhood obesity.

Implications for Nursing Education

Hoppe and Ogden (1997) suggest that while nurses counseling overweight adults and children reported high levels of confidence in their ability to give advice to obese patients, their expectations of patient compliance and weight loss was low. Furthermore poor outcomes were attributed to patient rather than professional characteristics.

Educational programs should ensure that nurses understand the complexities surrounding the etiology and management, not just from the nurse's but the parent's and child's perspective of childhood obesity. Program content should acknowledge the limited evidence base that currently underpins and guides clinical practice in weight management. Since there is ample evidence from this study and the literature examining health care professionals' attitudes that some professionals hold negative, stereotypical views about obese people, reflexivity on the part of nurses should be encouraged to help them identify and deal with personal biases. Health professionals should be encouraged to look at the impact of their attitudes and practices and to evaluate how these might act as barriers for clients.

Continuing education is an important element in maintaining professional competence and is a requirement for maintaining nursing registration. Development by colleges, universities and health regions of continuing education programs tailored to the needs of different nursing practice groups should be considered to ensure that the information about childhood obesity provided to parents and children is consistent and that advice is practical.

Implications for Research

The findings from this study are tentative at best. This study should be replicated using larger and more diverse samples including persons of Aboriginal background, different ethnic populations, rural residents, immigrant populations, and persons from a wider range of socioeconomic backgrounds. Methods of recruitment need to take into account parental sensitivity about their child's obesity and plan recruitment strategies accordingly. Some parents have had negative experiences with health care professionals

and may not be willing to engage in conversations with researchers without some initial assurances of safety, i.e. not being blamed for their child's weight. Accessing those parents who might not be comfortable with face to face interviews by using different data collection methods would help to reduce selection bias.

With the rise in blended families, it would be of interest to compare and contrast the experiences of step-parents in seeking health care for a step-child who is overweight with those of parents of biological or adoptive children. The issues pertaining to decision making about accessing health care services, obtaining consent for treatment and enacting advice may be different or more complex where two sets of parents are involved.

Concluding Remarks

The process of enacting simple advice to adopt a healthy lifestyle to have a child maintain or lose weight can be likened to the process of mapping out the space between a rock and a hard place. Until the rock is dislodged or the hard place is softened it appears unlikely that children who are currently overweight will fare well in terms of weight reduction. In the light of poor results of childhood obesity treatment, public health experts are choosing to focus on prevention. While prevention is a worthwhile goal, the generation of children who are now overweight and their parents deserve to have access to evidence based information and sensitive, compassionate support to help them deal with the health and social consequences of overweight or obesity.

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APPENDIX B: PARTICIPANT INFORMATION LETTER

Title of Research Study: Parents' Experiences of Seeking Health Services for Their Children Who are Overweight or Obese

Dear Parents,

My name is Brigitte Ahmed and I am a student in the Master's of Nursing Program at the University of British Columbia. Over the past ten years I have worked as a public health nurse in Maple Ridge. Currently, I am working as a diabetes educator at the Ridge Meadows Diabetes Center. In both of these positions I have worked with children and adults facing the challenges of dealing with weight management concerns. For my Master's thesis I will be carrying out a study that explores parents' experiences of seeking health care services and resources for their children who are overweight or obese.

The purpose of this study is to gain an understanding of parents' experiences of seeking health services and resources for their children who are overweight or obese. Your experiences and ideas regarding encounters with health care providers and services will help nurses and other health professionals to develop and/or improve health care interventions that will assist families in managing their child's condition. The voice of parents is notably absent from the literature pertaining to childhood overweight and obesity.

If you are interested and agree to participate in this study, I will arrange to meet with you for one interview, lasting approximately one to two hours. The interview will take place either in your home or in an alternate mutually agreed upon location. In order to obtain an accurate record, our conversation will be tape recorded. The tape recording will be transcribed onto a disc and then printed on paper. All information that you provide will be kept strictly confidential. Your name and any identifying information will not appear on any written report of the study. The electronic data records will be kept on a computer disk and stored in a secure file with password access. The paper records will be locked in a file cabinet. A summary of the findings will be provided to you at the end of the project if you request it.

Participation in this study is completely voluntary and involves no known personal risks or discomforts to you or other members of your family. Although there are no direct benefits to you as a participant in the study, other parents may benefit in the long term from improvement in health services for families with similar health issues. If you agree to participate you may withdraw from the study at any time. You have the right to terminate the interview or request erasing of a tape at any time. Non-participation or withdrawal from this study will not jeopardize your care or the care of your child with any agency or health professional.

Name of Participant (Printed) _____

Signature of Participant: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

Signature of Researcher: _____ **Date:** _____

APPENDIX D: INTERVIEW GUIDE

Title of Research Study: Parents' Experiences of Seeking Health Care Services for their Children Who are Overweight or Obese

The following questions are sample questions only. Not all questions will necessarily be asked during the interview. Probing questions will be used for clarification and to elicit greater depth of description where appropriate.

Explanation

- Introduction of self
- Thanks for agreeing to the interview

Purpose

- Brief review of the study
- I will be asking about your experiences of seeking health care services and resources for your child who is overweight or obese
- There are no right or wrong answers
- All comments, both positive and negative are welcome

Procedure

- Explanation of use of audiotape
- May choose not to answer certain questions or stop the interview at any time

Questions

1. Tell me a bit about your child's weight history.
2. When did you recognize that your child's weight was an issue?
3. What did you think needed to be done?
4. Tell me about your experiences of seeking help for your child
5. Where did you go? What kind of resources did you tap into?
6. Do you feel that you were heard and that your concerns were addressed?
7. Did you agree or disagree with the support/interventions offered?
8. Was the support/intervention effective?
9. Who or what was most helpful to you?
10. Who or what was the least helpful?
11. What is your perception of the usefulness of the help that you received?
12. What was the impact on yourself and your child?
13. In retrospect is there anything that you would you do differently in seeking health care resources?
14. Is there anything that you would like to add?

Health Services/ Resources Accessed

- ☐ Public Health Nursing
- ☐ Physician Office Nurse
- ☐ School Nurse
- ☐ Nurse Practitioner
- ☐ Dietitian

- ☐ Family Physician
- ☐ Pediatrician
- ☐ Weight Loss Clinic
- ☐ Weight Management And Lifestyle Program Sponsored By A Health Region
- ☐ Complementary or Alternative Health Practitioner.
- ☐ Other