# BRITISH COLUMBIAN DIETITIANS' PERSPECTIVES ON THEIR EXPERIENCES WITH WEIGHT LOSS COUNSELLING FOR CHILDREN AND ADOLESCENTS

by

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## Abstract

**British Columbia dietitians' perspectives on their experiences with weight loss counselling for children and adolescents**

The prevalence of childhood and adolescent obesity has been increasing rapidly over the past decade, yet at this time, there is a lack of evidence regarding effective treatment approaches on which to base practice. At the same time, confusion seems to exist among dietitians as to the meaning and integration of different treatment philosophies, approaches and appropriate outcome measurements, raising questions about how dietitians are managing cases involving pediatric obesity in their practice.

This study was undertaken to develop an understanding of dietitians' experiences of providing services to obese youth in British Columbia's Lower Mainland.

Between 2004 and 2006, 13 practicing dietitians participated in individual interviews where they discussed their experiences of weight loss counselling with obese children and adolescents. A qualitative research design informed by grounded theory methodology was used to analyze these interviews.

Experiences shared by dietitian informants reflected their frustration, doubt and conflict regarding what they should and could be doing with their clients when it came to weight management. They attributed this distress to four primary issues: inadequate time and resources to do their work effectively, client's lack of readiness to make behavioural change, the lack of appropriate counselling skills to be helpful to their clients and finally, uncertainty about how to best deal with the complex problem of obesity. These experiences impacted informants in different ways, and each found ways of addressing these challenges while continuing to work in the area of childhood obesity.

Informant dietitians felt unsupported in their work, inadequately trained to support their clients, and uncertain how their profession should proceed in the management of childhood and

adolescent obesity. The findings have important practice, education and research implications for the dietetics profession.

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## Chapter One: Introduction

### 1.1 Background

The past decade has brought a great deal of turbulence to dietetic practice on many fronts. Canadians and their children are gaining weight faster than ever before, and Canada is now part of what the World Health Organization has called a global epidemic of obesity, with an estimated nine million Canadians being either overweight or obese.[1-5] Of particular concern is the evidence that this increase in obesity prevalence is occurring amongst one of the most vulnerable segments of our population, children and youth, at an alarming pace. Currently 15% of Canadian children are considered to be overweight, with an additional 30-40 % being 'at risk' for overweight.[6] A recent report by the Canadian Institute for Health Research states "this high and rapidly increasing prevalence will significantly impact the health of Canadians over the course of the next century."[6] (p.4) This is largely predicated on the understanding that children who are overweight and obese are at significant risk for current and future physical and emotional harm as a result of their condition.[7-9]

Dietitians have been widely acknowledged as experts in weight management[10-13] and have been charged by their profession as having "a responsibility for exerting leadership" in this area. [12](p. 1152) To this end, the profession has worked closely with health and medical professionals to help cope with escalating levels of obesity in the population. At the same time, because of increasing concerns about the effectiveness of weight loss programs[14-17], the growing awareness of size prejudice and eating disorders in our culture, and concerns about the impact of dieting[18],

dietitians have been urged to consider whether or not it is ethical or advisable to promote weight loss. Out of this debate*, referred to by some as the 'dieting maelstrom', which has been waged publicly in the media and privately in professional journals and workshops throughout the continent, differing philosophies of weight control have emerged. Known variously as 'size acceptance' and 'non-dieting' these views have espoused a range of approaches that may include social support and advocacy for large people, an emphasis on healthy lifestyle choices over dieting, or self acceptance regardless of body size with an abandoning of weight loss guidance altogether.

In the case of childhood obesity, these differing philosophies have become even more salient. Children, who are still growing, are seen as particularly vulnerable to weight loss practices that may have undesirable effects, including stunted growth and weight preoccupation.[19] In addition, dieting has been linked to the development of eating disorders in this group, and paradoxically, to an increased risk for obesity.[20, 21]

At the same time, new ways of conceptualizing obesity itself have emerged, resulting in competing discourses both on a public and a professional level. Obesity is being framed both as an issue of 'individual' responsibility for health and an issue that is largely mediated by the environment, with responsibility being partially attributed to corporate and public policy.[22] Individuals' attitudes and practices regarding obesity reflect which view is given most credence. On top of this, the dietetics profession has undergone a significant shift in practice, where dietitians are no longer simply disseminators of nutrition information to clients, but rather, are

* In 1994 Kelly Brownell and Judith Rodin published their seminal paper "The Dieting Maelstrom: is it possible and advisable to lose weight?" (1) wherein they present the prevailing elements of the 'impassioned debate over the virtues and dangers of dieting' which are polarizing the field.

expected to be practitioners of client-centered counselling approaches aimed at helping clients modify their unhealthy behaviours. [23] Further, this expectation comes in a climate that increasingly demands verification of their effectiveness, with practice that is based on sound clinical evidence.[24, 25] While these latter developments are not specific to childhood obesity, they provide an important context for the practice of those who work specifically with children and youth.

There is evidence that the emergence of these philosophies has had an impact on dietetics practice in Canada[10, 11] and that confusion exists among dietitians as to the meaning and integration of these new philosophies and practices into their work. A recent survey of dietitians' practices regarding weight management in childhood and adolescence indicated a discrepancy between what some believe, and how they practice.[11] For example, dietitians stating they use a size acceptance approach would teach weight loss strategies to their adolescent clients. In addition, many have wondered how they can deal with the obesity epidemic while at the same time promoting a philosophy that views dieting as an inappropriate intervention.[26] At the same time, many dietitians have expressed concern that they lack adequate skills to effectively counsel their clients, [27-30] and sufficient time to counsel clients in the context of their jobs.[27, 28,30] The dieting maelstrom it seems, has expanded to become the 'obesity management' maelstrom.

The doubt and confusion that has ensued may serve to undermine the confidence of dietitians in their ability to work effectively, and threaten their position as 'trusted experts' on matters of food, diet and nutrition. As David Garner, a highly respected researcher in this area has stated:

"How can the professional, let alone the consuming public, make sense of these contradictory messages from professionals...?"[31](p. 28)

## 1.2 Problem Statement

Childhood obesity is increasing in prevalence, and is viewed as a problem of utmost concern because of its potential to impact the health of Canadians for many years to come. Dietitians are seen by many as having a significant role to play in addressing this issue, but there is evidence that dietitians themselves remain uncertain as to how best proceed, and have conflicting views regarding appropriate management strategies. As part of a larger study examining dietitians' attitudes and practices regarding weight management in general, researchers described a number of challenges experienced by Canadian dietitians in this area. [30] However, no one has explored the experiences of dietitians who do weight loss counselling with children. It remains unclear what impact, if any, these experiences may have on their practice. If there is an expectation that dietitians take a leading role in the management of children's obesity, then we need to know more about their experiences, challenges and practice needs. Gaining an understanding of these will assist us in developing appropriate education and training to support the efforts of dietitians as they strive to find their place in this turbulent domain.

## 1.3 Purpose of the Study and Research Question

The purpose of this study was to develop a deeper understanding of the experiences of dietitians who work with obese children and adolescents, within the context of the 'obesity management maelstrom', which includes the increasing prevalence of childhood obesity, the subsequent 'war

on obesity', the emergence of competing discourses on obesity management, emerging philosophies of weight management and counselling approaches and the trend to evidence-based practice in the dietetics profession. The research question was: What are the experiences of dietitians working in British Columbia's Lower Mainland, who have carried out weight loss counselling with overweight children over the past 5 years?

## 1.4 Relevance

Parham notes that dietitians are "unique in the extent to which being experts in weight management is a part of their professional identity."[13](p.187) Public and professional questioning of both the effectiveness and ethical validity of a significant part of their work cannot help but have an impact on dietetic practice. How dietitians respond to this may impact their credibility in public and with their clients. Wooley offers a striking example of this: "One might easily find prevention programs for obesity and eating disorders delivering diametrically opposed advice, one urging children to attend more carefully to diet and exercise and the other urging decreased concern."[32] (p.77) This confusion, combined with dietitians' increasing levels of frustration related to general practice and clinical competency issues, may also serve to undermine the confidence of dietitians as they struggle to find a personal and professional balance within this debate. Increasing our knowledge and understanding of dietitians' experience in clinical practice, especially that of those who work with children and adolescents, will enable us to support dietitians in their work. It will help deepen the dialogue amongst dietitians regarding childhood obesity management and practice, and will provide many with the opportunity to explore their own values, perceptions and practices regarding this area of practice. Finally, deepening our

knowledge of these important issues will provide guidance for the development of professional and continuing education for dietitians.

# Chapter 2 Literature Review

## 2.1 Preamble

In this section I will present the various facets that have contributed to the turbulence of the past decade in dietetic practice. I will begin with an overview of the increasing prevalence of childhood obesity in society, along with a discussion of some of the concerns, health and otherwise, that are associated with this increase. I will briefly discuss the current status of obesity treatment research and its limitations. I will present an overview of the concerns related to weight loss counselling in this population. These include fears of increasing disordered eating, of reducing self-esteem in this group, of inadvertently contributing to further weight gain, and of interfering with normal growth and development in this population. I will discuss the prevalence of dieting in this group including the concept of 'healthy' vs 'unhealthy' weight loss practices. Finally, I will examine the sister concepts of 'size-acceptance' and 'non-dieting', because proponents of these philosophies have been vocal in their criticism of dieting and have served to bring to the forefront the debate on this issue in both the dietetic and medical communities. While not directly related to childhood obesity, the evolution of these philosophies has had a significant impact on dietetics practice amongst Canadian dietitians, and I will discuss research pertaining to dietitians' practice of weight loss counselling in Canada, specifically as it relates to these philosophies. This discussion will include a brief overview of the shift in dietetics towards client-centered approaches and evidence-based practice, as well as a brief overview of how obesity is currently being framed in the media and professional circles.

## 2.2 Childhood Obesity

### 2.2.1 Definition

Definitions of childhood overweight and obesity vary in the literature.[33-35] In general, however, the term 'overweight' refers to excess weight in relation to height, while 'obesity' refers to excessive body fat in relation to lean body mass[34] Whitlock et al. note that a major limitation for clinicians in assessing overweight and obesity in children has been the uncertain criteria for determining clinically significant overweight.[39] Traditionally body mass index* (BMI) has been used as a simple measure of obesity in children, based on the reliability of measuring height and weight, and the fact that BMI is a valid index of fatness.[34] More recently, many countries have adopted BMI reference standards that are gender and age specific, to define overweight in children.[34] These standards, one of which has been developed by the American Centers for Disease Control and Prevention (CDC), address concerns related to the fact that children's body build and composition change with age. In Canada, a group of Canadian health organizations including Dietitians of Canada and The College of Family Physicians of Canada recently issued a Canadian Collaborative Statement that recommends using the CDC BMI reference data, with different labels for weight categories: a BMI between the 85$^{th}$ and 95$^{th}$ percentiles indicate that a child is 'overweight' (as opposed to the CDC that calls this 'at risk for being overweight') while a BMI over the 95$^{th}$ percentile indicate that a child is 'obese' ('overweight' per the CDC standards). In the literature, the terms are often used interchangeably, and I have chosen to do the same in this thesis, except where defined specifically in the literature. Whitlock et al.[33] note that uncertainty remains as to the clinical applicability of this standard to individuals. Such

* Body Mass Index is a measurement of the relative percentages of fat and muscle mass in the human body, in which weight in kilograms is divided by height in meters and the result used as an index of obesity. *The American Heritage® Dictionary of the English Language, Fourth Edition.* Retrieved December 21, 2006, from Dictionary.com website: http://dictionary.reference.com/browse/bmi

factors as individual variations in body composition with age, gender, race/ ethnicity, genetic predispositions and sexual maturity all play a role in determining whether or not a child is truly 'overfat' and at increased risk for health complications related to this.[36] Because of these factors, it is important to emphasize then that these definitions of obesity and overweight should be used for screening purposes only.

### 2.2.2 Prevalence of Childhood Obesity

Regardless of how it is measured or defined, obesity prevalence amongst children and youth in Canada and the rest of the developed world has been rising rapidly over the past two decades. The 2004 Canadian Institute of Health Information report on overweight and obesity in Canada [4] which used measured height and weight data from the 1981 Canada Fitness Survey and parent-reported data from the 1996 National Longitudinal Survey of Children and Youth, found the prevalence of overweight and obesity tripled in boys and doubled in girls over the 15 years reported – an estimate which was called conservative due to the nature of parental/self-reported data.[4] (p. 8) More recent findings from the Canadian Community Health Survey [37] which used direct measures of height and weight, similar to the 1978/79 Health Canada Survey, show that between 1978/79 and 2004, the percentage of 2-17 year olds who were overweight increased from 12% to 18%, while the percentage of those who were obese increased from 3% to 8%. Overall, in 2004, 26% of Canadian children and adolescents between the ages of 2 and 17 were either overweight or obese, a figure that was about 70% higher than it had been in 1978/79.[37] Many professionals and the media have used the term 'epidemic'[38, 39, 40] to describe this rising prevalence, adding to the already present fears about the need to act quickly to address this major health problem.

### 2.2.3 Consequences of Childhood Obesity

Moore uses the term 'tidal wave' to describe how the increase in obesity prevalence, especially amongst youth, is seen by scientists and clinicians alike as an "overwhelmingly large inrush of pathology."[38] (p. 885) The medical, social, psychological and economic consequences associated with childhood overweight and obesity have been documented and reviewed by many. [6, 8, 41-44] In particular, Reilly et al.[41] published a review in 2003, based on data published between January 1981 through to the end of December 2001, the aim of which "to provide a critically appraised, evidence based, summary of the consequences of childhood obesity in the short term (for the child) and longer term (in adulthood)."[41] (p. 749) Conclusions of this review were "based solely on evidence with low risk of bias" to ensure that recommendations based on evidence "were explicitly linked to the strength of the underlying evidence, and, where possible, based on high quality evidence." [41](p. 750)

Reilly et al.'s review categorized the consequences of childhood obesity as short term and long term. In the short term, evidence is now well established that:

- childhood obesity has adverse effects on the cardiovascular system similar to those found in adults
- obese children are definitely more likely to experience psychological or psychiatric problems (in particular, low self esteem and behavioural problems) than non-obese children, with girls being at greater risk than boys, and risk of psychological morbidity increasing with age
- asthma is a co-morbidity of childhood obesity

- childhood obesity is associated with a more than twofold risk of developing type 2 diabetes
- paediatric obesity may be associated with low grade systemic inflammation.

In the long term, consequences of paediatric obesity included:

- social and economic effects, wherein high quality longitudinal studies presented evidence that obesity has adverse effects on social and economic outcomes in young adulthood, including income and educational achievement
- persistence of obesity from childhood into adulthood is high, especially where children had at least one obese parent, obesity was more severe (defined as BMI >95$^{th}$ centile) and obesity was present at an older age (i.e. adolescent obesity is more likely than childhood obesity to persist into adulthood, and 40–70% of obese pre-pubertal children are likely to become obese adults)
- an impact on adult morbidity and risk of premature mortality, wherein increasing BMI at age 18 was associated with significantly increased mortality within 20 years of follow-up, based on two high quality relevant studies
- obesity mediated cardiovascular morbidity in adulthood, wherein this morbidity can have its origins in childhood obesity.

In addition, Reilly et al. concluded that other co-morbidities of obesity in childhood, including type2 diabetes, polycystic ovarian syndrome, and a variety of respiratory, orthopaedic, and hepatic abnormalities, while being fairly well established, had a more limited evidence base.

In addition to being a health risk, obesity also represents a significant cost to public health care systems. In Canada, the direct medical costs attributed to adult obesity defined as BMI > 27 $kg/m^2$, were estimated to be $1.8 billion Canadian dollars in 1997 (representing 2.8% of total direct medical costs for that year).[45] In the United States the figure was $99.2 billion in 1995 or 5.7% of National Health expenditure.[46] It appears obvious therefore that the public health burden of obesity is substantial and in need of attention.

On the basis of this and other reviews, the Canadian Institute of Health Research concluded that these consequences of childhood obesity will be "transformative forces in the lives of Canadians and Canadian society in the years to come" and that there remains a "pressing need for efforts directed at intervention."[6] (p. 6)

### 2.2.4 Treatment of Childhood Obesity

Despite the pressing need for treatment of childhood obesity, it is increasingly apparent in the literature that effective interventions are lacking. There appears to be a general consensus that prevention is an important approach to use in addressing obesity amongst children, because it is considered "the most effective, economical and socially acceptable approach to addressing the obesity epidemic."[6] (p. 5) But at this time, there is a striking imbalance in the literature regarding effective approaches – with treatment evidence significantly outweighing that of prevention, leaving researchers demanding that this area be considered an urgent research priority. Despite this perception of prevention being a priority, it is also widely acknowledged by many that with

the increasing numbers of already obese youth seeking treatment, effective approaches at this level are also essential.

To this end, existing evidence aimed at treating obesity has been systematically reviewed and critiqued by numerous authors. These reviews have shown that of the few randomized control trials performed, most are rated as poor quality, short term and lacking in generalizability.[6, 33,47-50] The conclusion repeated by many is that we lack evidence for specific interventions aimed at treatment, and are in the unfortunate position of "needing to do something now for the patient and family seeking help, regardless of the uncertainty about the nature of the disease and the absence of a cure."[50] (p. 139)

Lack of evidence notwithstanding, most reviewers have presented guidelines for practitioners because, as stated by the CIHR reviewers, "any treatment intervention is associated with significantly increased chance of improvement or resolution of obesity, and is favoured over no treatment."[6] (p. 4)

The principal goal of childhood obesity treatment interventions has been regulation of body fat and weight, while continuing to provide sufficient nutrition for continued growth and development. Because growth and development needs during adolescence are profound, treatment goals must consider individual factors such as age, stage of growth and development, degree of overweight and the presence of co-morbid conditions.[53] Kirk et al., noting that "maintenance of height velocity is a critical indicator of the safety of any intervention"[53] (p. 45) suggest that, depending on age and health status, weight goals for children who are at risk for

overweight (BMI percentile $\geq 85^{th}$ to $<95^{th}$) or overweight ($\geq 95^{th}$ percentile) can be set along a continuum of slowing the rate of weight gain, stopping weight gain or losing weight. Since growth is continuing, these outcomes will all result in some decrease in BMI – generally conceptualized as "growing into your weight".

In general, treatment approaches that are multidisciplinary and that involve the family are favoured, as no one treatment approach (including diet, exercise, behavioural therapy, surgery and medication) has been found effective enough as a sole tool in children.[6, 47,49-52] For example, recommendations from the CIHR review of childhood obesity concluded, "It is clear that treatment programs should include strategies to address diet, physical activity and behavioural change."[6] (p 6) More recently, Reilly et al.[47] noted that expert committee consensus reports on treatment have provided some clear guidance for practitioners. In particular, these guidelines specify that treatment[47] (p. 434):

- should probably be limited to motivated patients and families
- must entail dietary changes, but should not focus entirely on diet
- must aim to reduce sedentary behaviour (encourage reduced television viewing and media use)
- should treat the family, not the child
- must encourage increased physical activity
- must provide more time for consultation with families, and more consultations.

It is clear, he and others note, that many details regarding the specifics of such programs are lacking.

### 2.2.5 Dietary Guidelines for the Treatment of Obesity

Many of the treatment reviews mentioned above included dietary interventions, as these are considered a key component of virtually all programs to treat childhood obesity. However, it was generally concluded from all reviews that there is insufficient evidence to promote a particular characteristic of dietary interventions. [6]

Collins et al.[54] completed a recent systematic review of dietary interventions in childhood obesity, the intent of which was to "identify and present the best available evidence on the effectiveness of dietetic treatment and management for overweight or obese children and adolescents."[54] (p 907) After starting with 1310 English language articles pertaining to randomized control trials with subjects under 18 years of age and published between 1975 and 2003, they ended up with eight randomized control trials that met their criteria for quality. They concluded "It is not possible to evaluate the effectiveness of dietary treatment for childhood obesity because of the lack of high quality studies and the heterogeneity of designs, treatment combinations, outcome measures and follow-up."[54] (p. 906)

The Stoplight/Traffic Light program of Epstein et al.[64] was mentioned by several reviewers as having more potential than others, by virtue of the fact that it was the most commonly reported dietary intervention, and unlike most others [54, 55] it described the dietary intervention component in detail – a salient feature. Emphasizing calorie control, with a range between 900 and 1300 kcal/day for 6-12 year olds, this plan categorized food as 'red stop' (high in fat or simple sugar, very limited, not eaten at home), 'green go' (eat freely) and 'yellow caution' (somewhat limited

because of higher nutrient density). While evidence has shown this American program to be effective at reducing obesity* in the population being studied, Collins et al. emphasized the studies arose from "a single research group and applicability to other settings has not been established."[54] (p. 917)

The American Dietetic Association, in their evidence-based review of the literature[24], concluded that while "there is sufficient evidence to support including dietary therapy and/or nutrition education within a multi-component, family-based group intervention along with physical activity, behavior counselling, and family counselling for reducing overweight in school-age children" (but not adolescents), there was "limited" evidence available to support routinely recommending individual-based intervention for overweight children and adolescents (only two studies of acceptable quality were identified using an individual approach), and limited evidence to support using diet therapy and/or nutrition education alone with this group.[24] (p. 929) Individual-based interventions were defined as one-on-one counselling in a non-group setting, while dietary counselling included the prescription of a specified caloric and/or nutrient content per day, and nutrition education involved providing more general information on foods, shopping, and nutrition to promote healthful eating.[24] The term 'lifestyle modification' was often used in the literature to describe approaches that incorporate alterations to physical activity and diet.[47-50] However this term is used inconsistently in the literature, with 'lifestyle modification' being used to describe interventions that incorporate everything from specific calorie controlled prescribed diets [56] to general guidance on making healthier food choices based on Canada's Food Guide.[57]

* The combined results of 4 randomized clinical trial involving 154 overweight children aged 6-12 years, showed that 10 years after the intervention, 34% of the children had maintained a reduction in percentage overweight by 20% or more, and 30% were no longer obese[55].

As the preceding reviewers make clear, at this time, there is no direct evidence as to which dietary modification is most effective in this age group. Generally, study diets used portion control, reduction of high caloric density foods and a balanced hypocaloric approach. When recommendations are made regarding dietary interventions, reviewers generally suggest that they should follow national nutrition guidelines (e.g. Canada's Food Guide), with emphasis on increasing vegetable and fruit intake, making healthier snack-food choices and giving guidance on portion sizes.[24,47, 48, 53,55] On the surface, these appear to be quite different from the aforementioned Traffic Light diet, which is a structured, calorie –based eating plan used to guide food choices and increase the nutrient density of the diet.

This brief review of the status of treatment interventions has been presented to demonstrate that in spite of the concerns about childhood obesity, concrete solutions are not forthcoming, and effective dietary strategies are inconsistent and lacking.

## 2.3 Diets, Dieting and Childhood Obesity

At the same time that efficacy of dietary treatment options are in question, evidence has been accumulating regarding the potentially harmful effects of dieting. Adolescent girls have become increasingly preoccupied with their body weight and shape, largely because being fat is considered so unacceptable.[58, 59] They are trying to lose weight in increasing numbers, and many are using practices that may increase their risk for the development of eating disorders and, ironically, further weight gain. [20, 60, 61] These concerns have served to cause many in the dietetic

community to question the ethics of promoting dieting and weight loss in any group[14, 17] let alone amongst children and adolescents who are considered to be particularly vulnerable to 'overzealous efforts' that may have undesirable consequences.[62, 18] This is especially pertinent to dietitians, given their awareness that adolescence is a time of unprecedented physical and emotional growth and development. In the following section, I will briefly review the prevalence of dieting amongst adolescents, and the links between self-esteem, body image and weight concerns in this group. I will outline the concerns pertaining to dieting practices and both eating disorder risk and weight gain. Finally I will review the emergence of alternative paradigms to dieting and weight loss, including size acceptance and non-dieting approaches, that have become familiar within the dietetics community.

### 2.3.1 Prevalence of Dieting Among Adolescents

Hill, who has reviewed both the prevalence and demographics of dieting in adults as well as adolescents, observes that 'dieting' is not consistent in its presentation, making it difficult to approximate with accuracy just who is doing it and what exactly are they doing.[63] Research studies, he points out, often ask about self-initiated dieting behaviours that may or may not be defined. In reviewing studies of western adults, he does however estimate that 39% of women and 21% of men report they are currently 'trying to lose weight'; compared with 24% of women and 8% of men who are currently 'dieting to lose weight', and 55% of women and 29% of men who have ever dieted to lose weight. While adult dieting statistics are not relevant to this paper, they are noteworthy because parents, particularly mothers, can have a substantial influence on their children's dieting patterns[65,66] including those as young as 5 years old.[67]

In the case of children and adolescents, the prevalence of self-reported dieting behaviour is equally high. In a recent cross- sectional study of rural 8-17 year old American girls, Packard et al.[68] found high levels of dieting behaviour, with over 50% stating they were 'sometimes' or 'always' on a diet and with 'detrimental' changes in eating beginning at 11 years of age. Hill, citing a range of studies, observed that adolescent girls report higher levels of dieting than women; and that dieting increases in girls between the ages of 11 and 16 – with up to 25% of 11 year olds having already made one weight loss attempt.[63] In British Columbia, a 1993 survey of adolescent health showed the proportion of girls wanting to lose weight in grade 7 (69%) increased to 82% by grade 12, with over 50% actively trying to lose weight.[69] A repeat survey in 2003 demonstrated that this trend continues, and further, that 7% of healthy weight girls were "always" dieting.[70]

In reviewing dieting demographics, Hill also observes that while trying to lose weight and dieting are strongly related to BMI (with overweight and obese women more likely to be currently trying to lose weight) the relationship is not linear: almost 10% of women with a BMI below 20 are currently dieting while close to 70% of overweight women are not.[63] He notes too that across all groups, in normal weight females, dieting is most strongly related to perceived weight rather than actual weight. In the previously cited British Columbian study, 52% of healthy weight girls reported that they were trying to lose weight.[70] Similarly, Barker et al.[71] in their cross sectional examination of the relationship between body composition and diet in British adolescent girls, found that girls who were well within a healthy weight range per BMI standards (BMI 20.5 – 24), were 6 – 11 times more likely to be dieting than the thinnest girls

(BMI less than 20.5). Thus dieting would appear to have become virtually 'normative' amongst this population group.

### 2.3.2 Dieting and Psychosocial Correlates

Much has been written about body image dissatisfaction and weight concerns in adolescence, and dieting prevalence has been linked to body image dissatisfaction.[59] In our modern culture, thinness is endorsed, excess weight denigrated, and obesity is stigmatized.[75] Girls in particular have become increasingly preoccupied with their body weight and shape, largely because being fat is considered unacceptable.[58, 59] This problem appears to be getting worse, with data showing an increase in the stigmatization of fat children by 41% over the last 40 years.[58]

Obese adolescents are more likely to be dissatisfied with their bodies[75], more likely to be teased because of their appearance[58] and more likely to adopt dangerous dieting practices[60] than their 'normal' weight counterparts. Furthermore, girls' weight and dieting practices have been strongly linked to other social and psychological issues, and obese children are "definitely more likely to experience psychological or psychiatric problems than non-obese children."[44](p. 748) These social and psychological difficulties include lowered self-esteem and depression, both of which have been associated with weight and eating concerns. Some authors have suggested that dieting may in itself be a causal factor in the development of these negative psychological conditions[76-80] however this association is still being debated.[81, 82] Recently the Irish National Taskforce on Obesity concluded that the social and psychological difficulties associated with

obesity "may be related to the stigma and prejudice that obese children experience, which hinder their social development during childhood and adolescence." [83](p. 54)

### 2.3.3 Dieting Practices and Eating Disorder Risk

One of the more voluble arguments in the maelstrom has been the charge that dieting leads to the development of eating disorders in adolescent females. Polivy and Herman were amongst the first to suggest that dieting and eating disorders lay on a continuum. They argued that chronic dieting (described as 'normative' in 1987) requires behaviors and attitudes that are both self-destructive and pathologic, and called for further research to establish the 'causal primacy' of dieting and its correlated pathologies.[80] Since then, further evidence has supported the link between dieting and the development of eating disorders in young women. For example, Patton et al. prospectively studied adolescent girls in Australia and found that girls who dieted at a 'severe'* level were 18 times more likely to develop an eating disorder than those who did not diet.[98] More recently, Neumark-Sztainer et al. [61] found that dieting and unhealthful weight-control behaviors predicted outcomes related to obesity and eating disorders 5 years later. In 1998- 1999, this research group conducted 'Project EAT (Eating Among Teens)-I' wherein they surveyed 4746 junior and senior high school students in 31 Minnesota schools about their eating patterns and weight status. Five years later, in 'Project EAT-II', they managed to resurvey 53% of the original cohort in order to examine changes in the eating patterns and weight status as the younger cohort of juniors progressed from early adolescence to middle adolescence, and the

* Because dieting can mean different things to different people, researchers are now taking a closer look at the kinds of weight control behaviours that people practice. Such behaviours are often classified into two distinct categories: Those that are perceived as relatively benign or 'healthy' include portion control, avoiding fat, fatty food, sweet drinks and candies as well as eating more fruits and vegetables, whereas 'unhealthy' (more 'severe') practices consist of fasting, skipping meals, using diet pills and/or laxatives, and self-induced vomiting.[33, 53]

older cohort progressed from middle adolescence to late adolescence. They were attempting to answer the question, "Are adolescents who report dieting and different kinds of weight-control behaviors at increased or decreased risk for gains in body mass index (BMI), overweight status, binge eating, extreme weight-control behaviors, and the onset of an eating disorder 5 years later?"[61] (p. 561) Specifically pertaining to eating disorder development, they found that compared with participants in Project EAT-I, for participants of Project EAT-II, dieting was significantly associated with binge eating with loss of control[†] among female and male subjects. Further, among female subjects, dieting was also significantly associated with future extreme weight-control behaviors and a reported eating disorder. Female subjects who reported dieting in the original study were at twice the odds for engaging in extreme weight-control behaviors and reporting an eating disorder 5 years later (OR=1.95 and 2.34, respectively) compared to those who were not dieting at baseline.[61]

This evidence is particularly alarming because American and Canadian researchers have found that among young adolescents trying to lose weight, many practice dieting behaviours at the 'severe' end of the spectrum. Neumark-Sztainer et al.[84] surveyed adolescent teenagers (Grade 5 – 12) in the United States and found that of the 45% of girls who reported having been on a diet, 13% had engaged in binge-purge type disordered eating behaviour. For boys, the percentages were 20 and 7, respectively. Working with another team, Neumark-Sztainer et al.[85] found over 4% of adolescent girls and 2% of boys used diet pills and laxatives as weight control methods, while 6% and 2% respectively employed self-induced vomiting.

[†] Binge eating with loss of control was assessed with two questions (yes/no for each question): "In the past year, have you ever eaten so much food in a short period of time that you would be embarrassed if others saw you (binge eating)? During the times when you ate this way did you feel you couldn't stop eating or control what or how much you were eating?"

In Canada, Jones et al.[86] conducted a cross-sectional survey of 12 – 18 year old high school girls and found a current dieting prevalence of 23%. In addition, binge eating or purging was reported by over 18% of girls under the age of 15, and 26% of those over 15 years. To measure disordered attitudes and behaviours towards eating, the authors used three different scales, including the Eating Disorders Inventory (EDI), the Eating Attitudes Test-26 (EAT-26), and the Diagnostic Survey for Eating Disorders (DSED). They found significant symptoms of eating disorders were reported by 27% of the girls, including self- induced vomiting to lose weight by almost 7% of girls aged 12 – 14 years. In a more recent Canadian study, McVey et al.[87] examined the prevalence of dieting and negative eating attitudes amongst 2279 females, aged 10-14 in southern Ontario. They reported that 29.3% of the girls were currently trying to lose weight, and that 10.5% scored over 20 on an eating attitude test (ChEAT), a level which is associated with "more disturbed eating attitudes and an increased vulnerability towards development of an eating disorder."[87] (p. 1559) It seems then that Canadian girls too are at increased risk for the development of eating disorders along with their American counterparts.

### 2.3.4 Dieting and Weight Gain

In the past, cross sectional studies have observed strong associations between dieting and overweight, [61] leading some to question the wisdom of recommending diets for weight loss. Whether or not this association was causal, or related to the idea that over-weight people may be more likely to go on weight loss diets than non-overweight people, was not clear. More recently, researchers have prospectively observed an association between dieting to lose weight and

weight gain. Field et al.[20] prospectively studied 14972 boys and girls over a 3-year period. They found that dieters gained more weight than non-dieters during the 3 years of follow-up. Specifically, among the girls and boys, infrequent and frequent dieters* gained more weight than non-dieters, even after controlling for differences in caloric intake, percentage of energy from fat or protein, and intake of snack food. The authors noted that even despite an apparently healthy dietary intake, dieting frequency was predictive of a larger relative weight gain. The mechanism for this result was not determined, but the findings that dieters were more likely than non-dieters to binge eat may have been a factor. While there have been cross-sectional associations between dieting and binge-eating, the authors further note that this is the first prospective study to demonstrate such an association.

Similarly, Neumark-Sztainer et al. conducted a longitudinal study that addressed, in part, the research question, "are adolescents who report dieting and different kinds of weight-control behaviors at increased or decreased risk for gains in body mass index and overweight status."[61] (p. 561) They too found that dieting behaviour was predictive of weight gain and overweight status, with dieters at the outset of the study being nearly twice the risk for being overweight 5 years later, compared to non-dieters. In particular, they found that unhealthful weight control behaviours (including fasting, using food supplements such as diet drinks, skipping meals, smoking more cigarettes, using diet pills, laxatives, diuretics or self-induced vomiting) were the strongest and most consistent predictors of these outcomes.

* Dieting was assessed with the question" During the past year, how often did you diet to lose weight or to keep from gaining weight?"

These results have been questioned by others. In particular, Raynor et al.[88] cite a variety of randomized trials that have tested family-based behavioural modification interventions using low calorie dietary prescriptions, which have resulted in improved weight status, not weight gain. They offer two possible explanations for the discrepancy between their findings and those cited above. First, it may be that it is the unhealthy weight loss practices that are key to the findings of subsequent weight gain. Alternately, they suggest that individual difference factors, such as a personal tendency for over-consumption or a family history of overweight, may be responsible for moderating the relationship between dieting and eating behaviour, rather than the dieting behaviour itself. They note that a different study design, such as a randomized control trial, would rule out this kind of a third party issue, which is not possible in cross sectional or prospective trials.

In response to this controversy, Neumark-Sztainer in particular has been vocal in her iteration of a need to understand why population-based rather than treatment samples show this trend towards weight gain. She recognizes the need to "look toward population-based strategies in which home, school, and community environments are modified to be more supportive of more healthful eating and activity behaviors and more accepting of diversity in size and shape,"[89] (p. 1361) and acknowledges Raynor's perspective, agreeing that well-controlled and monitored family-based weight loss treatment programs do not result in weight gain in long-term follow-up. She further agrees it is important to find ways of supporting youth to develop healthful eating behaviours, and not resort to unhealthful practices to lose weight because of the societal pressures to be thin, and the stigma against overweight. Her fear is that messages from such well intentioned interventions may not be interpreted as such, contributing to even more girls dieting

dangerously, as has been previously reported.[18, 89] O'dea[18], who has documented potentially unhelpful or dangerous outcomes of obesity prevention efforts, has been particularly vocal in her efforts to draw the attention of health professionals to this matter. She exhorts her peers to be mindful of the unintended negative outcomes that may arise from focusing on 'the problem' of overweight, such as triggering girls to take on unhealthful weight loss practices that may have dangerous consequences.

Ongoing questions and controversies such as these remain unresolved in the professional literature. As such, they are likely to contribute to the uncertainty and confusion amongst dietitians and other health professionals regarding how to best approach the question of childhood obesity.

### 2.3.5 Alternative Paradigms: Size Acceptance and Non-Dieting

Historically, the increasing attention that has been placed on both the pros and cons of dieting, and the dilemma of what to do about the 'problem' of obesity has come largely from two fronts – that of the 'size acceptance' movement, and its ally, the 'non-diet' movement. Together, these movements have sometimes been referred to as the 'new paradigm'.

They have been studied extensively by Jeffrey Sobal, and a review of his work is enlightening.[90] Sobal has used content analysis of computerized and published information generated by the movement, mass media and medical sources, ethnographic interviews with movement leaders and participants, as well as participant observation at national and local (American) events of

size acceptance organizations, to clarify their philosophies and the social conditions that led to the development of these movements.

Sobal explains that size acceptance emerged as a social movement in the late 1960's. Arising out of consciousness raising about inequality, stigmatization and discrimination, size acceptance's primary focus is advocacy for fat people. Borrowing from various rights movements of the sixties, its main strategies included creating changes in ideas about weight by emphasizing fat pride, liberation and power. It strives to create support for large people living in an intolerant culture.

The 'non-diet' movement, on the other hand, did not emerge until the mid 1980's. As Sobal notes, it was both a backlash to the mounting evidence that dieting did not work in the long-term and could potentially be harmful; and a reaction to increasing public concern about eating disorders and excessive media portrayals of thinness. Fueled in part by a growing therapeutic community of health professionals dealing with eating disorders, and the emerging concept that dieting could lead to both anorexia and binge eating, the non-diet movement grew quickly. Sobal explains that even though the two movements drew from separate participants and leaders, they became close allies, creating the opportunity for significant social reform.

Even though size acceptance and non-diet advocates often work hand-in-hand with one reinforcing the work of the other, historically speaking, they have been separate movements – and people associated with non-dieting have not necessarily endorsed acceptance of large people. This appears to be an issue of major import in the dietetics community. For example, in 1999 The Journal of the American Dietetic Association (JADA) published the opposing viewpoints of

two eminent dietitians on the subject of body size acceptance.[91] On the non-acceptance side, Gladys Witt Strain argued that it seemed ill-advised to support weight acceptance with so much effort being directed by the profession towards "establishing the relationship of weight status and illness risk."[91] (p. 927) She stated that it was the mandate of dietitians to provide weight loss counselling, and questioned whether we should be encouraging comfort with weight status when instead, people should be counseled to attain a health-compatible weight.[91] Parham, on the other hand, more fully endorsed body size acceptance. [92] While not denying many of the health risks of obesity, she argued that size acceptance, which involves "recognition of one's value as a person" and "expanding one's body experience to include aspects other than size" [92] (p. 922) is necessary when working with the obese client. By focusing educational efforts on health rather than weight loss, a size acceptance framework allows for the creation of "diverse opportunities for success that are not tied directly to weight."[92]This is particularly important in light of the evidence showing that people are only likely to achieve modest weight loss with even the most sophisticated of weight loss programs. Foster and his colleagues concur [93], noting that by helping people work towards acceptance of their body, even at higher weights, the disparity between treatment expectation (large weight loss) and treatment outcome (modest weight loss) may be reduced. This in turn may influence a person's satisfaction with the process, and subsequent ability to maintain the modest weight loss.[93]

Recently, the historical division between size acceptance advocates and the non-dieting movement seems to be shifting, with both sides moving closer together. In a recently released

statement, The International Size Acceptance Association* notes that its approaches involve "improving self esteem, encouraging fitness for all sizes, healthy body imagery and healthy food choices."[94] This endorsement of the 'health at any size' philosophy echoes that of many others in the traditionally 'non-diet' camp[92, 95, 96], with an underlying assumption that health will improve as health behaviours improve, regardless of weight.

In Canada, both size acceptance and non-dieting have been incorporated into the Federal Government's health promotion program 'Vitality' which encourages people to feel good about themselves by emphasizing healthy eating, active living, and positive self and body image.[97] But in spite of this, dietitians remain uncertain and in some cases divided about whether they are to advocate weight loss or healthy eating practice. Barr and colleagues[57] used a cross-sectional mail survey of a stratified random sample of members of Dietitians of Canada to explore dietitians' views and practices regarding adult obesity and weight management practices. They found that Canadian dietitians appear to follow a life-style approach to weight management, where healthy eating and increased physical activity are emphasized over weight loss. Using this approach, most dietitians de-emphasized weight loss as an outcome goal, believing that "improved body image and self-confidence irrespective of weight loss" [57] (p. 509) was the most important weight management outcome. However, the majority also believed that "the loss of even a small amount of weight"[57] (p. 509) could be beneficial, and 87% believed it was part of a dietitian's role to counsel obese clients about how to lose weight. This would suggest that while

* [2] The MISSION of the International Size Acceptance Association (ISAA) is to promote SIZE ACCEPTANCE and fight SIZE DISCRIMINATION throughout the world by means of advocacy and visible, lawful actions. ISAA's primary purpose is to end the most common form of size discrimination and bigotry--that against fat children and adults; ISAA will strive to defend the human rights of members affected by other forms of size discrimination as well. ISAA defines SIZE DISCRIMINATION as any action which places people at a disadvantage simply because of their size. ISAA defines SIZE ACCEPTANCE as acceptance of self and others without regard to weight or body size.[65]

a non- diet approach is their preferred methodology, the majority of dietitians are not fully in favor of a size-acceptance perspective that includes fat acceptance and advocacy for weight discrimination. The authors note too, that there is not currently any research to support the efficacy of a lifestyle approach to weight management. As part of a related study, Marchessault and colleagues[10] used focus groups to explore Canadian dietitians' understanding and use of non-dieting and size acceptance approaches in weight management. They too noted that amongst Canadian dietitians there was an emphasis on lifestyle or non-diet approaches to weight management. They also found evidence of a divergence of belief systems wherein some believed in the concept of 'health *and* weight loss' (if you follow a healthy lifestyle, weight loss will follow) while others believed in 'health *not* weight loss' (health is an outcome of a healthy lifestyle, not weight loss). Thus, responses were "polarized regarding the desirability of weight loss goals."[10] (p.12)

Both the preceding studies focused on adult weight loss. Wray[11] developed a self-administered survey of Canadian dietitians specializing in pediatric practice to explore their weight management practices in children. She noted discrepancies between dietitian's beliefs and practices,[11] (p. 132) suggesting that Marchessault et al. and Barr et al.'s findings may be applicable to this group as well.

Of considerable interest is the most recent position paper from the American Dietetic Association (ADA) regarding paediatric overweight[24]. In it, the Association advocates for dietetic approaches that de-emphasize weight loss as a goal.

> It must be further emphasized that body weight is but one rather imprecise surrogate measure of health. Positive changes in dietary intake and/or

> nutrient status and physical activity will improve health even in the absence of changes in body fatness. Over reliance on measures of weight can put an emphasis on changing our children's bodies rather than changing their food and activity behaviors. Recent increases in disordered eating are believed to be in part caused by youth trying to control their weight at the expense of other health behaviors. Although this review focuses on weight outcomes as a marker for health risks associated with overweight, it is critical that dietetics professionals communicate behavioral, psychosocial, and medical end points to their colleagues and clients.[24] ( p. 939)

They go on to recommend that health related outcomes including dietary intake, activity levels, self-esteem, body image, blood pressure, blood lipids and blood glucose concentrations be included in future paediatric obesity research.

In summary, this section has outlined some of the concerns being expressed by members of the health and dietetics communities regarding the high prevalence of dieting in adolescents, and the associations between unhealthful dieting practices and the risks of becoming more obese or the development of eating disorders. The emergence of alternative paradigms to dieting and weight loss, and recent shifts in the professional dietetics community that de-emphasize weight loss as an outcome measure, represent changes in practice that cannot help but have an impact on the practice of dietitians who work in this area.

## 2.4 The Context of Dietetic Practice

Dietetic Associations the world over have been undergoing explorations in recent years regarding the future of their profession and how they can best face the demands of a world and health care environment that is changing rapidly.[25, 99-101] Numerous challenges have been identified, including issues of competency, recognition of the dietetics professional as the expert in nutrition, as well as competition from and encroachment by other healthcare professionals.[25, 99]

Of particular relevance to the practice of dietitians working in the area of childhood obesity is the trend towards evidence-based practice approaches, and the shift in practice away from the more traditional didactic education practice towards client-centered approaches. These issues have implications for how dietitians work with their clients, as well as how they apply and identify relevant research. Here, they will be briefly discussed.

### 2.4.1 **Trend to Evidence Based Approaches**

In the preceding section, the recent position of the ADA on paediatric obesity was presented. Their emphasis on "concrete, actionable outcomes appropriate for behavioral interventions"[24] (p.939 ) is a clear reflection of the trend towards evidence-based approaches that have come to the forefront of health care practice in the past decade. Indeed, the above ADA position paper represents the first evidence-based approach for the association.

Evidence-based medicine has been defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[102](p. 1) As described by Gray[102], one of the major factors in its development was the recognition that health-care practice amongst health care professionals showed considerable variation, and that a significant number of clinical decisions were "unsupported" by evidence from research. Gray notes that reasons for this include the fact that with the explosion in information and technology, no one can possibly keep up-to-date on new developments. This is true in particular with the explosion of research articles, journals and media scrutiny on the subject of obesity. At the same time, research results are frequently variable and subject to publication bias, with reviews being subject to reviewer bias.[102] The ADA prefaces its position by saying the major advantage of this new evidence-based approach is "the more rigorous standardization of review criteria, which

minimizes the likelihood of reviewer bias and increases the ease with which disparate articles may be compared" [24](p. 925)

With the advent of evidence-based approaches, dietitians are under increasing pressure to keep up to date with new research and developments. Furham, commenting in the Journal of the American Dietetic Association, notes that this is a major issue for the profession, if dietitians are to continue to be recognized as experts in nutrition.[25] The prospect of facing a challenge as daunting as that of childhood obesity with no clear evidence-based strategies is likely to create some doubt in the minds of those who choose to practice in this area. Of note however, while dietitians and their professional associations have identified this as a significant practice challenge, [25, 28] in a recent Canadian survey of dietetic practices regarding weight management, dietitians identified issues pertaining to client interactions as more important.[57]

### 2.4.2 Counselling and Behaviour Change

Several recent studies exploring dietitians' experiences in working with clients (overweight and other) have found that dietitians believe that they are lacking the necessary counselling skills to facilitate behaviour change with clients, to address clients' emotional issues, and to work with families in client sessions.[23, 27, 28, 30, 57, 103]

Cairns[103] administered a cross-sectional survey to 65 English speaking registered dietitians who work in the area of eating disorders in Canada, and found that 71% of respondents were dissatisfied with educational opportunities available to dietitians in this area. Focusing specifically on management of childhood and adolescent obesity, Story et al.[27] surveyed 444 registered dietitians (along with pediatricians and pediatric nurse practitioners) to evaluate their

attitudes, perceived barriers, perceived skill level and training needs in this area. They found the most common areas of self-perceived low efficiency included behavioural management strategies, guidelines in parenting techniques and addressing family conflicts. Similarly, as part of a larger study examining dietitians' attitudes and practices regarding weight management, Chapman et al.[30] conducted 15 focus groups including a total of 103 dietitians in 7 Canadian cities. They too noted that dietitians reported inadequate preparation for dealing with clients' emotional issues. In Barr et al.'s survey of Canadian dietitians' attitudes and practices towards obesity and weight management, dietitians' views regarding obesity did not always reflect the current literature, but "it was counselling methods that were most commonly identified as desired topics for future training,"[57] (p. 508) with participants indicating a preference for training on psychological aspects of obesity, motivational and other counselling techniques as well as behaviour modification techniques.

While some of this difficulty with counselling appears to be related to lack of training and education opportunities for dietitians, MacLellan[23] suggests that it is also likely due to poorly articulated standards as set out by their professional association. She and Berenbaum used a two-round reactive Delphi survey of Canadian dietitians to explore the concept of client-centeredness with nutrition counselling relationships. They had observed that client-centered counselling was considered a core concept of dietetic practice in Canada.[23] This approach, as quoted by MacLellan and Berenbaum, is defined by Dietitians of Canada as:

> The use of collaborative and partnership approaches where the client's own experiences and knowledge are central and carry authority within the client-professional partnership. In this approach mutual respect, trust and shared objectives are fundamental [23 p. 119]

In their excellent review of the history of counselling approaches in Canadian dietetics, [104] MacLellan and Berenbaum made the observation that dietitians have been struggling for the past 30 years "to define their role as nutrition counselors and to develop the necessary skills to be effective in that role."[104] (p. 15) They concluded that while the profession has made a commitment to practice using a client-centered approach, it is "far from clear what that means to us as practitioners." [104](p. 15) Further, on the basis of the results of their Delphi survey they noted with concern that:

> Some participants had little or no education/training in nutrition counselling during their undergraduate education or dietetic internship. Further, about one-third of participants had had no additional training/education in counselling since they had started their practice.[23 p. 123]

Clearly, dietitians recognize that this important area of practice is an issue requiring some attention, whether in working with obese adolescents or otherwise.

## 2.5 Framing of Obesity

At the same time that these practice developments have been taking place in the professional realm, much has been happening in the public (and professional) realm regarding how obesity is articulated. The media is full of conflicting and contradictory arguments that alternate between obesity being seen as a private matter of personal responsibility, or as a public matter with societal responsibility.[105] This debate is of relevance to dietitians working in this area because it can have such a profound influence on their beliefs about what constitutes effective practice, as well as on the beliefs of their clients who are equally subject to the influence of the media. In this section I will briefly articulate the relevant issues.

Social constructionist thought sees the construction of obesity as a social and cultural process. Harjunen describes this process as a discursive one, where the concept of obesity is "created, produced and reproduced through various social practices such as medicine and health care system, school, religion and media." [106] (p. 346) More simply, the social construction of obesity represents the blend of viewpoints put forth by individuals and various groups. These groups may have vested interests in the condition, and may be in competition with other groups. Ultimately, "these divergent groups establish how (this condition) is perceived and what it means to society as a whole."[107](p. 344)

Rogge et al. note that in Western society, we share a common social construction of obesity, where historically, obesity has been associated with sloth and gluttony* – two of Christianity's seven deadly sins. In this construction, obesity "represents the outward manifestation of self indulgence." [107](p. 305) Rogge et al. posit that it is this "culturally shared meaning of obesity as a consequence of self-gratification" [107] (p. 306) that is the basis for the pervasive discrimination against those who are overweight.[83]

The authors contend that this, when combined with the prevailing medical construction of obesity (as represented by such groups as the American Centers for Disease Control, the American Heart Association and the National Institute of Health) which stresses the relationship between obesity and the risk of death and disability, our cultural understanding becomes that of obesity as "unnatural, abnormal and unhealthy"[107] (p. 305) Harjunen, in his exploration of

* That this perspective is still prevalent can be seen clearly in a recent (2005) consumer-oriented publication of the Dairy Farmers of Canada, published by Rogers Health Group which stated, "The calorie-packed, mega-portions of current serving sizes and sedentary lifestyles are creating a society of both sloth and gluttony." [115 p.2]

obesity from the viewpoint of social sciences and women's studies, extends this and contends that the obese body is an abnormal body, a deviance that should be corrected, and suggests this is one reason why obesity has "become one of the most stigmatizing bodily characteristics in our culture" [106] (p. 345) and, as Stunkard has observed, the "last remaining socially acceptable form of prejudice."[108] (p. 417) Common to these constructions, is the notion that those who are obese are responsible for their condition.

It has been suggested that these dominant and historical ways of seeing obesity are being challenged in the public domain by other groups who are framing obesity differently, and policy analysts have suggested that there are two increasingly discordant sides in the debate about "what kind of a problem is obesity, what should be done about it, and by whom?" [105] (p. 57) Earlier I discussed the influence of the size acceptance movement and its framing of obesity from a political rights perspective, wherein fatness is seen as a form of body diversity. More recently, Lawrence [105] assessed the framing of obesity in news coverage since 1985. She argued that "a vigorous frame contest" (p. 56) is currently underway, where traditional arguments emphasizing personal responsibility for health are being countered with arguments emphasizing the responsibility of the social environment, including corporate and political domains.[105] From this perspective, obesity has become a public health crisis, and as such, is in need of a public health solution. The notion of the 'toxic food environment' fits in this frame, where individuals are placed within a larger context that includes environmental influences and public policy. Obesity then becomes a symptom of an unhealthy food and activity environment created (possibly intentionally) by corporations and government policy alike.[105] Lawrence notes that the public reframing of obesity as this kind of a systemic problem, as "a risk that individuals do not

assume fully voluntarily"[105] (p. 60), is necessary if health advocates can hope to have public health policy changed to address the rising prevalence of obesity.

An awareness of these competing and divergent frames is important because, as Saguy et al.[109] explain, different frames imply different ways to understand an issue and different courses of action. Opposing perspectives could cause confusion and undermine efforts at creating workable solutions that are agreed upon by everyone.

In summary, I have presented the various facets that have contributed to the obesity management maelstrom. This has included aspects of childhood obesity prevalence and management as well as an overview of the concerns related to weight loss in this group. Emerging philosophies of weight management and differing perspective on the framing of obesity were discussed, as well as some dietetic practice issues, including the trend to evidence-based practice and client-centered approach were included in an effort to give the reader an understanding of the complexity and diversity of issues facing dietitians in the field. It is apparent from this brief review of the literature that the situation is not straight forward and lacks clarity. Childhood obesity is on the increase, clients and professionals alike are desperately seeking effective research-based solutions, but these are not yet apparent. Fears abound that available treatment options may in fact further contribute to the problem, in ways that are as yet, unclear. The emergence of new treatment paradigms, along with new and discordant perspectives on who or what is responsible for the epidemic of childhood obesity, have served to add to the confusion. Practice challenges within the dietetics profession itself further add to the mixture. Truly,

dietitians are practicing in an obesity management maelstrom. How they experience this, and how these experiences influence their practice are the subject of this research.

## Chapter 3: Design and Methods

This chapter will begin with an overview of my research objectives, followed by a description of my research methods. This will include a description of my research paradigm and an overview of my methodology. A description of the procedures used in this study will be presented, including sample selection, recruitment, data collection, preparation and analysis. Finally, the role of the researcher and a brief discussion of study rigor will be presented.

### 3.1 Research Objectives

The objective of this study was to develop a deeper understanding of the experiences of dietitians who work with obese children and adolescents, within the context of the 'obesity management maelstrom.' This maelstrom included the increasing prevalence of childhood obesity, the 'war on obesity', the emergence of competing discourses on obesity management, emerging philosophies of weight management and counselling approaches, and the trend to evidence-based practice in the dietetics profession.

### 3.2 Research Paradigm

This project used an exploratory and descriptive qualitative design, and applied aspects of grounded theory methods to the question, "What are the experiences of dietitian's working in British Columbia's Lower Mainland, who have carried out weight loss counselling with overweight children over the past 5 years?"

Qualitative research is an umbrella term encompassing a set of philosophical premises and a number of research approaches including grounded theory, phenomenology and ethnography, to name but a few. These approaches embody a common belief that they can provide a deeper understanding of social experience than would be acquired from purely quantitative data. [110] Often, qualitative approaches are used when little is known about the subject in question, or as a means of generating hypotheses about social phenomenon.

Before setting out to do my research, I examined many of the beliefs I had about how people function and develop in their social environment, because I realized that it was important to choose a research methodology that was reflective of my own world-view. I assume that dietitians are inherently cognitive beings; they construct their own mental representations of dieting, weight, size acceptance and other aspects of what I have earlier referred to as 'the obesity maelstrom'; they communicate with symbolic language (a language that is often unique to practicing dietitians); and many of the processes and decisions related to diet counselling and weight control are done in the context of popular and professional culture. I assume too that dietitians do not make professional practice decisions in isolation, but as part of a social process where they might discuss their perceptions and strategies with others, and where they might in turn be influenced by the culture in which they live.

Symbolic interactionism, as described by Annells is "both a theory about human behaviour and an approach to inquiring about human conduct and group behaviour." [111](p. 384) In its simplest form, this constructivist approach assumes that the only realities possible are those that we construct, which we do through a shared language, that we agree upon.[112](p. 7) Symbolic

interactionism presumes that multiple realities exist, people construct their realities from symbols such as language, through interaction, and these may change over time – therefore individuals actively participate to create meaning in their circumstances.[112, 113] Thus, the assumptions that I make about dietitians, all of which are reflective of my 'world view', are similar to those of symbolic interactionism.

Clarke refers to our universe – geographically, organizationally, socially, culturally, politically, relationally – as social worlds and arenas.[112] (p. 10) Social worlds and arenas are 'universes of discourse'* [112] They are made up of "multiple collective actors (social worlds) in all kinds of negotiations and conflicts, in a broad substantive arena focused on matters about which all the involved social worlds and actors care enough to be committed to act, and to produce discourses about arena concerns."[112](p. 37) To extend these concepts to dietetics practice, dietitians function both as individuals and collectively in the context of their professional and private social worlds, which in turn reside within the broader context of society. Discursive concepts such as size acceptance, weight loss and dieting are constructions of meaning that are shaped by, and have influence in shaping these worlds and arenas. This meaning is communicated through various discursive representations (media, words, images, texts) and becomes part of our reality. Our perception of reality therefore, is a product of an ongoing dialogue over the meaning of objects, events and actions. Referring to Berger and Luckman's 'The Social Construction of Reality' (1966), Clarke reminds us that in order to understand our construction of the sense of

* Where discourse refers to the "relentlessly social phenomena" of language use "relative to social, political and cultural formations... language reflecting social order (and) language shaping social order, and shaping individuals interaction with society". Thus discourse concerns "constructions of meaning...by those somehow involved." [112] ( p. 147)

reality, it is important that we examine the "processes by which that reality system is produced."[112] (p. 149)

Social worlds and arenas are, as described by Clarke, a reflection of the 'ecological bent' of social interactionism, and Clarke features them in situational analysis, a methodological approach to grounded theory analysis that is decidedly post-modern in its ontological and epistemological groundings. While I did not do a situational analysis per se, my exploration of the world of dietitians involved an awareness that we are immersed in a sea of competing, conflicting and constantly changing discourses – a veritable maelstrom. Awareness of social arenas and worlds served to deepen the analysis of events occurring within.

## 3.3 Methodology

I chose to use a qualitative methodological approach that was both descriptive and analytical, and that used many of the strategies suggested by grounded theory practitioners. This was largely because this approach provides researchers with tools and guidelines to focus data collection and manage the data that emerges from the research process. However, whereas grounded theory is an approach that facilitates the development of theories about basic social or psychological processes for which little is known, my intention was different. My analysis of the data generated during this study served to identify themes and concepts amongst the symbols of language, as well as their relationship to one another. The goal was not so much to describe or 're-represent' the voices and perspectives of practicing dietitians in this time and place, but rather to critically analyze what they had to say and generate ideas and descriptions that could increase our understanding of their experiences working in the context of the 'obesity

maelstrom'. These ideas may be, as Clarke explains, "distinctive analytic understandings, interpretations and representations" of the situation being studied.[112] (p. 9) My hope was to use insights gained from my analytical interpretations to provide support to dietitians practicing in this challenging area of dietetics. Because I borrowed extensively from grounded theory, I will offer a brief overview of this approach.

Grounded theory methodology takes its name from the practice of generating theory from research, which is 'grounded' in data. It was introduced by the sociologists Barney Glaser and Anselm Strauss in "The Discovery of Grounded Theory"[116], and emerged as an alternative strategy to the more traditional quantitative approaches to research. It is a research approach that has been found to encompass a range of epistemological stances from positivist to social constructivist and, more recently, post modernist.[111, 112, 116]

The methods I used were informed by the grounded theory methodology as described by Corbin and Strauss [117] and further explicated by Clarke and Annells.[111, 112] As they explain, grounded theory uses a relativist ontology* that suggests reality cannot be known, but only interpreted, and that it is closely linked to time, place and context.[117] Further, as mentioned earlier, the epistemological assumptions underlying this theory† are those of symbolic interactionism – a social constructivist approach which suggests that the knower and the known interact and shape one another.

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* Ontology is defined as that branch of the science of metaphysics that studies the nature of being, reality and substance. It asks 'what is the nature of reality?'

† Epistemology is the branch of philosophy that deals with knowing and the methods of obtaining knowledge. It asks 'what is the relationship between the knower and the known?'

Qualitative methodologies facilitate the development of insight into situations and experiences for which little is known. No previous effort has been made to understand the experiences of West Coast Canadian dietitians in the context of the 'obesity maelstrom' from the unique perspective of those in practice.

Using grounded theory techniques, I chose to start with the direct experience of people experiencing the phenomenon of interest, in this case, the dietitians themselves, exploring and analyzing their perceptions with preliminary questions - therefore any 'analytic understandings' and insights that emerged are closely connected to the data.[111, 116] That is, rather than making assumptions about their experiences based on my own personal experiences as a practicing dietitian, this qualitative approach allowed the development of understanding to emerge from the voices of the informants themselves.

### 3.4 Research Procedures

The research procedures that follow, while presented in a linear fashion, were in fact conducted very differently. The analysis of my data was an active, non-linear and complex process. Sample selection, recruitment, data collection and analysis were conducted at times simultaneously, with the fruits of the analytic process helping to determine who would make an appropriate next informant.

### 3.4.1 Sample Selection, Inclusion Criteria and Recruitment

Purposeful sampling, which involves a well thought out decision to sample specific informants based on a predetermined initial set of criteria,[118] was used for the initial interviews. Dietitians who had done weight loss counselling with children and adolescents within the past five years were considered likely to have been strongly influenced by the obesity maelstrom, given the controversy surrounding dieting risk and the development of eating disorders. To this end I sent by email an initial contact letter (Appendix A) to practicing dietitians living in the Lower Mainland and Vancouver Island who were identified on the Dietitians of Canada website as practitioners of weight loss counselling. A total of three dietitians responded to this initial contact. I then contacted these dietitians and arranged an interview at a location of their choice. Once the analysis of these initial interviews had begun, further informants were chosen on the basis of the data that had emerged from the process, a practice known as theoretical sampling. Thus, after determining that relatively few dietitians were practicing weight loss counselling with children in the area, a decision was made to interview dietitians working in a community context to explore why this might be, and possibly, to interview dietitians who had chosen to not work in this area. Similarly, snowball sampling, a type of convenience sampling in which referrals for potential participants are made by those already in the sample, was employed to expand the initial poor response to recruitment attempts. A revised letter was sent to these informants (Appendix B) to reflect the shift in focus. For logistical reasons, dietitians working in the Lower Mainland of British Columbia were chosen for the study. Ideally, sample size is determined on the basis of theoretical saturation, with data collection ending once redundancy of information is achieved in the core categories. That is, once no new material emerges from the data, and all categories are considered full, the categories are considered 'saturated', and hopefully, make

sense. At this point, theoretical saturation has been reached, and data collection can end. In this master's level study, because of time and resource restraints, only thirteen informants were interviewed. One of these, the thirteenth informant, was purposively selected because she was known as someone who had consciously chosen to not work with obese youth. Here, I was attempting to get a perspective that might help me to ask questions of my data that I might not otherwise have considered, and in this way add depth to my analysis.

Participation in this study was voluntary. Once contact was initiated with an informant, and she had agreed to participate, an interview was scheduled at a location of her choice. 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. Anonymity was assured by not identifying recorded tapes with any personal information. Following transcription, tapes were kept in a secure location at the home of the researcher, identified by pseudonym and number only. There were no anticipated risks to the informants during this study. Approval for the study was obtained from the Behavioural Research Ethics Board at the University of British Columbia.

### 3.4.2 Data Collection

The primary source of data for this study was participant interviews. Data were collected in the form of face-to-face interviews that were tape recorded and subsequently transcribed. I used an interactive semi-structured interview format[119]. Essentially this meant that I used an interview guide (see appendix D) that contained general open-ended questions to be addressed at some

point during the interview. However, flexibility was the key. Questions regarding the topic were framed broadly in the first interview according to guidelines suggested by Charmaz.[116] They represented my attempt to place information in context, and be "sufficiently general to cover a wide range of experiences as well as narrow enough to elicit and explore the participant's specific experience."[116](p. 67) In an effort to minimize leading the participants with questions that made assumptions of their knowledge and practice, the interview guide and background description of the study did not include 'size acceptance' and 'non-dieting' terminology. Rather, questions were aimed at getting informants to reflect on actual cases. Probes were used to explore how practices have changed because of the maelstrom. Although an interview guide was used, I tried to conduct the interview as a guided conversation and provided the participant with an opportunity to communicate what was important to her. My comfort with this process improved over the course of the 13 interviews.

Interviews were conducted in a location of the informant's choosing. Six informants chose to be interviewed at their home, in three of these cases, included an informal meal. Six were interviewed at their workplace and one in a restaurant. The interviews ranged in length from 60 – 90 minutes. Following each interview I wrote field-notes that described my impressions of the process. For example, following my initial interview I made technical observations about the recording process including 'what not to do' for the next one, vis-à-vis placement of the microphone. Following another, I observed that the informant had appeared nervous, as if she was afraid of saying the wrong things. This made me wonder if social desirability bias might be an issue in my interviews. Later still, I observed that I was feeling more comfortable with the interview process, and more able to probe informants without feeling that I was being

judgmental of them and their work, something that I had earlier wondered about. No longer did I perceive nervousness in the informants. Field and reflexive notes were kept to provide details of setting, mood and circumstance as a means of enhancing the 'thickness' of the data and lent additional depth to the information obtained regarding the subject matter. Demographic information including age, work history and educational background was obtained in order to describe the sample.

### 3.4.3 Data Analysis

Data were collected, analyzed and arranged in a systematic manner so that patterns in the data were allowed to emerge.[113, 118] This process required that incidents occurring in the data were categorized through the use of various types of codes, or initial groupings. I made use of ATLAS.ti qualitative research software to organize my initial data and initial coding. This initial coding took place on a line by line basis. Following my coding with ATLAS.ti of the initial 10 interviews, I had approximately 1200 codes. This process was fairly perfunctory. I did not ask a lot of questions about the data. I jotted rough notes to myself (I had not yet begun memoing on the computer) and noticed that as I was going I was grouping my codes in fairly 'mechanical' categories. I did this by prefacing the codes as I went with my own subjective categories: change, counselling, external constraints*, frustration, outcomes, internal constraints†, and readiness to name a few. At the same time I began asking questions of the different codes. I asked many types of questions – theoretical, sensitizing, guideing - in a form of microanalysis,

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* Roughly, external constraints represented things that dietitians brought up that had a structural impact on their work: time available at work, job descriptions, government funding, economics; these were somewhat 'negative' or 'limiting' in my mind

† These represented things that the dietitians brought up that had an impact on their work – often limiting their ability to do their job; not enough training or skills.

using techniques unique to the methodology. This allowed me to more efficiently group my codes into categories, where a category represents the words of many reduced into and represented by several highly conceptual terms.[117] These concepts are "an abstract representation of an event/object/action/interaction that a researcher identifies as being significant in the data."[117] (p. 103) Categories were then developed in terms of their properties or attributes, and dimensions – also derived by microanalysis. Finally, after much writing or 'memoing' patterns began to emerge from the categories, as groups of properties begin to align themselves along various dimensions. For example, the concepts of frustration, doubt and conflict were evident throughout many of my interviews. I began to ask questions of these data – wondering under what circumstances were they present, how did informants talk about them, were they aware of these experiences, under what circumstances did they arise, were they similar for all informants, in what ways were they different? I began to recognize that informants had different ways of explaining their emotional experiences – and that these could themselves be categorized. I recognized similarities and differences in how they experienced related and diverse situations, and tried to develop a way of understanding these altogether. Altogether, these codes, concepts, categories and patterns were constantly compared with one another in a unique process known as the constant comparative method.[113] In theory, once no new material emerges from the data, and all categories are considered full, the categories are considered 'saturated', and hopefully, make sense. At this point, *theoretical saturation* has been reached, and data collection can end. It became clear to me that the lack of dietitians who were working with obese youth and who were also experiencing 'successful' interventions, would be a significant limitation in my ability to reach saturation of core themes.

My memoing throughout this process was basically a documentation of insights and ideas gained from my constantly reading, thinking and rereading my data, and included memos about theory (dissonance, dialectics and conflict were on my mind at that time), and my methodology. I even memoed my dreams that kept telling me I was trying to go the wrong way down a one way street. Quite frustrating. I wrote many, many pages, and it was during this process of trying to fit everything together in a way that made sense, that my patterns started to make sense. At this time I conducted my final interviews, in an effort to validate and refine what I was seeing in the data. I asked more pointed questions along the lines of my categories and emerging patterns to see if they 'fit' with the experiences of these new informants. Around this time, I began to develop a model of my initial results. I met several times with my supervisor and discussed various aspects of the model that was emerging. As I continued to write, it seemed to me that my representations of informants' experiences were making sense. I re-interviewed several informants to ask if what I was seeing was in fact a reflection of their experience, and if not, what was different. They expressed satisfaction that what I was saying was 'true' to them. Some expressed gratitude that I was able to articulate and validate their experience. Of interest, I received the same response from several dietitian attendees at the conference where I presented my preliminary results.

## 3.5 Assessment of Research Quality (Rigor)

Rigor (or trustworthiness) refers to the strategies and techniques that are required to ensure the quality of any research.[113] Traditionally, good quality must respond to questions of truth-value, applicability, consistency and neutrality. In quantitative research these questions have been answered with the corresponding positivist constructs: internal validity, external validity,

dependability and objectivity. Qualitative research, operating from a post-positivist paradigm (in this case symbolic interactionism) sometimes uses the following parallel constructs: credibility (or validity), transferability, dependability (or reliability) and confirmability.[120-122]

In this study, the combination of purposive and theoretical sampling, served to enhance both its credibility and dependability, by trying to ensure both the appropriateness and adequacy of the data. Morse defines appropriateness as "the process of selecting participants who could best inform the research."[113 p. 189] Adequacy, on the other hand, "refers to the amount of data obtained and whether or not saturation has occurred."[113 p. 189] This was a Master's level thesis and I was beset by personal challenges during its progression. I believe that I developed rich and descriptive data, but fell short in reaching saturation in my core themes. In particular, as mentioned earlier, I was unable to connect with dietitians who were experiencing success in their interventions with obese youth. Rather than expanding my search to centers outside of the Lower Mainland, I decided to end data collection with 13 participants, knowing that my lack of saturation would be a limitation of my study results. However, by using secondary sources of data, including professional dietetics workshops attended by myself in the same time frame, and with the addition of an extensive audit trail – written process oriented memos – I believe I was able to enhance the study's dependability. In addition, I had the study reviewed by some 'skeptical peers' and my supervisor who had conducted similar research in the recent past. This process helped ensure my analysis 'fit' the data and was not simply a reflection of researcher bias. Dependability was also enhanced by performing member checks wherein I provided each of the informants with a summary of my findings for their comments and their validation. Six of them agreed to meet and discuss my results. These follow-up interviews were not recorded,

though I did take notes following our talks. They took place in restaurants, at my place of employment and at a conference on childhood obesity in Vancouver, where I was presenting a poster of my preliminary results. As a further validation of my findings, several dietitians who lived and worked in other parts of the country (Ontario and Alberta) approached me at the conference to comment on my poster and results. They expressed gratitude that I was giving voice to their similar experiences of frustration and doubt. They acknowledged that these feelings came from the sources that I had identified in my poster. They expressed an interest in further dialogue with other dietitians about these experiences.

Confirmability of the project was strengthened in several ways. As I proceeded with my analysis and made decisions regarding how to arrange my codes, categories and data, I saved this information in the form of different versions of my results, with each version being a different iteration of the preceding. This practice served to capture the ebb and flow of this highly repetitious process. By allowing a window into the analytic process for others to see and evaluate, confirmability is enhanced. In addition, I wrote reflective notes over the course of the data collection and analysis, including insights and ideas I have had during the analytical process. These took the form of written memos and included my perception of my own role in the analytic process. This process of bringing myself and my tacit knowledge into the open, and allowing my role as the research instrument to be acknowledged is referred to as reflexivity.[123]

### 3.6 Reflexivity

Reflexivity is an integral part of qualitative research in that it relates back to the ontological and

epistemological underpinnings of symbolic interactionism, wherein reality is constructed from individual and shared interactions over time. As Cuttliffe summarizes, reflexivity "legitimizes the researcher's creativity as an integral part of the grounded theory inductive process."[118] (p. 1479) To deny it, he goes on, "is likely to limit the depth of understanding of the phenomenon and impose unnecessary, rigid structures."[118] (p. 1480) Clarke takes this further and suggests that putting one's experience and interests on the table is a means of becoming "more visible and accountable for, in and through our research." [112] (p. 13)

However, this aspect of qualitative research has been criticized, questioning the ability of the researcher to remain neutral in the process and not contaminate the information gathering process by, for example, asking leading questions of the informants.[118] (p. 223) One technique that has been used to remove interviewer bias is known as 'bracketing', wherein the researcher consciously identifies her biases and sets them aside. This may be accomplished in part through the use of non-standardized interview questions that allow for the researcher to respond directly to the informant – and therefore ask the appropriate questions in the context of the interview.[113] In addition, Dick recommends an active process of seeking information that "disconfirms your own assumptions and interpretations"[124] – a process that I facilitated with the help of skeptical peers.

In keeping with Clarke's viewpoint, I am more comfortable putting my perspective on the table as a means of making myself more visible in this process, than pretending that I was not somehow simultaneously positioned as a participant and a researcher. At the same time, I acknowledge that I was as much influenced by cultural discourse as my dietitian informants. As

an ethical researcher I strove to be aware of and give voice to perspectives that were different to my own.

### 3.6.1 Situating/ Bracketing the researcher

In my 20 years as a practicing dietitian, I have witnessed first hand the impact of the dieting and obesity maelstrom on my own practice and on that of my professional peers. Indeed, this is what has motivated me to do this research. I have changed from being a dietetic intern who would instruct obese men on 1000 calorie diets as prescribed by their physician, to a dietitian who counselled clients to destroy their scales and celebrate the joys of healthy eating, to a professional who works primarily with adolescents and adults struggling with eating disorders. I have been angered by dietitians who continued to promote restrictive weight loss diets long after I believed they were considered an inappropriate strategy, and have angered some by my suggestion that weight loss is not a panacea. I have seen dietitians stop counselling overweight children because they are afraid of doing 'the wrong thing', and have heard dietitians express their disgust with obese clients who just don't seem motivated to lose weight. I believe that as a profession, dietitians must develop a critical awareness of why we do what we do in practice – given that our practices seem to be, at times, divergent and counterproductive. I believe that we can benefit from a deeper understanding of our collective response to the maelstrom, in order to support each other in practice, and in order to better serve our clients. In these ways, I am a biased researcher. However I remain open and curious to the experiences of others, and believe I can let dietitians speak their own truths without contaminating their voices with my own experience. At the same time, I believe my own experiences will help keep me closely

connected to the data from informants, and will inform my analysis in a constructive and insightful manner. This is referred to as theoretical sensitivity and represents the ability of the research instrument – me – to enter the research setting with as few preconceptions as possible[125], while at the same time having an understanding of the prevailing literature. In this way, I will be able to remain sensitive to the data collected from informants. Thus, it refers to a personal quality of the researcher, or as Strauss and Corbin suggest, "[It] refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't."[117]

I was concerned when I first went into the interview process that I might be critical or judgmental of dietitians who practiced weight loss counselling with children, because of my views. Initially, I found that I tried to 'tread easily' on the subject matter, so as to not be perceived in this manner. To my surprise, as I interacted with informants, and as they shared their experiences, I felt empathy and compassion more than judgment. They spoke easily of their trials and tribulations and expressed gratitude that I was asking the questions and listening to them. Many felt isolated with this work, and welcomed the opportunity to share their stories. Because I, like them, was a practicing dietitian, I believe they were able to speak more to their emotional experiences than to the details of their practice. Since we share a common language there was no need for them to explain what one referred to as "the nitty gritty" of dietetic practice. I believe this significantly enhanced the quality of the interviews.

## 3.7 Summary

In this chapter I provided a description of my methodology and my rationale for using it. I discussed how the data were analyzed, and how scientific rigor was addressed. In Chapter Four I will present the findings from this study.

## Chapter Four Results

### 4.1 Introduction

This study focuses on the experiences of twelve dietitians who had practiced in the area of weight loss counselling with children and adolescents, or who had a substantial portion of their job devoted to the issue of childhood or adolescent obesity. A thirteenth dietitian was purposively chosen as an interviewee, based on her choice to not work in this area of dietetics.

Early on in our conversations, I became aware that many informants were voicing considerable distress as they talked about their experiences of weight loss counselling with children and adolescents. At times this distress was voiced as frustration, at other times as doubt. Frequently it emerged as a questioning of the role of the dietitian. As my analysis proceeded, it became clear that this distress related to four primary issues identified by informants over the course of our conversations. These included: i) their experience of inadequate time and resources to do their work effectively, ii) their perception of the clients' readiness to make behavioural change, iii) their perception that, as dietitians, they lacked the appropriate counselling skills to be helpful to their clients and iv) their uncertainty about how to best deal with the complex problem of obesity. In spite of, or perhaps because of their experiences of distress, informants had found various ways to continue working in this challenging area.

This Chapter begins with a brief description of the study participants. This is followed by three main sections. The first provides an overview of informants' descriptions of the work they are doing, along with their expressions of the frustration, doubt and uncertainty that related to this work. The second section describes, in four broad themes, the ways informants have come to

understand their discomfort. In the final section, I present the various ways that they have responded to and tried to mitigate their discomfort.

## 4.2 Participant Characteristics

Thirteen English speaking registered dietitians of varying age and employment background, living in the Lower Mainland of British Columbia and on Vancouver Island were interviewed. Eight were in their 40's, two in their 30's, two in their 20's and one was over 60 years old. All but one had at some time in the past five years worked with children or adolescents desiring or requiring weight loss, or had a substantive portion of their job devoted to issues of childhood obesity. Two worked in hospital outpatient programs, two in in-patient rehabilitation programs, two in acute care hospital settings, three were community nutritionists, three worked in private practice, and two were involved in academic work at the post graduate level. Some worked in more than one setting. Two had obtained Doctorate degrees, two had Master's degrees and nine had undergraduate Bachelor degrees.

## 4.3 How Dietitians Work With Obese Children and Adolescents

### 4.3.1 Using the Lifestyle or 'Non Diet' Approach

*"I never diet them"*

Most informants espoused the 'lifestyle approach' when it came to nutrition education and counselling with obese children and adolescents. This approach has "improved health through healthy eating and physical activity"[10] as its overarching goal. As one informant explained, "I

want to talk about your eating pattern and your eating habits, your meal plan and all that. You know, just a healthy way to eat is what I want to talk about". This approach was very different from the rigid diet prescription focus of the early 1980's where, as Helen quipped, dieting meant "deprivation" and "taking away" and "Dietitian, you know, means diet, means something bad".

In the old prescriptive weight loss diet paradigm, weight loss was the goal, and if weight loss was not achieved, it was considered the client's fault because they were being non-compliant with the diet. Or, as Alice explained, "If you won't do that, that's too bad - that's why it's not working." None of the informants liked this old rigid and prescriptive approach, and none liked to talk about dieting with their young clients.

> Well, we won't say diet, and I tell my patients right off the bat, I say, 'You know, I keep saying diet because I'm a dietitian, but I really don't mean diet, because when you think of a diet you think of restrictions and not being able to eat this or that'. And that's not what I want to be talking about. (Ellen, 1247)

They saw the lifestyle approach as one of the ways that they could work with individuals in this population, who were still growing. Rather than being focused on 'the numbers' – weight, fat, calories and carbohydrates – the emphasis with lifestyle counselling was on educating children and youth about healthy food choices: how to increase consumption of fruits and vegetables and grains and decrease consumption of added fats and sugars through such things as changes to snack choices, meal planning, grocery shopping, label reading and eating out. Alice referred to this, along with reference to the need to increase physical activity, as "the nitty-gritty" of dietetic counselling. In addition to the above information, some informants would focus on the feeding relationship between parent and child, issues pertaining to self-esteem, media literacy,

physiology, physical activity and other individualized guidelines, depending on what they assessed the client's needs to be.

At the same time, informants emphasized that they strived to listen to their clients and develop a rapport so that they could "start with where that person is at" and "find out where they're coming from". Irene summed up this client-centered approach when she said,

> And when I am counselling I try more than anything to try and figure what they want, the same as you would with any kind of counselling, but finding out what they want to do before I start telling them what they should do. So I try to make it their choice. You know always that there's a little bit of, "You should do this," in it, but for the most part I would really like them to come up with their own plan. (Irene, 1103)

Faye, who had done some research in the area of dietitians' practice of weight loss counselling, confirmed this, and summed up these aspects of their work nicely,

> I think we're, like I said, in the last 20 years we're doing a lot of similar things. We are. We're talking to people, finding out a little bit about what their lifestyle is, encouraging them to do those small steps. Choose one or two things to work on, looking at behaviour as well as – like lifestyle behaviours as well as the healthy eating thing. There's a little more, emphasis on physical activity. But things haven't changed that much with regards to – and even the tools we use. We still use Canada's Food Guide, which is good, I think. Maybe the one thing that is changing, or that we're more aware, that there's not one fix for all. And we're doing really more focusing on the individual approach and asking people where they are with regards to what type of changes they want to make. I think we're a little aware of that, including doing the client's individual approach and making sure that we understand our clients more. (Faye, 401)

In summary, study participants advocated an individualized lifestyle approach to nutrition counselling with obese youth, where teaching about healthy eating was emphasized over prescribing rigid diets.

### 4.3.2 Experiences of Frustration, Doubt and Uncertainty

*"So I do find it extremely frustrating – pediatric obesity. What can a dietitian do? I wish I knew more."*

Throughout informants' descriptions of their work with obese children and adolescents, their experiences of doubt and frustration came through loud and clear. One informant "cringed" when she got referrals for pediatric obesity because she had "no idea" whether she was going to be able to help her client. Another admitted referring obese youth to therapists, because "seeing a therapist is more helpful than seeing me sometimes, right?" One dietitian described "faking optimism", because she didn't want her clients picking up on her belief that "things are hopeless". One admitted she "hate(d) getting referrals about obesity" because she didn't know what was going to fix it, while another new grad candidly observed, "It's a very hopeless feeling to think that I could help others with (obesity)." One felt she was "going into these things blind all the time", not knowing what to expect from family dynamics. Another believed that her expert nutrition knowledge was an abuse of power,

> You just spout off the nutrition facts and they're like, "Oh, really. Wow!" I mean like it's like such an abuse of power...it really is. Because, you know, I feel like I'm tricking these people and like I'm kind of fooling them into thinking that I'm actually doing them some good but I don't think I am. (Karen, 1154)

Others were less harsh in their judgments, but clearly frustrated with their ability to be helpful.

> So I find that really frustrating. I find it almost – I find it a waste of time. The best I can do is educate the child and we all know that education doesn't actually come, you know, result in outcomes. So it's very frustrating (Irene, 83)

One older dietitian, who was new to the area of clinical dietetics, referring to her lack of counselling skills, said she was "working on a hope and a prayer that I don't screw some kid up". Some felt frustrated with society in general for not seeing childhood obesity as a "serious" issue. Informants saw children as innocent, and many implied that government and the food industry were shirking their responsibilities to both children and families. Others were frustrated and disappointed with their professional association for not providing any guidelines. As one community nutritionist declared, "I separate myself from Dietitians of Canada because I feel like it compromises my integrity." Still other dietitians seemed to be directing their frustration at the obese youth themselves, and their unwillingness to "do the sacrificing" that was necessary to improve health and weight. Often this was directed at families who were seen to want "the quick fix" for their child. Many informants perceived families as being unwilling or unable to take responsibility for their child's eating behaviour.

> Well, this happens all the time. They phone you to ask you for something and they want, you know, people want to send their kids in to get fixed and they don't really want to do anything about that. (Grace, 363)

In summary, it is clear that the clinical and community dietitians in this study were experiencing significant distress as they attempted to address the challenge of childhood obesity. This distress was experienced as personal doubt, professional doubt, and frustration in themselves, in their clients and in society at large.

## 4.4 How Dietitians Understand Their Experiences

*"Why? Do I want to do this?"*

Further analysis revealed that informants had several different explanations for the distress they experienced when confronted with childhood obesity, and that these explanations could be divided into four broad themes. These included: i) their belief that they had neither the time nor the resources in their jobs to help clients develop and maintain lifestyle changes, and that 'the system' would need to address this before they would have any success, ii) their perception that obese children and adolescents were 'not ready' to change their behaviour, and that they as dietitians lacked the skills to help them facilitate this change, iii) their feeling that somehow, they as dietetic professionals, were lacking important counselling skills and were therefore unable to address the complex needs of obese children and iv) their uncertainty about how they as dietitians could (or should) best deal with the complex problem of childhood obesity, from defining appropriate goals, to planning effective treatment strategies. There was overlap in the use of these explanations, with some dietitians referencing several, others only a few. At times, these explanations were articulated clearly and directly, at other times they had to be analytically teased out of confusing and contradictory statements made by informants.

### 4.4.1 Inadequate Time and Resources

*"I see the big picture but I don't have the time or resources to do anything about it"*

All of the informants had fairly clear beliefs about what they 'should' be doing with obese children and adolescents to help them make healthier food choices, possibly lose weight, and make a difference in their lives. This was often very different from what they were actually able

to achieve in the context of their professional work. Frequently this was related to time and resource constraints within the context of their working lives.

### 4.4.1 a) The Ideal: Multidisciplinary Approach to Treatment

*"But it would be great if you had a team"*

Most of these dietitians had a number of ideas on what the most appropriate treatment for overweight children and adolescents would look like, whether they were practicing clinical dietitians with a caseload, or involved in research or community development. Virtually all of the dietitians who worked individually with obese youth and their families, and several of the community-based dietitians, spoke of the need for a multi-disciplinary approach to weight loss. Such an approach, as they described it, would generally include a program, either community or hospital-based. Ellen wasn't sure which location would be ideal:

> Maybe it shouldn't be in a hospital. On the one hand I think it's good because you've got the background and the support of the medical people and you've got your facility that's THE place to come, you know, but maybe we're not grabbing those people who are out there on the street that could really use some help. And I don't know if we would catch them if we did it in a community center. And I don't know if it would be better if we did it in a school (Ellen, 460)

All agreed that such a program would have to include several different health professionals: a nurse (to take blood pressure, weights and other clinical measures), an 'activity specialist' (kinesiologist or personal trainer), a mental health specialist (psychologist, psychiatrist, social worker or family therapist), a physician (possibly as someone to oversee the program and address any medical concerns) and a dietitian, who would address the 'nitty-gritty' aspects of

food and diet. Connie, a clinical dietitian who worked in an outpatient setting, described her vision for such a program, and why she felt it was necessary,

> Well I guess it goes back to that same old – what is the little old dietitian all by herself able to accomplish? The team approach. And really, because I don't like to lecture people on what they should eat, I see my role as fairly limited that way. We need someone who is going to be very good at physical activity with kids. You know someone who can just get those kids sweating and loving it you know. And maybe a mental health counselor as well. Plus a physician overseeing things because God knows, that would be ideal. I don't know if that exists. (Connie, 704)

Some emphasized that such a group program would need to be fun, "or else they won't do it and they won't keep with it", while others stipulated that having parental involvement and support was key. The need for a hands-on experiential process where children could learn to prepare healthy snacks and meals was emphasized, as was a program that would enable kids to talk amongst themselves about their feelings and experiences, and support them in learning how to make healthier choices.

Informants differed on whether weight loss should be the focus of such a program and on how much importance should be placed on nutrition itself. Some clearly said that just focusing on food was not very helpful, especially when the child/ adolescent had already been into dieting (generally the older teens). As Diane wryly observed about such clients, "I'm not the one that's going to be helpful there – they know more about food than I do!" In spite of informants' ideas and enthusiasm toward multidisciplinary team approaches for obesity treatment, only one currently worked in a multi-disciplinary obesity-treatment program (a pilot program which was the only multi-disciplinary obesity-treatment program in the Lower Mainland at the time). What

these dietitians actually did in sessions with obese youth was therefore very different from what they believed would be helpful.

### 4.4.1 b) The Reality: What We are Actually Able to Accomplish

*"We are so strapped for professional time, we can't see them that often."*

As described earlier, all of the study informants espoused using a lifestyle approach with their obese pediatric clients, which focused on improved health through healthy eating and physical activity. All of the educational approaches they described were lifestyle oriented and attempted to be client-centered. However, from the outset in our conversations, it was apparent that there was a huge disconnect between what these dietitians believed should be done, what they strived to do in a session, and what was accomplished in the context of a 30 –60 minute appointment. Even with 15 to 30 minute follow-up sessions that were scheduled to take place between two and six months following an initial appointment, it was only possible to provide dietary advice "bit by bit. As Ellen described:

> E Unfortunately our 'bit by bit' is long spaces of time so it's a little bit, you know, a little bit frustrating from that point of view, yeah. Because if you could see them a little bit more often, but because we're part of the whole team and we are so strapped for professional time, we can't see them that often. It's at best once every six months.
>
> S Wow.
>
> E But the majority, once every nine months. (Ellen, 1088)

All of the dietitians who worked in publicly funded programs, both community and hospital-based, commented on the lack of time, if any, that was available to them to treat obese children and their families. Diane, for example, stated that she was not allowed to do more than two follow-ups with her weight loss clients, and that "two hours in a three month time" was never enough time to help. At most she could address only a few minor food-related issues. Indeed, when food and nutrition information was relayed to obese youth, many informants said that they had to keep the information very simple due to time constraints. They would, for example, limit advice to "the top two" strategies, such as limiting sweetened pop, or perhaps being sure to have breakfast every day, depending on what seemed most pertinent given their client's food recall or nutritional assessment. Being limited to having to "try a little bit of patching" and possibly focus on teaching clients how to cut back on "some of the easy types of foods" that might help them to lose weight was extremely frustrating for some informants for a number of reasons, not the least of which was because their "heart (was) really into having to do something for these kids". Several commented that they just "did the best they could", and hoped that the client would "see value in what they're doing".

For some, however, time was not an issue. Betty, for example, found that an hour was plenty of time:

> I am able to adjust the schedule with the secretary that does the booking (I) have 4 -1 hour blocks and then the rest are 15 minute blocks for follow-up. So the one-hour seems to work out well. I'll spend at least a half an hour usually just getting information. And then maybe 10-15 minutes doing calculations if I need to, or assessment. You know I usually give information then show them how to use the food guide and the tracker and information for them to read, and then the next, the follow-up sessions are where you get into more of the teaching. So the action plan is just sort of summarizing. But as I'm getting information I'm also teaching at

> the same time, sometimes. So it's sort of intermingled and mixed. But yeah, an hour seems to work well. (Betty, 420).

Lynn, whose choice to work in private practice meant she no longer had to experience the time limiting frustrations of her public practice colleagues, remembered her time as an outpatient dietitian as frustrating because "it just wasn't enough time". She felt that an hour should be the minimum for follow-up.

While lack of time was a concern for many of the dietitians, lack of available resources in the community to support their efforts was equally challenging. As Irene observed, those "one time, one-shot deals where I fix the kid are such a waste of time". Two of the community nutritionists pointed out that even though their mandate was *not* to provide individualized counselling for overweight youth, sometimes they did, albeit 'under the table'. Diane worked in a program that was not supposed to see individuals for weight loss counselling. She explained that treating obese children was " something that's on the side and it is not really part of the system". To her, this was "extremely frustrating", in part because the need was "not taken really seriously". She believed this was because obesity was "just not glamorous enough a condition". Others believed that hospital politics and health care funding were more likely to blame for the dearth of weight loss programs. They thought that decisions were made "at the administrative level" to discontinue weight loss counselling and focus human resources (i.e. dietitians) on other nutrition related conditions such as diabetes. However, as frustrated as they were with the status quo, no one was really clear why more time and resources were not available for treatment.

In summary, most informants believed that childhood obesity could best be treated in a multidisciplinary setting. However only one such program actually existed in the region. Instead they were limited to working individually with children and families for brief sessions, during which time they were able to address only one or two food related issues, hoping that somehow they could make a difference.

### 4.4.2 Client's Readiness to Change

*"Sometimes it's just not a stage for change"*

Another common theme that ran through our conversations pertained to the issue of whether the obese children and adolescents they worked with were ready and able to change their behaviours – to do the work that these dietitians believed was necessary – to be healthier and possibly lose weight.

All of the informants were familiar with the Trans-Theoretical Model* of behaviour change, which includes the stages of change concept, introduced in the early 1990's as a way of understanding how people changed their addictive behaviour. Informants made reference to it frequently when talking about their experiences with obese youth and their families. The ways they used this model to lessen their distress with their client's behaviours were noteworthy. Ellen explained this perspective very well:

* Developed by Prochaska, and DiClemente, essentially, this model offers a framework for understanding how and why people make decisions to change their behaviour. Individuals move from being unaware, or in denial of, the problematic nature of their current behaviour(precontemplation); through consideration that their behaviour may be problematic and in need of changing (contemplation); through preparing to make changes to their behaviour (preparation); to actively working on changing their behaviour (action); and on to maintaining their hard-earned changed behaviour (maintenance). Each stage represents a state of 'readiness' to change - if someone is not yet ready to change their behaviour then efforts to convince them otherwise are likely to fail. (Prochaska J, Norcross J, DiClemente C. "Changing for good" (1994) William Morrow: New York.)

> E In terms of my acceptance of weight management, there's in the way past, a long time ago, you know, there's been lots of talks and discussion on motivating people and stages of change and that you can't change people. They have to be ready to change. So, you know, it isn't anything that we aren't doing. So it makes you feel like, well, you're doing what you can. So I think that keeps confirming in my mind that I just have to be there to just help them, but it doesn't matter, and if they can't do this it's just because there's other things that get in their way. So I think it's good and that's made a difference. Maybe that's what it is, you know. That I'm just not – my expectations aren't as great of myself and of them too.
>
> S Yes. So you can be easier on yourself and them.
>
> E Right, right. And more accepting of their not being able to succeed. (Ellen, 902)

Ellen expressed quite succinctly that lack of success in changing behaviours was a direct function of the youth not being *ready* to make behaviour changes – and clearly, this was a relief to her. It wasn't about her ability, or skills, or even knowledge. This awareness seemed to underlie comments such as Betty's, "You just do the best you can, you know."

Not everyone took solace in letting go of their expectations of clients. Connie would become quite frustrated with them, and acknowledged this,

> I think it's more frustration with not being able to get kids to change and mostly to get them more physically active ... People just aren't prepared to get out there and work it off as much as they need to and to be able to make dietary changes that are required. (Connie, 382)

This rationalization of readiness was used by some informants to explain why their young obese clients were not able to follow through on their recommendations, as in "for her, it wasn't the right time". Some also referred to readiness to explain their successes, as when Alice described a young boy who had made "tremendous changes" because "he's just ready and he's listening". It

helped that his parents were also ready to support him in making these changes. Irene described a youth who was able to lose weight as "being in the right place at the right time".

Several informants used the readiness concept to explain to frustrated parents why they were not going to be able to help their child, as when Janet told mothers who have been dragging their kids in for weight loss, "It's not the time. Sometimes it's just not a stage for change", or Alice who explained to them, "If this person isn't ready, it doesn't benefit either one of us to be sitting here". Lynn described why she does this,

> There's always this pressure that I feel as the dietitian, that I need to perform or that the kid's got to make some changes because parents are expecting change, especially when they bring their kid to see me, right? They want to see some change. So I often have a session with the parents and say, "Look, your kid's not ready. I don't necessarily think it's a bad thing that they come see me but don't expect any changes from your kid. (Lynn, 106)

Readiness was also used to explain why children and youth did not return for follow-up appointments with the dietitian, as when Alice observed "Sometimes I find when the parent isn't necessarily able to follow through with things, I may not see them again". In addition to using the readiness model to explain their clients' inability to change behaviour, some informants admitted they lacked the skills in being able to help motivate obese youth. Irene, for example, believed her efforts to help young clients were largely a waste of time, "Yeah, we want to say that if you educate somebody that they'll automatically get motivated to do something to change it but it doesn't work that way and I don't know what makes people tick", whereas Lynn used her understanding of the stages of change to tailor her assistance. She explained

> Often I get them to rate their, you know, willingness to change on a scale of one to ten, ten being like, "You know, I'm ready. Give me whatever you've got. I'm ready to change," and one being like,

> "I don't want to be here," and that usually gives me a good sense of where they're at. (Lynn, 94)

Once she knew where they were at, she could modify her approach to meet their needs, whether that was simply rapport building for those who were resistant, "because I realize that trust needs to be built before we're going to get anywhere", or education to help shift them to a different stage of readiness.

In summary, to varying degrees, the informants were familiar with the trans-theoretical model and the concept of stages of change. This understanding helped some explain youth's inability to make behavioural changes, and served as a means to help them reduce parental expectations for change. Others used their understanding of this model to help facilitate dietary change.

### 4.4.3 Inadequate Skills as a Dietitian

*"You know I feel limited in what I know, in how much I can offer them"*

All of the informants graduated with the belief that they were professionally prepared to help their clients achieve certain nutrition related goals. Over time, however, as they interacted with obese children and youth in challenging real life situations, their experiences brought them to the realization that they were lacking important counselling skills to help people achieve these goals. This was perceived largely as a result of inadequate training, as well as lack of personal maturity and life experience. Only one informant believed that she had been adequately trained, and this she had sought out on her own many years after being in practice. Some of these challenging

situations will be described in the following section, as will informants' perceptions of their inadequate training, personal experience and life maturity.

### 4.4.3 A) Challenging Situations

*"This is beyond my scope"*

The challenging situations that informants encountered with obese youth were many and varied and included instances of children and adolescents being dragged in, literally and figuratively, by parents who were afraid of the health and social consequences facing their child, and who wanted their child fixed; or who somehow felt they were a 'failure as a parent' because their child was fat. As Janet described:

> Nine out of ten times mom is Type A, you know, high achiever,
> slim, and has this kind of overweight kid that they are dealing with.
> It's in their head, all this, you know, failure as a parent. (Janet, 199)

Such situations could be "tough" or "tricky" to deal with, as Betty dryly observed, "you can tell this isn't really going to go well". "At times like that", Diane explained, "I'd rather say that I don't, that there isn't anything that I can do."

In some situations, the child was seen as being used "as a pawn" in custody disputes. Other cases were complicated by family dynamics, with blended families, absent parents or over-indulgent grandparents being part of the mix, making it difficult to get a handle on "the whole picture". Dietitians were particularly distressed when they felt that families were actively contributing to stigmatizing a child because of their weight. Lynn described "probably one of (her) worst experiences as a dietitian" as a family situation where the younger obese child was being treated very differently than the older child, the parents were "obsessing" about food the

child ate and "being punitive", and foods were disallowed that the rest of the family enjoyed. She described her acute discomfort with the episode and her feeling of inadequacy:

> So it was just a horrible dynamic set up in the family, and you know, I just felt really uncomfortable the whole time the kid was there... . Like it's almost like I felt like again, I was the wrong – they needed a therapist in the family.... This is beyond my scope. I felt like at that point it was very much behavioural stuff, and I don't know if I made any sort of impact. (Lynn, 466)

Situations that they found equally beyond their scope were those that involved youth with 'underlying issues' that they believed needed to be addressed. Generally, those issues were psychologically based, and included everything from depression and low self esteem to a history of being bullied at school. Diane, for example, mentioned that she would see youth suffering from depression. She did a lot of reading on "how to help people", because she was "really hesitant to do it with the food and calories", but did not feel she had enough information on how to address such problems. She would "try sometimes to do a pep talk" with teens, but recognized that it was not much help in the long term. Connie, describing a male adolescent who was obese and humiliated with his breasts, said "I don't delve into feelings and emotions and things like that....I'm not very good at (it)". As she explained, "It's just never one thing. It's always a whole tempest of things brewing in there and boy, if you open that can, you better know what you're doing."

### 4.4.3 B) Inadequate Training

These experiences of "not being very good" at dealing with client's emotions, or of "going into situations blind" were indicative of informants' perceptions that they had not been adequately

trained to deal with the emotional issues their young clients were dealing with. Indeed, Connie described how completely unprepared she felt for this aspect of her work, "Actually counselling? I would say absolutely nothing prepared me for this job." This was a common refrain from some informants, which they considered really tough. "Half the time you feel like you're their psychiatrist, and that's not comfortable because that's not my area of expertise" complained Betty.

Karen, a recent graduate who had just obtained her RD status, believed that her schooling had "not even remotely" prepared her for dealing with complicated youth. She believed that the assessment model which she had been trained with was "totally not working for the dietetic profession", and wished that instead she had "a toolbox of counselling techniques" that she could draw from. Janet said early in her career, she didn't know "what to do" or "how to do it".

Many informants questioned whether new grads would be prepared for the challenges of working in the area of childhood obesity, suggesting that obesity counselling with families required specialized training and skill development. Some felt that a certain degree of maturity and an awareness of the complexity of the dynamics involved was important. They believed that new graduates would need to be patient and prepared for disappointments. Janet passed on the lament of some new interns that she had recently worked with,

> I think a lot of – and what the dietitians said this to me, the interns who were here, said, "We need help with counselling." I said, "You do." I know because I know I didn't have it. And I think a lot of help in terms of counselling, whether it's mom and babe, whether it's a teen, whether it's knowing the stages of change theory and understanding that counselling model. I think that's a huge piece that's missing. And if I had to, I'd go back and do - probably I'd do a degree in that. (Janet, 923)

Janet had received specialized training in working with families and childhood obesity. Out of all of the informants who worked in this area, she alone expressed confidence in her ability to work effectively with this group. She was in fact quite effusive about the training she had undertaken

> We had to go through training... and that's where the learning curve came in about family process, family systems and stages of change, and all those pieces and how you work with a family, a family as a unit. This wasn't just about the child. (Janet, 65) ... (I) Didn't know how, didn't know what to do, and now I really recommend it. Oh man, I love it. I LOVE it, what I do. (Janet, 1025)

### 4.4.3 C) Life Experience and Maturity

The new graduate dietitians seemed to be more critical of their educational training than the older ones who had graduated in the past. Helen, who was recently retired, laughingly pointed out that when she was young "it was a time when we didn't know things". Concepts such as client-centered counselling and stages of change theory did not exist, and so it all boiled down to "common sense" and "stopping, learning, listening". For her, helping people was a matter of trial and error, "there's nothing like the odd mistake" to teach you what's helpful and what's not. She and others commented that it had taken them several years of trial and error before they began to feel comfortable being able to 'connect' with people. Diane summed up some of these sentiments:

> How many people, (who) don't have enough experience dealing with families? I don't think a student coming out of university would be the right person for that. You know, I think it is a very complex and difficult problem and you have to have a bit more

> maturity and life experience to get into something like this (Diane, 757)

These informants who had been working in the field for a number of years generally felt that time and experience – especially having children of their own - had helped them to feel more comfortable with their work. As Helen said, "I was useless with kids before I had kids, you know?" She and others felt that having children "make(s) you become much more realistic" in terms of how dietary advice is framed. Several informants commented with dismay that their inexperience and lack of maturity may have had a negative impact on their interactions with clients when they were younger. Diane, for example, noted that her lack of maturity had been quite problematic early on:

> And I think it's kind of like I am older, I'm more mature, I've done some stupid and said some very terrible things when I was a younger dietitian and I think I have learned a lot from that and to be you know, a little bit more gentle with the people. (Diane, 194)

In summary, most of the informants questioned whether they had the professional skills needed to be successful in helping obese children and their families. In particular they felt they were unable to deal with complex family dynamics and individual emotional issues. Their explanations for why they lacked these skills included inadequate training, as well as a lack of personal maturity and life experience. Only one informant believed that she had done the needed professional development to address these areas, and was thus very happy with her work.

### 4.4.4 Uncertainty About How to Best Deal With the Problem of Obesity

*"(We need) someone to come up with that magic answer, which is not there."*

Most informants believed when they graduated that they had some answers to the 'problem' of obesity and that their unique training would enable them to help people address their overweight and obesity. However, their experiences - client interaction, unclear goals, poor outcomes and an environment that was in a rapid state of flux - had taught them that perhaps there were no concrete solutions, and perhaps dietitians were not the best people for the job. At the same time, many had underlying concerns about the safety and efficacy of weight loss practices, and wondered if in fact effective treatment approaches existed. In the following three sections I will present the ways informants spoke about how they viewed the complexity of obesity, the practice dilemmas that this complexity created for them, and the ways this served to create uncertainty for them regarding their professional role.

#### 4.4.4 A) Complexity of the Problem

*"Weight loss isn't rocket science, it's more complicated"*

All of the informants agreed that the problem of childhood obesity was a complex one, complicated by the lack of consensus on what contributed to the problem. These factors could be individually based, family based, culturally based, environmentally based or socially based. Individual factors included genetics, underlying psychological or behavioural issues and the use of food as a coping mechanism for dealing with these, as well as the complex array of factors that drive individual food and activity choices. Family factors mentioned by informants included parenting styles and the parent's tendency to 'give in' to whatever the child wanted; parental

ignorance about healthy versus unhealthy food choices; parents interfering with their child's 'natural' feeding relationship causing the child to distrust their natural cues of hunger and satiety; parents forcing only healthy choices on their children and disallowing 'junk' food – creating a situation where 'forbidden' food becomes 'desirable' in the mind of the child; parents lacking the time to be physically active with their children and parents' fear of letting their children outside to play. Cultural factors were cited in reference to families from minority cultures not understanding the value or specifics of healthy eating in Canada. Societal factors generally included the idea of the 'toxic' food environment, where children and families are overwhelmed with a surfeit of unhealthy, cheap and tasty food alternatives. Food marketers and weak regulatory bodies (generally government, though non-governmental organizations were also cited) were commonly viewed as culprits here. Poverty and food choice availability were also cited as societal factors. Environmental factors included poor urban planning (no place to walk in urban and suburban centers) leading to less optimal physical activity and unsafe communities contributing to parental fears about letting their children out to play. The idea that obesity was a stigmatizing condition was noted by all of the informants.

While not every dietitian cited all of these factors, all referenced the multi-factorial nature of childhood obesity. As one young dietitian framed it, in reference to a workshop she had recently attended in Vancouver, "Weight loss isn't rocket science, it's more complicated".

### 4.4.4 B) Dilemmas of Practice

The awareness of the complexity of obesity that informants developed did not give them confidence in their work. Rather, it created some significant practice dilemmas for most. Unlike the previous issues of time, client motivation and lack of skills, these quandaries were rarely articulated clearly by the informants. Rather, they seemed to underlie much of the doubt and uncertainty informants experienced, and had to be teased out from contradictory statements about their work with obese youth. These dilemmas revolved around the issue of weight loss as a goal in the context of fears about eating disorders and obesity stigma, and the issue of how to treat obese youth in a helpful and effective manner.

### 4.4.4 B) i) Dilemmas Around Weight Loss

*"If I give my clients what they want, I may be doing them harm"*

On the one hand, informants believed that being fat was not a good thing for children and adolescents. Being health professionals, they were well aware of the health concerns of obesity – from sleep apnea and elevated lipids, through to children being "on the road to having diabetes." They recognized that obesity could be a significant problem for their young clients, increasing their risk of becoming obese adults with all its attendant risks. They were even more aware of the nature of our fat phobic culture and the stigma that being fat has produced, and spoke at length about this. Many commented on bullying as an issue for fat children, noting for example, "the stigma that's associated with that (obesity) is so huge and kids are so mean". Connie recalled an article she had read comparing the quality of life of fat children with children

going through chemotherapy, "and these pediatric obesity patients will rate their quality of life as poor."

In addition to being aware of the negative health and social consequences, several informants referenced the magnitude of the obesity problem – one calling it the biggest "health issue facing Canadians at this point in time" - and the idea that there was more urgency than ever to finding an answer and helping "those poor things" so they could live better lives. In these regards, all but one informant articulated a belief that not being fat would be a good thing for the youth.

On the other hand, most informants had number of a underlying concerns about the safety and efficacy of weight loss practices, and believed that weight loss should not be promoted in this group. These concerns pertained to medical issues, the risk of eating disorders and stigma, and inconsistency with the size-acceptance philosophy. At times the concerns were articulated clearly, but generally, they were implicit in other comments informants made.

Several informants made the point that professionally, weight loss was contraindicated in children, largely because of fears of impacting growth and nutritional status during this stage of rapid growth and development, and so weight loss could not be a goal. A few did acknowledge that weight loss as a goal might be appropriate for some obese youth, but they were very cautious, saying for example that they only wanted "a little bit for health." As Janet observed, "We're only talking sometimes about just a ten percent weight loss. I don't want to see huge drops." She also pointed out that weight loss would not even be considered as a goal unless someone also had psychosocial or medical concerns secondary to their weight. One informant

seemed quite alarmed when I asked if weight loss was a focus in her work. "No! Absolutely not!" She related this discomfort to her awareness of eating disorder risk. She worked with adolescents who were at risk for type 2 diabetes, and was pleased that she was in a position to focus on blood sugars rather than weight, in terms of outcome measures.

> They're on the road to having diabetes, so I can always refer to the blood sugar and not their weight management, which is probably a big plus in terms of like have your way out from the eating disorders thing, not talking about their weight all the time. Ultimately the blood sugar and their diabetes is dependent on their putting on so much weight too, but I don't have to focus on that. (Ellen, 740)

Concerns about not wanting to damage a youth's fragile self-esteem were also referenced as the rationale for not wanting to focus on weight loss. Karen, for example, commented on her concern with physicians, whom she believed referred children to weight loss programs rather than dietitians, "They just tell the kids stuff, 'lose weight'. They don't try to – I want to say - buffer the effects of that negative body image and all those things". She thought that dietitians, at least, were aware of this connection and the need to 'buffer' information, and should be the first choice of referral amongst physicians:

> K Because without that, I mean the child is really at risk of, you know, really damaging their body image and I know that dietitians probably do know. Like I think that they should know. Wouldn't they know, or is it just me?
>
> S Should know what?
>
> K That, you know, talking about calories and, you know, like trying to work on reducing fat on their body and all of these kinds of chitchat. Like what you would do in adult weight loss is really detrimental to children. So I would believe that most dietitians would know that, right? (Karen 1467)

For others, the fear was about not wanting to further stigmatize their young clients. Several spoke of the work they did with obese children as an exercise in caution, a need to tread carefully so as not to be hurtful. For Diane, this was about not wanting to further stigmatize families, who have "been hurt a lot". She believed that they often felt that they were being blamed for their child's obesity, and so she took great effort to "be very careful" with her words.

Two informants who wanted to support weight loss, acknowledged that they believed strongly in a size acceptance perspective. They were well aware that these views were contradictory, but did not know how to resolve their dilemma. As one said,

> You can't change the fact that people hate fat people. Like you can't change that. It's really sad. And if you could then – mind you, size acceptance isn't all that it's cracked up to be. I'm not fully a size acceptance kind of person either, and don't quote me on that one because some people probably think I am and they admire that but I'm not. Like I believe size acceptance to a point, like try to find your genetic set point within your healthy weight range, you know, but don't freak out if you're, you know, ten pounds overweight or whatever. (Karen, 831)

While these informants tended to believe that a 'size acceptance' approach might be appropriate when working with this young population, they did not feel comfortable promoting this with youth who for medical reasons, needed to lose weight. Faye for example, was in support of this concept in theory, but in practice, concerns with health issues got in the way of full acceptance. She articulated this perspective well,

> Because I know, and I know this with me, the size acceptance. I accept everyone for who they are and respect people for that, but at the same time when I see a very large person walking down the street, I also think about health. It jumps into my head. So even though I respect people for who they are, I really believe in that value. (Faye, 548)

In keeping with this theme, several spoke about supporting their clients in finding a weight that was reflective of their genetic phenotype, but beyond that were less certain. Informants who voiced their awareness of society's tendency to stigmatize the obese seemed particularly interested in the size acceptance perspective, but had difficulty with the fact that youth and their parents did not agree with, or perhaps understand the concept. As Lynn observed,

> I mean size acceptance is brilliant but it's like anyone I've ever suggested it to absolutely loathes it. You know, it's for us health professionals out there. I've had clients say to me, "I think that's a big copout, you know. You're just trying to take the easy way out." Like to me, as a dietitian, you know, "Oh, you don't want to figure it out. You're just saying, you know." It's like a bad word. (laughs) You know, they just don't want to go there because they don't want to – because they loathe their bodies so much. (Lynn, 518; 541)

In terms of the dilemma overall, Irene was perhaps the clearest in articulating her difficulties. She used the concept of 'walking a tightrope' to explain her inability to find a balance between wanting to help youth lose weight, and not wanting to be part of the problem.

> I don't know how to walk the tightrope, to be honest with you. It is a tightrope and it's how do you tell somebody that you need to lose weight because their health is, their physical health is suffering, and yet worry about their mental health at the same time.... I guess that's sort of also why I get the, "Oh no" feeling when I get another referral because I know that the referral that is coming to me isn't just coming to me out of the blue. It's coming from a history of something, and often that history is that that child has been told, "You're overweight. You're gaining weight. You're getting fat." You're not good enough basically is what they're hearing I bet. And so when I go in there I have this "Oh no" feeling that this poor kid has been told for however long that there's a problem with them. Once again they have to do something about themselves. I hate that feeling. I hate that and I hate being part of that. On the other hand I also hate the fact that they are suffering physically because of it. So yeah, I don't know how to walk that tightrope." (Irene, 1059)

Here Irene is able to articulate both the dilemma, and the degree of discomfort she experienced with it.

### 4.4.4 B) ii) Growing into Your Weight: Solution to the Weight Loss Dilemma?

Even though the weight loss dilemma did not always appear to be clearly understood, it seemed that the primary way informants tried to solve it related to the concept of 'growing into your weight'. This concept essentially means keeping children's weight steady while they continue to grow during the pubertal growth spurt. Virtually all of the informants mentioned that that this was key when working with young people who were still growing. Helen explained this concept to obese youth like this:

> Well, you know, like it's a matter of holding the weight because look, on this pink or blue chart," you know, and I would work with the person. "If you can just stay the same or maybe go down five pounds, and I mean you can go down a fingerful if you want over time but okay, if you keep your weight there you're going to be growing. How tall is your mom? How tall is your dad? Where have you been? Wow! You're going to get over here. Wow! Your weight is going to match your height. (Helen, 380)

By focusing on growth in height, not weight loss, informants were, for the most part, able to avoid negative talk about being fat, and instead focus on the more encouraging and hopeful idea that youth could outgrow their excess body fat.

Only one informant mentioned any difficulty with this concept. Karen believed that there were times when 'growing into your weight' was just not going to work, as she explained here when asked if weight loss was a focus of her practice:

> K No, weight loss hasn't been a focal (point) at all. It can't be. Well, I mean weight loss is contraindicated for children as well.

S Growing into your height (sic)?

K Growing into your height (sic). Mind you, that doesn't work always, because when I was in my internship I had one child obesity case and she will never grow into a healthy weight, right? She's so overweight that she is – like it's impossible. She'd have to lose weight. I think she was twelve, and I don't know.

Unfortunately, this focus on growth not weight loss had the potential to create some challenging and conflictual experiences between informants and their clients, who, not surprisingly, had dissimilar goals. The informants were very much aware that obese youth were coming to them specifically because they wanted to learn how to lose weight – whether it was families wanting their child to slim down for health or social reasons, or adolescents wanting to lose weight because of body image concerns – there was no doubt that the goal was weight loss. And, from the dietitians' perspective, this goal could be emotionally charged. Lynn explained this when she said,

> The parents are scared of their kids, you know, being overweight and developing diseases. Actually, you know what they're more scared of I think, is more the social aspects, because I get a lot of parents coming in saying, "You know, my kid's coming home and they're telling me that they're being teased and bullied and they're not happy. They're starting to talk about dieting." And then usually parents get really, you know, concerned that their kid's going to develop an eating disorder or, you know, or they're going to get depressed. So that's usually when they're coming in. So parents are dragging them in usually. (Lynn, 143)

The informants believed that parents had high expectations of their services; that the dietitian would somehow be able to 'fix' their child. With this level of expectation, weight loss became more than just about body size.. It became the key for families to stopping bullying and to enhancing social acceptance and, quite possibly, the solution to other issues within the family.

Connie wished she had "a magic wand" under her desk because she believed that's what parents wanted, "They want you to fix their overweight child for them and you just can't."

It wasn't only the parents who had high expectations. According to the informants, most of the adolescents who came willingly to see the dietitian were not interested in general healthy eating guidelines, nor were they concerned about health issues. Generally, they were concerned about their "outward appearance" and how they were fitting in with their peers. They believed weight loss would help them with this. As Alice explained

> They often think that this, you know, that they'll be accepted by their peers and family and all that. I seldom find them thinking about it (weight loss) from the perspective of health. Of course. Well they're teenagers that are after(all), you know. Even adults you might say. It just seems, it's all about their looks and their size. How they look, how they appear. Their body image. (Alice, 348)

In spite of high expectations for weight loss, most informants actively discouraged a focus on weight loss. Alice, for example, pointed out that the first thing she would tell parents in a counselling session was that they weren't there for weight loss. She would explain the concept of growing into your weight and try to enlist their support especially if the child was young. Betty too, in an effort to convince teenage boys that they did not want to lose weight, would tell them that dieting could cause them to stunt their growth and lose muscle mass and would use growth charts to demonstrate this concept.

Of particular interest, during our conversations, virtually all of the informants talked about the importance of getting to know their clients' needs, supporting their food and activity related goals, and seeing things from their perspective. They emphasized that being 'client-centered'

was an important part of the counselling process. However, none of the informants appeared to recognize the contradictions inherent in talking obese youth out of weight loss as a goal. The practice dictum of allowing children to grow into their weight for health and nutritional safety reasons seemed to supercede concerns about the importance of client-centeredness. The focus on engaging youth in interventions that were positive also appeared to draw attention away from this discrepancy. Lynn explained:

> I kind of thought that I want them to have some esteem in themselves, to know that – to have some assurance that they are doing what they need to do to be healthy, and just because their body type doesn't reflect maybe where society tells them they should be at, that they still, you know, that they should still make those efforts to be healthy and just to give them some confidence in their efforts, to firm their steps (Lynn, 298)

While the idea of 'growing into your weight' made sense to most from a health and risk avoidance perspective, it too presented some practical challenges for informants.

### 4.4.4 B) iii) Dilemma Around Treatment Approach

On the one hand, informants were very clear that they did not want to give children and youth structured meal plans. They perceived this approach to be rigid, punitive and inappropriate for children. As well, several spoke about their fears that focusing on calories and restrictive dieting practices might cause the youth to 'obsess' on these, and lead to problems with disordered eating, or with self-esteem. Betty, for example, made a connection between how focusing on dieting could lead some youth to focus on the need to lose weight,

> You, you really have to be careful, because it's very easy you know, to get the, well especially with the parents focusing so much on the weight as well, for them to fall into this dieting, you know. That 'I have to diet'. 'I have to be on a diet'. 'I have to lose weight'. And it's very, you have to be

> very careful and always be emphasizing that its health. That you're looking at getting healthy, and not getting to a specific weight (Betty, 348)

Instead, as described in Section 4.3.1, informants followed a lifestyle approach to weight management, which they believed to be flexible and one of the few ways that they could comfortably continue working with this age group. As Alice explained:

> I don't believe in the diets. So I think that, I think in that regard I think that that's where I see that we can still work with this population. Of course they're growing. And all that. So – you have to take all that into consideration for sure. Um, and I think that by teaching them good eating habits – is a whole different thing to me. And I think even weight management versus trying to get them to you know see weight loss. That's why the scale doesn't matter. It's watching them make changes that are going to just, that are going to help now ok. May not get their weight off right now, but if they continue to do the - increase their activities and be careful with the choices they make and so on and so forth, then these are the things that are going to impact the rest of their life and how they feel and all that. (Alice, 617)

The lifestyle approach included an emphasis on educating youth about healthy food and activity choices as ways to achieve improved health. Weight loss was not the focus of this approach, though the adoption of healthy eating and activity behaviours had the potential to result in weight loss. On the other hand, the lifestyle approach was not what most obese youth wanted. According to informants, many wanted structured meal plans and weight loss diets. By staying focused on using a lifestyle approach, informants were again in a position of not being able to attend to the wishes of these youth, contradicting their stated belief in the importance of client-centered approach.

At the same time, even though they used the lifestyle approach, some informants expressed disappointment that the approach was unlikely to help their clients achieve their goal of weight

loss - which was in itself a contradiction of the 'growing into your weight' concept. Lynn, for example, believed that the lifestyle approach was not likely to result in weight loss because it wasn't "hard core" enough. This, she noted, was "frustrating for them and frustrating for me". She wryly observed that once the girls "switch over and do the crash dieting" in order to have success at weight loss, she would end up seeing them for the "rebound bingeing or overeating". She was therefore "cautious", tending to "err on the side of do no harm". Lynn believed that in order to help her youth actually lose weight, she would need to help them develop a disordered relationship with food. Referencing research from the weight loss registry in the USA, she said

> I know what research says about weight loss. I know the difficulty and the statistics are not in favour of weight loss in most people unless they're, you know, consuming a very small amount of calories and they're very, you know, food focused, portion focused (Lynn, 233)

This was an anathema to her, because she believed strongly that an individual's relationship with food was very important.

The observation that weight loss was not likely to be a result of the gentler lifestyle approach was mentioned by a few informants, and indicative of the difficulty that some experienced with this approach, as well as their ambivalence around the issue of weight loss. Karen, for example, took umbrage with it because she thought that perhaps a more 'hard-line approach' could be useful.

> R Yeah. We're being careful. We don't – sometimes it frustrates me because I'm like, you know, maybe somebody who's a chocolateholic might need to actually cut out all the chocolate, but is that too much to say when we're saying that all foods fit, you know? It's like that's where I find that I'm conflicted a little bit, because you know, I don't want to say that, "You know, maybe you should cut out a food group, or like a type of food that you really like. Maybe that might be the best thing for you. Maybe we need to

> go more drastic." Yet we feel that if we go too drastic they don't – they're not sophisticated enough to understand what we're trying to do and that they will just head off in another fad diet. I don't know. Like it's hard. (Karen, 984)

Not everyone articulated this belief. However, many were frustrated with the lack of results that they were able to achieve using the lifestyle approach. According to them, interventions that actually resulted in weight loss were relatively infrequent. This lack of success was attributed to lack of time, clients' lack of readiness, and their own inability to facilitate behavior change, as we saw in earlier sections. This in itself was an interesting observation, especially because for the most part, the informants did not actually weigh obese children and youth, fearing that focusing on the 'numbers on the scale' might indirectly contribute to the development of an eating disorder. So in reality, they had no means to actually monitor whether or not their interventions were successful.

### 4.4.4 B) iv) Dilemmas Regarding Measuring Success

The informants' uncertainty regarding use of lifestyle approaches versus more rigid diets was exacerbated by the lack of evidence they had regarding outcomes of their interventions. When they were reluctant to weigh clients, there was no way of knowing if their treatment approach was successful in achieving weight loss or even weight maintenance as clients grew into their weight. As Faye commented,

> On the one hand we know that there's some work out there that has suggested that frequent weighing and monitoring has led some people into some of those negative behaviours and put them at a higher risk for eating disorders. But on the other hand we have to (offer) people some kind of outcome measure, some kind of goal. (Faye, 440)

Since weight loss was not their primary focus, most informants were challenged to define what they would call a 'successful' intervention. Some spoke of wanting to use outcome measures other than weight. Alice described her use of behavioural outcomes: "I see the changes by how positive his, their behaviours are. You know, he's happy to be there, he's listening ... to other choices, other information that's coming out." Others said they looked for changes in the way clothes fit, and their attitude, and listened for youth's comments that they were feeling better and were able to run when before they could only walk. But since clients rarely returned for more than two follow-ups, this approach was limited at best.

Janet, who worked in a multi-disciplinary treatment program, recounted the most successful experiences in working with obese youth. While weight loss was promoted as a desired outcome in the program, it was not the main goal. Instead, the program assessed psychological outcomes such as depression and self-esteem to track progress. To her, this was very rewarding.

> R So we have kids who haven't lost anything but yet their self-esteem has gone up. Their communications have improved immensely with family and with friends so they're doing okay. We consider that successful and still they haven't changed their weight.
>
> I Do they consider it successful?
>
> R Yes, yes. So the success is not the weight loss. This was a tough point to get through to the docs in terms of the evaluation and that's why the evaluation questionnaire, which measures self-esteem and depression (Janet, 639)

Janet emphasized that staff and client education regarding the importance of these other aspects of success was instrumental in helping everyone feel positive about the program.

Some informants talked about the need to encourage young people to feel good about themselves no matter what their size, and to strengthen their self-esteem. Focusing on behaviour change as an outcome was the key here. Betty explained:

> If you can just get the children to be accepting of who and what they are, you're doing great. You know. Cause a lot of these kids'll come in and they're very negative about themselves. And it's really sad, you know. They're very unhappy... so being encouraging and um trying to make them see that small steps are really quite big accomplishments. You know, just eating breakfast everyday is something really great. You know, just getting that extra walking in a couple times is something that's really wonderful and you have to be really encouraging and really positive (Betty, 473)

Unlike Janet's experience, however, none of these informants felt very positive about their experiences, possibly because they had no concrete way of measuring progress.

In summary, the complex nature of obesity created some uncomfortable dilemmas for informants. They appreciated that being fat was not good for children and youth, but they had difficulty accepting weight loss as a goal. Instead they emphasized the concept of 'growing into your weight' to allay concerns about the impact of weight loss on youth's health. They also believed that the lifestyle approach to weight management was a safer alternative to weight loss diets, but some lacked confidence in its effectiveness. However, neither the lifestyle approach nor the concept of 'growing into your weight' were perceived as desirable strategies by their clients, leaving informants in the position of prioritizing their own goals over those of the youth. These dilemmas seemed to underlie much of informants' doubt and uncertainty in their work, but rarely were they able to articulate this. Indeed, it was challenging for me as a researcher to articulate these dilemmas, even after many hours of analytical thought and writing.

### 4.4.4 C) Uncertainty about the Role of the Dietitian

As the dietitians became aware that obesity was so complicated, some began to wonder whether they were the most appropriate health professional to be addressing the problem. They questioned whether their professional association was providing appropriate support in this area, whether obese children would be better served by other health professionals, and whether dietitians might be more effective by focusing on advocacy and leadership, rather than treatment and counselling.

#### 4.4.4 C) i) Is Our Professional Association Supporting Us Appropriately?

Some informants raised questions about the way their profession presented obesity management and the dietitian's role in this area. For some, the questioning related to the perception that dietitians do not, as a profession, have an understanding of the complexity of the issues. One community nutritionist suggested that this was all "uncharted territory". Awareness of the complexity of obesity was thought to be a recent phenomenon and that no one really knows "how to put the pieces together". Another believed that organizations like Dietitians of Canada "oversimplify" nutrition for the general public "making it seem like total health and wellness can be, you know, summarized in a one leaflet handout of, you know, eat your fruits and vegetables". Yet another felt that dietitians were "trying to solve the problem so like – like cause and effect. One cause, one effect, and yet it's not like that".

While some thought that their profession was oversimplifying the issues, others believed that the profession's promotion of dietitians as 'experts' in food and nutrition, was equally misleading, and were uncomfortable with the high expectations placed on them by clients and the general public to have all the answers.

Several observed that there were differing opinions in the dietetic community as to what approaches to obese youth were helpful. One wondered if it would be possible for dietitians to agree on a set of values or 'pillars' that could guide practice, while another said "there needs to be a better body of information that we're all working from, that we're all agreeing". Grace was not hopeful that this could happen. She was particularly discouraged that she couldn't "think of a single Canadian leader in dietetics" – a perception that was shared by others.

> F We're sort of – are we leaders in this whole area? Or, like we're so stuck. Some people feel that we're leaders in this profession.
>
> I Mm-hm. Dietitians, weight loss. I mean they go hand in hand.
>
> F They go hand in hand but are we leaders? What are we doing about making changes? I'm not sure. I'm not sure how that whole thing works. (Faye, 491)

### 4.4.4 C) ii) Would Obese Children be Better Served By Other Professionals?

Study informants generally agreed that a multidisciplinary approach would be the ideal approach for management of childhood obesity, but their opinion about the role of the dietitian in this team varied significantly – from "pivotal" to "there might not need to be a dietitian". Karen, a recent graduate, was the most direct in her comments about whether dietitians in general, were the most

appropriate choice for providing treatment. When asked what she would say to physicians who were referring children for weight loss counselling, she became thoughtful and said,

> I think that maybe personal counselling, like psychological counselling might be more appropriate, family counselling would be more appropriate. Well, it's so sad. I'm not really promoting my profession. It's the first place to go but I don't think that we have the counselling skills to deal with childhood obesity in a way. That's pretty sad, isn't it? (Karen, 1455)

Others too believed that a psychologist to address underlying issues should be the first person to address obesity, while another felt that a personal trainer would be more appropriate. This questioning of the role of the dietitian was partially related to how informants saw the underlying issues. Some, who believed that obesity was not a nutrition problem, thought that hiring dietitians to do nutrition counselling was not enough.

> It's a much bigger social problem than just - it's not a nutrition problem at all almost. I mean of course there's the nutrition aspect of it but there's so much more involved ... if we're talking about the general picture of obesity as being an epidemic, that's only addressing one little person. (Irene, 499)

### 4.4.4 C) iii) Should We as a Profession Be Focusing Ourselves Differently?

Those that worked in the community and academic settings tended to have a different perspective on the etiology of obesity. They were more likely to express the belief that obesity was largely a societal issue, and that solutions, if any, were to be found in addressing the 'toxic' food environment. Mostly, these solutions were seen as needing to focus on prevention. Several suggested that the move towards involving schools in working towards preventing childhood obesity was a great idea largely because "the schools are a great place to influence young

children". "If we can change the culture in the school it may have some impact". One dietitian believed that prevention would be easier than treatment,

> Not that it's easy to change environments but it's a little easier to say, "This is what should be happening so let's try to work towards that." So it might take another 30 years before we have that healthy school environment but we know that's a – we know it's doable (Faye, 651)

However, hers was a lone voice. Those who believed prevention was the 'way to go' were largely cynical that it could be done. Whether it was the belief that teachers had "too many other issues they had to cover" in oversized classrooms, or the idea that ultimately, "the choice is still up to the people, you know", no one voiced much hope that there were in fact any viable solutions.

Some informants believed that when it came to obesity management, dietitians were as a profession "behind the times". They suggested that their role was changing from being disseminators of information to something new, but that no once seemed to be clear on what this might be. Several suggested that advocacy could be an important role, possibly at the school level, but preferably at a political or policy level.

> So I think what a dietitian's role could be is to help point out where the lack is. Not just in the nutrition but advocating for looking at the whole big picture. And personally I think it should go as far as the federal government but right now it's the provincial government because health is provincially run, and just making sure that the powers that be understand the whole scope of the problem instead of just saying, "Well, we need to have healthy snacks in schools and that will fix the problem." Well, it's our job as dietitians to say, "Yes, that's part of the problem but, you know, as a nutrition professional, nutrition isn't the only thing." (Irene, 475)

However, no one saw evidence that dietitians were involved at this level – other than in the area of school nutrition. And even here, as Irene observed above, school nutrition is just one part of the problem. Grace, a community nutritionist, was somewhat more cynical in her judgment of how the dietetics profession was handling obesity at the school level. She thought that it was "a big experiment", and was outraged that kids were not, to her knowledge, being included in the discussions.

In summary, as a group the informants recognized that obesity is much more complex a problem than previously believed. This awareness had led many of them to question the role of the dietitian in addressing obesity. Some felt that their profession was partly to blame for oversimplifying the issues, for not providing them with guidance and leadership, and for being behind the times in recognizing the complexity of this health issue. They wanted society to take the problem of obesity more seriously.

### 4.5 How Dietitians Continue to Work Despite Their Distress

It is clear from the preceding presentation of results that informants faced significant challenges in their work with obese children and youth and distress with their ability to intervene in positive ways. In this section, I will briefly explore some of the differing ways informants responded to these experiences. This process appeared to be an ongoing one, and was unique to each dietitian. The way they continued to do their work took various forms, dependent largely on their personal characteristics and circumstances. These included both personal and work related experiences over the course of their careers, their role as parents themselves, continuing and other educational opportunities that they had availed themselves of, and personal values and ideals

pertaining to working with youth. In this section, I will introduce the voice of one dietitian not yet heard in these results. Her voice was absent because she had consciously chosen to not work in this area of dietetics, and so was not part of the original sampling. I chose to interview her as a counter-point to the voices of those who were working in this area, in an effort to shed a different light on the subject.

### 4.5.1 Doing the work carefully

Several informants worked in out-patient settings, and did not have a substantive portion of their jobs devoted to weight loss counselling. Indeed they expressed relief that they did not see more obese children and youth because they had grave doubts about their ability to be effective. They just "did the best they could" and tried to be positive with them, hoping that something they said would sink in, and that they did not contribute to what they perceived as their client's already low self esteem. This process was "disheartening" at times as Betty explained,

> But you just have to keep focusing on you know, making sure that you're doing the best you can for that child. You hope, you know even from those few visits that if you're positive enough, if you can just even get through on a few points, that it's enough to get them started. So they don't feel like it's all negative when they come to see you. (Betty, 493/501)

Because these informants did not seem to feel they were in a position to be of substantive help to youth in the area of weight management, they put effort into modifying their counselling approach – choosing to tread very carefully with advice or focusing on educating children and youth about the dangers inherent in dieting and weight loss. Diane, who was acutely aware that she did not have enough time to devote to this work, focused her efforts on trying to keep

families from feeling guilty for their child's obesity. She believed that the stigma of obesity was profound and regretted earlier experiences of contributing to this stigma when she was a young and immature dietitian. This apparent remorse seemed to have contributed to her new approach, where she tried to be "a little more gentle." When asked how families responded to this new approach, she said

> I think they are thankful. Or I wish to think that they are thankful that I am looking at it that way instead of just again, telling them it's their fault and, you know, that they are doing bad things to their kids. (Diane, 215)

### 4.5.2 Seek out Further Education and Training

For some, their experience of distress was a motivating factor in seeking further education and training. Karen, who was setting up a private nutrition counselling practice, recognized early on that she felt ill equipped to address the needs of obese youth and this was a source of significant distress to her, which she articulated very clearly. She believed that more counselling skills would be most helpful and would help her to feel more confident in her work, and might actually be beneficial to her clients. At our follow-up interview, I asked her how she was feeling about her work with obese children. She indicated that her plan to develop more counselling skills was a source of hope. She remained passionate about wanting to continue in this line of work, and confident that with further training, she would be able to contribute to the wellness of obese youth.

Another of the informants had a different perspective on what skills would be helpful to her. She believed strongly that it was clients' lack of 'readiness' to make dietary or lifestyle changes that

was responsible for most poor treatment outcomes. She did not experience significant mental distress in her work. Her energies at work were directed towards trying to find new ways to motivate obese youth to be interested in making behavioural changes, and she was in the process of exploring innovative experiential group programs that could facilitate this.

Yet another informant made a point of seeking out continuing education opportunities in the area of obesity management that would help to broaden her view. She commented that she knew dietitians who had done "one type of work for a long time...(who) think that that's the only way" and did not believe this was a good thing. To her, growth and development was a continual process that one had to be open to. Her personal experience with obesity had been a factor in seeking out this area of work.

### 4.5.3 Seek out Alternate Ways of Working

One informant believed that it was a combination of her intense discomfort with being unable to address complex family dynamics, personal experience with obesity, as well as her recognition that there were no services available to address these needs, which led her to seek out alternate treatment modalities. This led her to help champion a weight loss program that addressed many of the concerns that had been plaguing her: lack of counselling training, complex family dynamics, lack of multi-disciplinary approaches and needing to address the underlying psychological issues of obese youth. Unlike any of the other informants, this dietitian had become absolutely passionate about working with children and families. She believed very strongly that this approach, which included many of the 'best practice' recommendations from

the literature, was a good one. She stated, "the program is pivotal with the dietitian. The others can be more consultant. The dietitian is the hub."

From a different perspective, some of the informants who were involved in education and in community nutrition had no direct client contact. They sought out opportunities to enhance their understanding of the broader issues at play. Many had a strong belief in the 'ecological' perspective of obesity, wherein individuals are placed within a larger context that includes environmental influences and public policy, and individuals are not considered totally responsible for their obesity. These informants found some hope in political and societal initiatives aimed at obesity prevention. Irene, for example, had recently been invited to attend a provincial forum on obesity, an exciting and empowering event for her,

> For the first time since I've been working in dietetics in this place, I have a feeling that somebody's doing something and that I've been asked to be part of it but I'm not THE part. I'm not the only part of it. And I guess that's maybe also the feeling that you're getting from me is that I don't feel like this is a lost cause. I just feel like there's a lot of issues that need to be addressed and they're in the process of being looked at (Irene, 940)

Similarly, Grace, who had been working in a community position and focusing on childhood obesity from an ecological perspective, was now in the process of broadening her perspectives even further to explore the issue of government policy and food availability issues.

### 4.5.4 Discontinue Working in this Area

One dietitian, who had found dietetic counselling in publicly funded positions to be very frustrating, made the switch to private counselling. This was an improvement for her in that she had much more control over timing of appointments and follow-ups. However, in the course of our conversation, she acknowledged that she was experiencing a great deal of conflict about working with families and children around weight loss. She had come to believe that healthy eating strategies would not help them to achieve their goal of weight loss. She explained her rationale for continuing to see these obese youth for weight loss, "I want them to have some esteem in themselves, to know that – to have some assurance that they are doing what they need to do to be healthy." This approach however, made her feel that she was "not doing something right". At our follow up interview, this informant said that her increasing awareness of her discomfort in doing this type of work had caused her to shift her approach. She now no longer saw parents and kids together, just the parents for the initial appointment, hoping to alleviate or avoid power struggles between the two. She indicated that she was probably going to stop doing weight loss counselling altogether, because it made her too uncomfortable.

This conscious awareness of discomfort is essentially the reason why the thirteenth dietitian had chosen to not do work with obese youth and their families at all. Early on in her dietetics career, Mary was led into thinking about weight and body image in a way that was very different from her upbringing. During her dietetic internship she was introduced to some feminist literature that inspired her to explore the concept of body image. Later, while working on working on her Master's degree, she began to further explore concepts such as size acceptance, women's roles

and feminism – a process that she says really started "shifting" her perspective and way of working. This was followed by a mentoring relationship with a therapist, where she began to explore the concept of people's relationship with food. She explains how her work continued shifting from here

> And I was shifting and moving away from traditional notions of dietitian, where I was thinking about size acceptance. So I felt at that time that size acceptance was not part of the discourse, dietetic discourse. At least I hadn't heard it, and I was ready to – I guess it was fitting in with my life's experiences saying, "Yeah, you've learned all this stuff about nutrition, and for a while there it made you pretty uneasy with your eating, so what was that about? And sure, there's other things going on but it's just like screw it. I don't want to pay attention to that stuff anymore. I find it more cumbersome, more debilitating than liberating." So the nutrition knowledge had - and I was just like screw it. I don't want to burden myself with that. I want to look in other directions for how to help support people, and it's still in the name of health. (Mary, 257)

This shifting in approach led to experiences of conflict with adult clients who sought her out as a dietitian for weight loss counselling,

> Sometimes there was a huge disconnect, in that they had anticipated it would be something that it was not, and so sometimes there was a conflict that arose out of that and a decision not to continue. (Mary 394)

Now, Mary is very clear before she takes on a client that her work focuses on the "emotional aspects of eating", not weight loss. "It's relieved me from again, having to be something that I felt was incongruent with my beliefs and that isn't congruent."

For Mary, being aware of her beliefs and working in a way that was congruent with these, had been a driving force behind her decision to not focus on weight loss, much the same way that Lynn was becoming aware of her discomfort with weight loss practices and considering giving

up this line of work. In a similar way Grace was re-focusing her attention on the larger policy issues in her community work, and was now choosing to obtain a doctoral degree so that she might work at an even broader level.

In summary, each of the informants had found her own unique way of addressing her frustration and discomfort with working in the area of childhood obesity. Largely, this appeared to be dependent on their personal characteristics. One had chosen to not work in this area, while others were considering leaving the area. Still others were working towards solving or minimizing their distress as best they could.

## 4.6 Summary of Results

All of the informants graduated with the belief that they were professionally prepared to help their clients achieve certain nutrition related goals. In their practices, they followed a lifestyle approach to weight management with obese youth, where the focus was on developing healthy eating behaviour rather than on prescribing a structured meal plan. Most informants spoke about using a client-centered counselling approach, which involved listening to their clients and finding out what they were willing to do, rather than telling them what to do. However, in practice, they tried to dissuade obese youth from weight loss as a goal, and did not seem to be aware that this practice may in fact be contradictory to their client-centered ideals. As they continued to interact with obese youth in challenging real life situations, their experiences created significant distress, including frustration, conflict and doubt – in themselves and in their ability to help these clients achieve their weight related goals.

They attributed this distress to four primary issues including their experience of inadequate time and resources to do their work effectively, their perception of client readiness to make behavioural changes, their perception that, as dietitians, they lacked the appropriate counselling skills to be helpful to their clients and, finally, their uncertainty about how to best deal with the complex problem of obesity. These experiences impacted informants in different ways, and each responded in her own unique way to find ways of addressing her frustration and conflict with working in the area of childhood obesity. Some worked toward minimizing their distress, some sought out further training, while others are considering leaving this area of dietetics. These responses have considerable implications for the profession.

## Chapter 5 Discussion

The purpose of this study was to develop a deeper understanding of the experiences of dietitians who work with obese children and adolescents, within the context of the 'obesity management maelstrom,' which includes the increasing prevalence of childhood obesity, the 'war on obesity', the emergence of competing discourses on obesity management, emerging and sometimes competing philosophies of weight management and counselling approaches, and the trend to evidence-based practice in the dietetics profession.

My results showed that dietitians who participated in this study experienced significant distress in working with obese youth, including frustration, uncertainty and both personal and professional doubt. Their experiences revealed a number of issues at play including work context, their interactions with obese youth – which were made up of the clients' expectations and needs as well as the personal and professional expectations and demands of the dietitians themselves - and the influence of society at large.

Other researchers have found evidence that dietitians are experiencing practice challenges in a variety of areas, including work constraints such as time available to counsel, [25, 27, 28, 30, 126-129] the perception they are lacking in counselling training and experience, [23, 27, 28, 30, 57, 103] frustration with their clients' motivation, [30, 129] and uncertainty about effective weight management practices. [27, 57, 129] In addition, Chapman[30] as well as Campbell and Crawford[129] have reported on the impact of the broader social environment on dietitians' practice as an area of challenge, and Marchessault[10] has indicated that the uncertainty of dietitians' understanding of size acceptance

and non-dieting terminology also has an impact on their practice. My findings show that, in the case of childhood obesity management, all these challenges are prevalent.

Recently, Devine et al.[28] used grounded theory to explore community dietitians' experiences in the field. Out of their work, an ecological model emerged, showing the importance of context and process in helping us to understand the unique challenges and satisfactions in this profession. In particular, they found that practice satisfactions experienced by their participants included positive interactions and measurable outcomes, as well as recognition for expert and helper roles and involvement in prevention work.

It is not surprising then, that with the exception of one person, the informants in this study encountered few satisfactory experiences in working with obese youth and their families. Work constraints, uncomfortable client interactions due to a perceived lack of counselling skills, lack of measurable outcomes and – at the treatment level – no involvement with prevention activities, conspired to create experiences that were decidedly 'challenging' for informants. Given the paucity of satisfactions experienced working in the area, it is also not surprising that the dietitians found themselves questioning themselves and their profession in terms of their role in obesity management. As evidenced by the responses of some informants to these challenges, including leaving this area of practice, there are significant implications for the profession.

My results are congruent with the current literature, and I will show how they increase our understanding of the experience of dietetic practice in this area. Limitations of the study, and the implications for research and dietetic practice will also be presented.

## 5.1 Time and Resource Constraints of Dietitians at Work

In their ecological model, Devine et al. described dietitians' work settings as having a largely negative influence on practice[28]. In their study, which took place in New York State, characteristics of work settings in the larger health care system included lack of resources, management expectations that dietitians would assume non-dietetic duties, and a lack of opportunities for networking with professional peers. Work settings were described as one of four contexts influencing dietitians' practice challenges and satisfactions.

With the exception of one informant who worked in a multi-disciplinary childhood obesity program and another who chose to not work in the area of childhood obesity, work settings of the informants in this study also created experiences that were largely negative. These 11 informants were clearly frustrated with the lack of time and resources available to them to work with children and adolescents. They demonstrated a knowledge and awareness of what constituted current effective management (given the proviso that both research and guidelines are limited), but none had the opportunity to carry out these best practice recommendations. Work in a multi-disciplinary setting was simply not available. In addition, they frequently found themselves working with unmotivated families or families who were 'dragging' in unmotivated children, and they had limited time for appointments and a limited number of appointments. As well, they commented that they were often only able to address one or two food issues or activity related behaviours, once their information gathering was complete, rather than offering a range of management options.

Campbell and Crawford[129] too found that dietitians believed they experienced time constraints in their work that were limiting their treatment options, while Harvey et al.[128] reported that dietitians found 'resource constraints' to be the most influential influences on their weight management practices, with dietitians' reporting limited time available for appointments and follow-up sessions with clients. Similar results were reported by Cowburn and Summerbell in 1998.[127] And in Canada, the dietitians in Chapman's focus groups reported that constraints of their work setting limited their ability to see clients when and as often as needed.[30]

Campbell and Crawford[129] speculated that these work and time constraints could likely be responsible for the fact that dietitians were not able to implement 'best practice' guidelines in their practice. Short appointments and infrequent follow-ups with unmotivated clients go directly against Reilly's evidence-based criteria for potentially successful interventions, including the provision of more time for consultations with families, and more consultations.[47] Similarly, Campbell and Crawford suggested that these time constraints influenced dietitians' ability to provide a range of weight management options, also considered an important component of best practice.[129]

While a detailed analysis of dietitians' weight management strategies was not the intention of this study, the fact that the informants experienced considerable frustration over their inability to practice dietetics in the manner which they believed would be effective is noteworthy. Dietitians are considered by other professionals and the public alike to be effective providers of weight management advice. [129] Their inability to implement recommended treatment strategies due to

work constraints could have a negative impact on this perception. At the same time, Dickin et al.[130] have found effectiveness of nutrition intervention programs may in turn be related to nutrition educators' perception of the value of their program, with better outcomes attributable to educators who believe in the value of the program. Clearly, many of the informants expressed a lack of confidence that their programs were valuable, and that their efforts could be of use – a factor that could also impact their outcomes and effectiveness.

## 5.2 Clients' Motivation

Evidence–based guidelines for the treatment of obesity recommend that clients and families alike be ready and motivated to make behavioural changes.[47] It was encouraging to see that all study informants were aware of this concept of client readiness, as articulated in the Trans-Theoretical Model. Few, however, actually indicated that they assessed the readiness of obese children and youth to make changes prior to treatment. Nevertheless, they did use the concept of readiness in other ways. For example, they tended to attribute their clients' inability to change behaviours, or clients not returning for follow-up and their resultant poor outcomes, to a lack of readiness. At the same time, some informants expressed frustration with their clients' lack of readiness and inability to make change.

Frustration with clients' ability to make behavioural change has also been reported by Chapman[30], and implies a belief that those who are obese are primarily responsible for their condition. This belief is part of a common social construction of obesity in Western society, where obesity "represents the outward manifestation of self indulgence." [107] (p. 305) Rogge et

al.[107] along with others, have suggested that it is this culturally shared meaning of obesity that is the basis for the pervasive discrimination against those who are overweight.[83]

A number of authors have reported that negative attitudes towards obese people are common amongst health professionals, including dietitians[131, 132], a factor that some have suggested could affect their clinical judgment and deter obese people from seeking medical help for weight loss.[133] Berryman et al.[133] reported on finding no difference in overall attitudes between dietetics students and a control group, and a level of fat phobia similar to that of white women. This, they suggest, indicates that dietetics education does not adequately dispel common cultural prejudicial attitudes, a factor which could impact dietitians' ability to work effectively with obese children and youth. In speaking about their frustration with clients, some informants observed that before they had 'matured', their behaviour towards obese people was less than favourable, lending weight to such fears.

Devine et al.[28] include client motivation as an aspect of client characteristics in their ecological model. In this model, client characteristics, needs and expectations comprised one of four contextual issues that influenced dietitians' work challenges and satisfactions.

My results suggest that this aspect also overlaps with dietitian characteristics (another of Devine et al.'s contexts) in terms of their response to their clients' perceived motivation. This response is, at the same time, a reflection of the impact of societal norms on dietitian beliefs about obesity. That these different contextual issues influence and inform each other is a salient feature of Devine's ecological model.

These results indicate, as Berryman et al.[133] have suggested, that education programs for dietetics students that actively work towards reducing negative attitudes towards obesity are warranted. Such programs may be of value in helping dietitians be less frustrated with their clients, as obese children and youth continue seek help in increasing numbers. At the same time, reducing negative attitudes towards obesity in the dietetics profession may serve to enhance their ability to work both compassionately and effectively with this population.

### 5.3 Clients' Needs and Expectations

As described by informants, children and youth and their families sought dietary counselling for weight loss because they wanted to lose weight. They wanted clear direction (i.e. structured diets) on what they needed to do so that they could achieve the positive outcome of weight loss. Their expectations were such that they believed the dietitian could help them achieve this goal.

Unfortunately, these needs and expectations were at odds with informants who believed that weight loss was not an appropriate goal for obese youth and who remained themselves uncertain of the outcomes of their interventions. This resulted in frustration for both, and on several different levels.

At the practice level, the dietetics profession places great import on the concept of client-centered counselling.[104] The informants were aware of this and expressed the belief that their client's needs and wishes were very important. By not honoring clients' goals, informants are going against the recognition that in a client-centered model, goal setting should be a collaborative effort. However, for the most part they did not acknowledge that these disparate goals were problematic, suggesting that their belief in doing no harm (i.e., placing people on

diets), superceded the importance of the therapeutic relationship – a concept which remains largely unexplored in the dietetics profession.[104]

On a more pragmatic level, by not focusing on weight loss and by de-emphasizing weighing obese children and youth, informants were left without measurable outcomes. With the exception of one, none of the informants had any other objective measures of whether or not their interventions were successful. Their frustration and disappointment with this was significant, suggesting that this is an area of pediatric weight management that bears further investigation. Only one of the informants expressed satisfaction with her weight management work. She ascribed this, in part, to the fact that outcomes were both obtained and measured in a clinically meaningful way in the context of the multi-disciplinary program in which she worked.

Devine et al.[28], also found dietitians experienced frustration with this aspect of their work. Evaluation of outcomes was considered to be an important and satisfying aspect of their work. When this was thwarted, frustration resulted. As documented by the American Dietetic Association[24], the issue of outcome measurement is a significant one in the dietetics profession, and dietitians have been called upon to provide such data in an effort to contain costs and justify services. As the frustration and disappointment of informantsin this study suggests, dietitians working in the area of weight management are in need of guidance and support regarding what constitutes an appropriate outcome. The latest report by the American Dietetic Association regarding outcomes in pediatric obesity is perhaps a reflection that this issue has become a significant one for many dietitians working in this area. They note that weight should not be a focus of interventions, and instead state: " It is critical that dietetics professionals communicate behavioral, psychosocial, and medical end points to their colleagues and clients." [24] (p. 940)

Precisely what these endpoints might be, how they can be evaluated and when they should be measured, is an issue that will require both dialogue and training amongst dietitians, who traditionally, have relied on weight as their marker of choice.

## 5.4 Dietitians' Counselling Training and Skills

Most informants questioned whether they had the professional counselling skills that were needed to be successful in helping obese children and their families. In particular, they believed they were unable to deal with complex family dynamics and individual emotional issues. Their explanations for why they lacked these skills included inadequate training, as well as a lack of personal maturity and life experience at the outset of their careers. This questioning led many to wonder about their ability to actually help their clients, and in some cases to be fearful that they may do harm. Those who were parents noted that this experience had enabled them to feel more comfortable working with children, but only one informant who had received specialized counselling training expressed confidence that she could work effectively in this area.

Several recent studies in Canada and abroad exploring dietitians' experiences in working with clients (overweight and other), have found that dietitians believe that they are lacking the necessary counselling skills to facilitate behaviour change with clients, to address emotional issues, and to work with families in client sessions.[23, 27, 28, 30, 57, 102]

Barr et al.'s [57] finding that Canadian dietitians did not feel their undergraduate training prepared them for weight management, was clearly echoed by the informants in this study. Similarly, Story et al.'s findings, [27] as well as those of MacLellan and Berenbaum [23], that dietitians have expressed a strong interest in further education and training in counselling, were iterated by

informants in this study. These findings support the growing awareness of a pressing need for improvement in training at the undergraduate level in Canada, especially with regards to counselling techniques that include behavioural and other strategies. Similarly, opportunities for those professionals already practicing dietetics are necessary. MacLellan and Berenbaum[23] found that one third of their participants had received no further training since their internships, while Story et al.[27] noted that a high proportion of the health care professionals they had surveyed, identified continuing education as preferred a education method. Barr et al.[57] also found this in their survey of Canadian dietitians, as well as a preference for informal 'mentoring' type training.

In Devine et al.'s [28] ecological model of dietitians' practice challenges and satisfactions, personal characteristics are highlighted as another important contextual influence. They described these characteristics as including work and professional development opportunities, roles (including parenting) and their own career path.[28] As the informants in this study have described, all of these factors came into play in their experiences of weight loss counselling – some in a positive way, others negative.

Obesity prevalence, as we have seen is growing. If dietitians are to feel confident, continue in their role as trusted experts in weight management, and maintain their position as "the group to whom medical practitioners most often refer their overweight clients,"[129] (p. 702) then further training both at the undergraduate level and in continuing education, would seem to be essential.

## 5.5 Influence of the Larger Practice Environment

There are many different issues and components that go into making up the larger practice environment of dietitians and weight loss counselling. It was apparent that the concepts of size acceptance and non-dieting had influenced all of the informants in their work. For the most part, all had adopted a non-dieting 'lifestyle' approach, in keeping with best practice guidelines. However, it was also apparent that some had difficulty with this approach. At the same time, some articulated a belief that a size acceptance perspective might be more helpful for youth, but were aware that this was not well received by clients, and some were uncomfortable with this approach when health issues necessitated weight loss. As a result, many remained conflicted about which approach would be most helpful for obese children and youth.

These results are similar to those found by Marchessault[10] as well as Barr et al.[57], who explored Canadian dietitians' views and practices regarding obesity and weight management in adults. Barr et al.[57] found that Canadian dietitians were following a lifestyle approach to weight management, with a partial embracing of the size acceptance perspective, to the extent that they discouraged the practice of weight monitoring. This would suggest a degree of uncertainty with the size acceptance concept in practice, something that Wray [11] also found. Marchessault[10], who did a closer examination of dietitians' understanding and use of non-dieting and size acceptance approaches in weight management, found evidence that dietitians had differing understandings of both size acceptance and non-dieting in their use of weight management strategies. She suggested that clarification of terminology and practices common to these approaches would be useful in assisting dietitians to reflect on their own perspectives and practice.

Devine et al.[28] limited their description of the larger practice environment which influenced practicing dietitians in New York State, to the so-called 'toxic' environment of unhealthy food choices and a limited activity environment. My results suggest that in this region, at least, this concept needs to be broadened to include other domains, such as cultural understandings of obesity (as we saw in section 5.3.1) and perhaps more importantly, emerging approaches to the treatment of obesity. The uncertainty and confusion that informants experienced regarding these different approaches, is likely to have had an impact on the way they practiced and interacted with clients as well as their confidence in their work. Both of these have implications for dietetic practice.

## 5.6 Continuing to Work Despite Distress

On a different note, Gingras suggests that dietetic education has a role to play in preparing dietitians for the reality of their practice [134], a reality that includes the full complexity of emotional interactions with clients and culture. In her study of dietetic practice she states: "The paucity of dietetic curricula that privileges embodied knowledge (ideas/ imagination/ emotion) over technical knowledge might predict the distress experienced by dietitians later in practice."[134] (p. 274) She goes on to say that if during times of conflict dietitians have the opportunity to express their feelings and ideas with colleagues, resolutions could be identified, and conflict alleviated.

As my results show, informants did, over time, find ways of alleviating their distress. But this was not necessarily a productive or a timely process, in the sense of finding solutions that favoured resolution of conflict, or solutions that benefited clients. Rather, most informants, in a

very individual and happenstance manner, found ways of working that alleviated their own discomfort. Some 'trod carefully' with obese youth, some sought out the skills they believed they lacked and some moved away from providing individual treatment to obese youth. One dietitian was fortunate to have found a way of working that addressed all of the challenges she had been experiencing in this area. She alone felt confident in her work with obese youth.

During our interviews, many informants expressed gratitude to be able to talk about their frustrations and challenges. At the same time, many expressed dissatisfaction with the support they felt they were receiving from their professional association. In consideration of Gingra's observations, had there been opportunities for these informants to articulate their dilemmas and share their experiences early on and throughout their careers, it is entirely possible that productive solutions could have been explored collectively, in a manner that could enhance the strength of the profession. There is a need for the profession to take the lead in facilitating such opportunities for students and practicing dietitians.

## 5.7 Implications for Practice

Devine et al.[28] have suggested that challenges that leave practitioners feeling dissatisfied may impact professional retention. Similarly, in her exploration of dietitians' education and practice, Gingras suggests that a desire to leave a specific position or the profession entirely emerges "when promises of professionalism are discontinuous from the expectations attached to dietetic education and performativity; dietetic theory and practice."[134] (p. 273) The evidence in this study suggests dietitians face significant distress, sometimes referred to by others as 'practice challenges'[25, 28, 30] in four major contexts in their working lives including their work context, that

of their clients' and their own professional lives, as well as that of the larger practice environment. One informant had chosen to not work in the area of childhood obesity, while others were considering leaving it. My results support Devine et al.'s suggestion that efforts to improve nutrition and dietetics practice need to take into consideration the experiences of dietitians on all these different levels.[28] Acknowledging these practice challenges would serve to validate the experiences of dietitians and could pave the way for much needed dialogue.

Specifically, in recognition of the time and resource limitations for dietitians working in the public health sector, there is a role for the dietetics profession to advocate for services that have a hope of adhering to 'best practice' guidelines for the treatment of childhood obesity. Dietitians are considered by other professionals and the public alike to be effective providers of weight management advice. [129] Their inability to implement recommended treatment strategies due to work constraints could have a negative impact on this perception.

There is a strong and obvious need for education and training in the area of counselling, both supportive and behavioural, if dietitians are to feel comfortable and competent in this area. Similarly, education programs for dietetics students that actively work towards reducing negative attitudes towards obesity are warranted. Such programs may be of value in helping dietitians be less frustrated in their work with obese youth as they continue seek help in increasing numbers.

There is a need for dialogue regarding emerging treatment paradigms. Clarification of terminology and practices common to size acceptance and non-dieting approaches would be useful in assisting dietitians to reflect on their own perspectives and practice. This would help

dietitians to explore their own belief systems, and find ways of working that are congruent with these. Similarly, if dietitians are to employ behavioural and psychosocial endpoints as outcome measures, as recommended by the American Dietetic Association, both dialogue and training amongst dietitians, who traditionally, have relied on weight as their marker of choice, will be necessary.

In addition, my results suggest there is much room for improvement in the area of dietitian-client interactions. While client experiences were not explored directly, indirect evidence from informants indicated several areas of conflict – both evident and potential. Ahmed, in her recent dissertation[135], explored parents' experiences of seeking health care for their children who are overweight or obese. They reported a high level of dissatisfaction with health care providers' services, and a lack of resources and supports in the community. Parents found the advice they received tended to be simplistic and did not take into account the challenges they faced in carrying out this advice. The parents reported having their concerns dismissed and feeling blamed for their child's obesity. These reports are remarkably similar to the challenges experienced by the informants in this study. Attention to counselling education and training would have an obvious impact on improving such encounters, as would dialogue, education and support regarding treatment approaches, outcomes and attitudes towards obesity.

While this study focused on the experiences of dietitians working with obese children and adolescents, it could be argued that many of the same issues apply to working with obese adults. The realities of challenging work contexts as well as those in the larger practice environment will remain the same, whether dietitians are working with children or adults. Dietitians' lack of clarity regarding size-acceptance and non-diet approaches will impact their work with adults in

much the same way as children. Similarly, public and professional 'framing wars' will influence their attitudes to adult treatment approaches, in much the same way that their attitudes towards obesity will influence their work with obese clients – adult or child. Dietitians' experiences of competence in counselling ability are not likely to differ whether they are working with the young or old, nor will their need for work environments that allow them adequate time and resources to follow 'best practices' to meet the needs of their clients. In these regards, practice issues regarding education, training and support will likely be as pertinent for dietitians working with adults as for children and youth.

## 5.8 Implications for Research

My results reflect the continuing need for research into effective treatment approaches for childhood obesity. To date, there is insufficient data to support the use of individual nutritional counselling in weight management of childhood obesity. [47 48, 54] Does this mean that dietitians should not be providing nutritional counselling and support pertaining to weight loss in isolation? Should dietitians who are not part of a multi-disciplinary program continue to see overweight and obese youth? Do we risk losing satisfaction and confidence when we let dietitians continue to work in isolation, with little support and few resources? Do we risk harming the confidence of the public in dietetic expertise, when we limit client weight loss contact to brief and infrequent appointments? These are questions that demand answers. Further research into the experiences of dietitians and their young clients' experiences of obesity counselling will add depth and substance to our knowledge of this challenging area.

Research is also needed to determine which outcome measures should be used when working with child and adolescent obesity. If not weight, then what? What should our goals be? Should

we continue to ignore the wishes of our clients for weight loss, or is there value in continuing with our current approach? Does a size-acceptance philosophy strengthen or weaken the dietitian-client relationship? Is it helpful or harmful? These are just a few of the questions that further research could address in this area. As discussed previously, some of these questions may be equally applicable to dietitians' work with adults. In particular, further research regarding the utility of size-acceptance and non-diet approaches in this older group, and its impact on the dietitian-client relationship are warranted.

### 5.9 Study Limitations

This study used a qualitative research approach to carefully study a small group of English speaking, female dietitians living in the Lower Mainland of British Columbia and on Vancouver Island. The findings are not generalizable or transferable to other groups. Rather, as with most qualitative research, the intent was to obtain a deeper understanding of the experiences of dietitians.

The quality of this research project relied heavily on the quality of the interview and the ability of the researcher to elicit meaningful conversations. Being a mother of two teens, a Masters' student and a full time employee while carrying out this research, made time and energy a limiting factor for me in terms of the numbers of informants interviewed and the amount of data collected. Clearly, more interviews with more dietitians in more regions and in more work settings would enhance the transferability of this study. In spite of the aforementioned time and resource limitations, I believe that I was able to achieve a rich collection of data from the 13 informants, both in terms of the length of time spent in initial and follow-up interviews and the

fact that all initial interviews were transcribed verbatim – allowing an in-depth immersion of their experiences. On the down-side, my interviewing experience was limited, which may have limited my research findings. However, I attempted to minimize leading informants in the interview by using a semi-structured interview. They could have misrepresented their experiences in the interview, because I, like them, am a registered dietitian. Social desirability bias, which represents a tendency to distort responses to present a favorable image, may have been at play. However, I believe this was unlikely with these informants. They spoke freely of their experiences and many expressed gratitude to have their experiences sought out, some saying they felt isolated working in this area. Because I was a practicing dietitian who shared a common knowledge and understanding of dietetic practice, I believe informants were able to speak to their emotional experiences, providing me with the opportunity to develop thick descriptions of their experiences. In part, it is the rich detail that enables the reader to judge whether or not the findings from this study may be transferable to other situations or populations

My inability to find more than one dietitian participant who was experiencing success in her interventions with obese youth was a significant limitation in my ability to reach thematic saturation. As mentioned, time and resource limitations precluded me from expanding my search outside of the Lower Mainland and Vancouver Island. It would be most fruitful to interview other dietitians who are able to voice practice successes working with obese youth, to determine if my one informant was really an exception to the others, or whether she was part of another group of dietitians with very different practice experiences. For example, dietitians working in multi-disciplinary settings could have experiences very different from the majority of study informants, by virtue of that particular set of circumstances. Unfortunately, no such

programs were available at the time I collected my data, and dietitians with successful experiences did not respond to my initiatives, nor were any identified by informants. A further limitation was my decision to purposively select only one dietitian who had made a conscious decision to not work with obese youth. Given the difficulty I had finding informants who *were* working with this population, it is quite likely there were many who had chosen not to. An understanding of their reasons for such a choice would serve to deepen our understanding of the complexities involved in this area of dietetic practice. However, my decision to interview only one dietitian was based on my wish to add some analytic depth to my research, rather than extend my research question.

I also tried to enhance my dependability of the findings by performing member checks with my results, wherein I provided most of them with a summary of my findings for their comments and validation. While I made some successful attempts to obtain feedback on my data interpretation, and re-interviewed several informants, not everyone responded to my requests. I did, however, have the opportunity to share my results with several dietitians who did not take part in the study at a childhood obesity conference in Vancouver, and received feedback that validated my findings. A few exclaimed that no one had ever addressed the extent of their frustration with this work, and were pleased to have this experience validated. Another said she thought it was "about time" for someone to talk about the difficulties involved in working in pediatric obesity. All hoped to be able to talk with others about their experiences, but did not know how this could happen, given their isolated positions in disperse communities. Regardless of the limitations of this study, the insights that it has generated are valuable for improving our understanding of the

experiences of dietitians who do weight loss counselling with the pediatric population in this region.

## 5.10 Summary and Conclusions

The purpose of this study was to develop a deeper understanding of the impact of the obesity management maelstrom on dietitians who work with children and adolescents, from the perspective of a group of practicing dietitians. This was accomplished with an exploratory approach that included interviewing 13 practicing dietitians in the Lower Mainland and analyzing the transcripts of these interviews for common themes.

My results showed that the informant dietitians were experiencing significant distress in their practice, including frustration, uncertainty and both personal and professional doubt. This distress related to four primary issues identified by informants over the course of our conversations. These included their experience of inadequate time and resources to do their work effectively, their perception of the client readiness to make behavioural change, their perception that, as dietitians, they lacked the appropriate counselling skills to be helpful to their clients and finally, their uncertainty about how to best deal with the complex problem of obesity.

With reference to the ecological framework of Devine et al[28], it became apparent that there were a variety of variables that influenced these dietitian informants and shaped their experiences and practice. These variables included their work context, their interactions with clients – which were made up of the clients' expectations and needs, as well as the personal and professional expectations and demands of the dietitians themselves - and the influence of society at large.

Informants' experience of distress was itself a variable in shaping the way they each responded to their circumstances, a factor that has significant implications for the profession.

In conclusion, dietitians' knowledge and understanding of childhood obesity and its treatment is in the process of changing. Effective solutions to this growing problem are not yet apparent, yet demands for solutions from overweight youth and an overburdened health care system, are increasing. This is creating substantive conflict for dedicated dietitians, who are attempting to adapt to this rapid change. Despite their best efforts, they are feeling unsupported in their work, inadequately trained to support their clients, unable to help in a meaningful way and uncertain how their profession should best proceed. As a result of these experiences, some are choosing to discontinue doing this kind of work, a factor that has tremendous implications for the dietetics profession who refer to themselves as "the experts in the science of food and nutrition."

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# Appendix A

## Letter of Initial Contact

## THE UNIVERSITY OF BRITISH COLUMBIA

**Food, Nutrition and Health**
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NAVIGATING THE DIETING MAELSTROM: HOW HAVE DIETITIANS RESPONDED TO THE TURBULENT WATERS? (Masters of Science Thesis)

Dear Dietitian;

We are writing to ask you to participate in a research study. Our primary aim is to gain insight into how dietitians who work with children and adolescents, have responded to the many developments that have been taking place in the field of dietetics and weight loss counselling over the past decade. There is now a great deal of diversity in the way dietitians practice their trade. We want to learn more about how you and others now carry out the work you do in this area. We hope to develop a better understanding of what is going on in actual clinical practice, so that we can support dietitians in their efforts. To this end, we are interested in hearing your stories of working with children and adolescents around weight loss issues. We want to talk to you about the joys and frustrations you may experience, as well as your insights and perceptions into this challenging area of practice.

This is a qualitative research study, and as such, data will be collected in the form of personal interviews with interested participants. If you agree to participate, the co-investigator (Shelagh Bouttell) will interview you for 60 – 90 minutes, at a time and location of your choosing. This interview will be audio taped and transcribed by Ms. Bouttell, who will then code and analyze it (and others') for common themes and patterns. Over time, as yours' and other interviews are analyzed, Ms. Bouttell may wish to interview you a second time to clarify and confirm themes that are arising from the data. The total time commitment to this project will be no more than one (1) to three (3) hours. Ms. Bouttell is working under the guidance of her faculty advisor - Dr. Gwen Chapman, Associate Professor in Food, Nutrition and Health, Faculty of Agricultural Sciences at the University of British Columbia.

Should you agree to participate, all transcripts and data pertaining to your interview will be identified by a pseudonym, and your name will never be associated with your responses. Data will be maintained in a locked filing cabinet until the completion of the study, when it will be

destroyed. If you have any questions with respect to the study, you may speak with either Gwen Chapman (principal investigator) at xxx-xxxx or Shelagh Bouttell (co-investigator) at xxx-xxxx.

Your participation is completely voluntary. You may withdraw at any time and request that your interview be withheld from the study.

Thank you in advance for considering your participation in this project. If you wish to participate, please contact Shelagh Bouttell at xxx-xxxx or email her at: shelagh_bouttell@xxx

Please note that if we have not heard from you, we will contact you by telephone approximately 1 week after you have received the letter, simply to ask if you are interested in participating. If you are interested, Ms. Bouttell will ask you some questions about your work experience, answer any questions you may have about the study, and arrange an acceptable time and location for an interview. If you do participate in the study, you will be asked to sign an 'informed consent' form at the time of your interview. Following the interview, you may be invited to suggest the names of other colleagues who you think would like to be approached to participate in the project. This strategy is known as 'snowballing' and is often used in qualitative research studies to reach appropriate participants. As usual, you may decline at your discretion.

Sincerely,

Gwen E. Chapman PhD
Principal Investigator
Associate Professor
Food, Nutrition and Health
University of British Columbia

Shelagh A. Bouttell RDN
Co-Investigator
Masters of Science Candidate
Food, Nutrition and Health
University of British Columbia

## Appendix B

## Letter of Initial Contact(revised)

## THE UNIVERSITY OF BRITISH COLUMBIA

**Food, Nutrition and Health**
Faculty of Agricultural Sciences
2205 East Mall
Vancouver, B.C. Canada V6T 1Z4
Phone: xxx-xxxx
Fax: xxx-xxxx

NAVIGATING THE DIETING MAELSTROM: HOW HAVE DIETITIANS RESPONDED TO THE TURBULENT WATERS? (Masters of Science Thesis)

Dear Dietitian;

We are writing to ask you to participate in a research study. Our primary aim is to gain insight into how dietitians who work with children and adolescents, have responded to the many developments that have been taking place in the field of dietetics and weight loss counselling over the past decade. There is now a great deal of diversity in the way dietitians practice their trade. We also want to speak with dietitians who have chosen not to work in this area of practice. We want to talk to you about the joys and frustrations you may have experienced, as well as your insights and perceptions into this challenging area of practice. We hope to develop a better understanding of what is going on in actual clinical practice, so that we can support dietitians in their efforts. To this end, we are interested in hearing your stories of working with children and adolescents around weight loss issues.

This is a qualitative research study, and as such, data will be collected in the form of personal interviews with interested participants. If you agree to participate, the co-investigator (Shelagh Bouttell) will interview you for 60 – 90 minutes, at a time and location of your choosing. This interview will be audio taped and transcribed by Ms. Bouttell, who will then code and analyze it (and others') for common themes and patterns. Over time, as yours' and other interviews are analyzed, Ms. Bouttell may wish to interview you a second time to clarify and confirm themes that are arising from the data. The total time commitment to this project will be no more than one (1) to three (3) hours. Ms. Bouttell is working under the guidance of her faculty advisor - Dr. Gwen Chapman, Associate Professor in Food, Nutrition and Health, Faculty of Agricultural Sciences at the University of British Columbia.

Should you agree to participate, all transcripts and data pertaining to your interview will be identified by a pseudonym, and your name will never be associated with your responses. Data will be maintained in a locked filing cabinet until the completion of the study, when it will be

destroyed. If you have any questions with respect to the study, you may speak with either Gwen Chapman (principal investigator) at xxx-xxxx or Shelagh Bouttell (co-investigator) at xxx-xxxx.

Your participation is completely voluntary. You may withdraw at any time and request that your interview be withheld from the study.

Thank you in advance for considering your participation in this project. If you wish to participate, please contact Shelagh Bouttell at xxx-xxxx or email her at: xxxx.

Please note that if we have not heard from you, we will contact you by telephone approximately 1 week after you have received the letter, simply to ask if you are interested in participating. If you are interested, Ms. Bouttell will ask you some questions about your work experience, answer any questions you may have about the study, and arrange an acceptable time and location for an interview. If you do participate in the study, you will be asked to sign an 'informed consent' form at the time of your interview. Following the interview, you may be invited to suggest the names of other colleagues who you think would like to be approached to participate in the project. This strategy is known as 'snowballing' and is often used in qualitative research studies to reach appropriate participants. As usual, you may decline at your discretion.

Sincerely,

Gwen E. Chapman PhD
Principal Investigator
Associate Professor
Food, Nutrition and Health
University of British Columbia

Shelagh A. Bouttell RDN
Co-Investigator
Masters of Science Candidate
Food, Nutrition and Health
University of British Columbia

# Appendix C

## Informed Consent by Subjects to Participate in a Research Project

**Navigating the Dieting Maelstrom: How Have Dietitians Responded to the Turbulent Waters?**

This is the title of a Master's thesis being carried out by Shelagh Bouttell RDN MSc. Candidate (XXX-XXX-XXXX); Faculty of Agricultural Sciences, University of British Columbia, Vancouver, B.C., under the guidance of Principal Investigator: Gwen Chapman PhD RDN Faculty of Agricultural Sciences, University of British Columbia Vancouver British Columbia Telephone XXX-XXX-XXXX.

*Purpose*

The purpose of this study is to gain insight into how dietitians who work with children and adolescents, have responded to the many developments that have been taking place in the field of dietetics and weight loss counselling over the past decade. The investigators hope to develop a better understanding of what is going on in actual clinical practice, in order to support dietitians in their work.

*Procedure*

You have been selected along with several other dietitians working in British Columbia who have worked with overweight children within the past 5 years, to be interviewed with the use of a semi-structured questionnaire by the co-investigator for approximately 1 hour. You may also be asked for a follow-up interview that would last no longer than 1 hour. The interviews will be audio taped and transcribed. As analysis of the interviews proceeds, more dietitians will be selected on the basis of theoretical sampling, to extend and deepen the analysis. In order to facilitate this, you may be asked if you would like to recommend a colleague to be contacted as a potential participant. You may decline at your discretion.

*Confidentiality*

Any information that is obtained during this study will be kept confidential to the full extent permitted by law (as per the Professional Code of Ethics for the Dietitians of Canada, of which the researcher is a member). Knowledge of your identity is not required for this project. Neither you nor the investigators will be required to write your name or any other identifying information on the research materials. Materials will be held in a secure location and will be destroyed after the completion of the study. Data records will be stored in a locked box at the co-investigators place of residence

### *Contact for information about the study*

If you have any questions or desire further information with respect to this study, you may contact Gwen Chapman or one of her associates at xxx-xxxx.

### 1 Contact for information about the rights of research subject

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at xxx-xxxx.

*Consent*

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Subject Name _____ (please print)

Subject Signature _____Date_____

Signature of a Witness_____Date_____

*Consent form: Version 2 January 19, 2003*

Appendix D

## Interview Guide

I am interested in understanding some of your experiences working with young people who are dealing with overweight. There is no right or wrong way to answer the questions, they are intended to serve as a framework for the topic being discussed, not as a test of the informants expertise nor as a judgement of their practice.

### Demographics: who is being interviewed

Can you tell me a bit about your professional background?

- Year of graduation? Where? Internship? Where?
- Primary nature of your practice? Years of practice?
- Workshops, continuing education, counselling background?

This info will be asked throughout the interview, or at the end.

### Clinical Practice

If you were training me to work with you in this area, where would you begin?

What are some of the issues involved in working with overweight children?

Can you tell me a bit about some of the clients you have worked with in your practice?

Can you tell me about a specific client that you felt really good working with. What was good about it? Tell me more: probe for family and other involvement; strategies used in counselling etc

Can you tell me about a client or a situation that wasn't such a good experience? What made it different? Tell me more: probe for strategies used, family involvement etc.

What to you would be a successful outcome of an intervention? How do you know when you have been successful?

What in you training prepared you to work with kids? in the weight loss field?

Some people have expressed uncertainty about weight loss counselling with kids. What are your views on this?

What has been your biggest joy in working in this area?

Hopes and fears?

What would you want to say to someone who was considering working in this area of dietetics?

Is there anything else that you would like to say?