Culture & Childhood Obesity: Investigating maternal experiences

Özlem Baykaner

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Abstract

Childhood obesity is one of the most serious and ongoing public health challenges, with the many negative physical and psychological outcomes well acknowledged in the literature. Ethnic and race disparities in childhood obesity in the UK have also been demonstrated. The experience of parenting an obese child however is less well researched, particularly in relation to minority ethnic families living in the UK. The current study aimed to explore minority ethnic parental experiences of childhood obesity. Six semi-structured interviews were conducted with the mothers of obese children, who were from a minority ethnic background.

Interpretive Phenomenological Analysis (Smith, Flowers & Larkin, 2009) was used to identify themes and connections across parents' accounts. Five superordinate themes were identified: 'Ambiguity towards 'fat'', 'The complexity of food', 'Culture & family: torn between worlds', 'Dilemmas of motherhood', 'Managing my child's weight'.

The findings highlighted the complex interactions between ethnicity, acculturation and parental feeding. The importance and meaning of food and its link with culture and heritage was also a key finding. The findings also expressed the significance of family and their involvement in parenting. Negative experiences of health care interventions for their overweight children were also highlighted.

Several research and clinical implications are recommended for healthcare professionals working with this unique client group.

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Chapter 1: Introduction

1.1 Overview

Engaging minority ethnic populations in mental health services is an area of lively debate within clinical psychology. In the United Kingdom (UK), guidance on mental health service provision advocates for mental health workers to be able to deliver culturally sensitive and clinically effective therapeutic interventions (Bassey & Melluish, 2012). Consequently, effective, evidence based therapies that consider and address the needs of diverse communities are required.

The aim of this research study was to explore minority ethnic parental experiences of having an overweight or obese child in the UK. The study sought to understand ideographic experiences of parents from minority ethnic communities based on participants' individual accounts, with the aim to enhance understanding of different cultural ideas on family, food and weight, and to highlight important factors to consider when working with minority ethnic families. The study aimed to contribute to the knowledge base, and existing efforts to tackle the epidemic that is childhood obesity, and aid treatment models to be equitable for families from diverse ethnic backgrounds.

This chapter charts the development of the research aims; starting with a discussion and definitions of terminology in relation to ethnicity, culture and race. The importance of culture will follow moving on to consider the current picture of childhood obesity. Ethnic and Race disparities in childhood obesity will then be underlined. The effects of

childhood obesity will then be discussed, including Physical, Psychological and Social effects, followed by a description of the causes of obesity and the evidence base for nature vs nurture will be highlighted, moving on to the current treatments of childhood obesity. Finally, a review of parental experiences will be examined, arguing that qualitative examinations are needed, leading to the aims, objectives and rationale of the current study.

1.2 Terminology

Concepts, labels and terms are created to establish a shared understanding of a given phenomenon. Undeniably, labels are loaded with intended and unintended meaning (Sewell, 2008), and can be both helpful and risky.

1.2.1 Ethnicity, race and culture

There has been much research into accurately defining the terms 'culture', 'race' and 'ethnicity' and how they relate to one another (Fenton & Sadiq-Sangster, 1996; Shah, Oommen & Wuntakal, 2005; Sewell, 2008; Bhui, 2002). It is beyond the scope of this study to accurately describe the many definitions and intricate relationships between ethnicity, culture, and race. Nevertheless, these concepts are highly complex. Psychological literature often claims that behaviour and beliefs of a particular group is informed by their 'culture' and 'ethnicity', suggesting that culture is intricately tied to ethnicity and thought of as a determinant of behaviour (Gelfand & Fandetti, 1980).

In the current study the terms will be defined as follows to ensure consistency in the context of existing research;

- *Race;* is a phenomenological description based on physical characteristics (Shah et al., 2005).

- *Culture:* describes features that individuals share and which bind them together into a community (Shah et al., 2005).

- *Ethnicity:* is fixed and encompasses religion, language, geography, physical appearance and the culture associated with these factors (Sewell, 2008).

1.2.2 Black Minority Ethnic (BME)

The term or label BME is widely used in the UK to describe minority groups, particularly those who are viewed to have suffered racism or are in the minority because of their skin colour and/or ethnicity (Sewell, 2008). Whilst it has become increasingly popular in government and academic literature, it is important to be critically aware of its problematic connotations. The term BME most reliably conveys disadvantage and, often inferiority (Bhopal, 1997). Referring to people with an acronym is reductionist and depersonalising. Distinguishing between a white majority ethnic group, and a black minority ethnic group is not only exclusionary, but inaccurate as it implies that black people do not belong to an ethnic minority in the same capacity that white individuals may. It also implies that white people all belong to a single group, 'the majority', obscuring significant differences within the white population. Moreover, such

homogenizing terminology that groups diverse minority communities in a single group prevents people from defining themselves in all their complexity and uniqueness (McGoldrick & Hardy, 2004). Therefore, it is important that it should be viewed as a convenient label placed on minority ethnic groups, rather than how individuals would identify themselves. The term has been adapted to 'minority ethnic groups'. The current reversed description, although grammatically incorrect (with an adjective following a noun), makes it clear that those being referred to are ethnic groups, that together or singularly are in the social minority (Sewell, 2008).

In the current study the term 'minority ethnic' will be used. Although the term 'minority ethnic' is used in this report to ensure consistency in the context of existing research, it is recognised as problematic and readers are encouraged to be mindful of its limitations.

1.3 Importance of ethnicity and culture

According to the 2011 census, England and Wales have become more ethnically diverse over the last two decades. It was reported that 86% of the UK population was White (a fall from 92% in the 2001 census) (Peach, 2006). Across the English regions and Wales, London was reportedly the most ethnically diverse area and Wales the least. Generally, in the UK, minority ethnic populations are concentrated in urban deprived areas. However, the distribution of minority ethnic groups in the UK is changing and they are becoming less geographically segregated. It is predicted that the UK is likely to become more multi-ethnic in the future (Ethnicity and National Identity in England and Wales, 2011).

With this prominent ethnic diversity within the UK - particularly in London - comes a wide variety of non-western cultural and religious practices, which in turn influences health care practices. It is important to try to understand where and how ethnic and cultural differences impact on healthcare delivery if health inequalities are to be reduced across the whole population (Szczepura, 2005). Ethnicity may impact on healthcare and access to it at many levels, such as: differences in service uptake; communication issues; culture and attitudes; socio-economic factors and differences in disease prevalence. These differences affect access to services and act as barriers to good healthcare (Szczepura, 2005). It is important to address these barriers to good healthcare as health inequalities for most minority ethnic groups in London in 2011 were reported to be more severe than elsewhere in England and Wales (Ethnicity and Health, 2007; Census, 2011).

1.4 The current picture of childhood obesity

"There is no doubt that obesity is an undesirable state of existence for a child. It is even more undesirable for an adolescent, for whom even mild degrees of overweight may act as a damaging barrier in a society obsessed with slimness" (Bruch, 1975, p. 92).

The terms 'overweight' and 'obesity' are defined as abnormal or excessive fat accumulation that may impair health. There are internationally agreed limits of body-mass index (BMI) to outline those who are under-weight, normal weight, overweight, and obese in adulthood. However, in children, the effects of gender, age, pubertal status and race/ethnicity on growth make classification difficult (Han, Lawlor, & Kimm,

2010). Nevertheless, BMI has been adjusted for age and standardized for children (WHO, 2015). The most commonly used growth and BMI charts in the UK are produced by the Royal College of Paediatrics and Child Health (RCPCH) which are based on the WHO Child Growth Standards (Wright et al., 2002), which commonly uses the 91st and the 98th centiles as cut off points for overweight and obesity respectively.

The World Health Organisation (WHO, 2015) has reported that obesity in childhood is currently one of the most serious public health challenges faced in the 21st century. World trends in childhood overweight/obesity was reviewed in 2006 and it was concluded that the prevalence of overweight and obesity had increased over the last two to three decades in most industrialised countries (except for Russia and Poland) and in several lower income countries, particularly in urban areas (Wang & Lobstein, 2006). Furthermore, the prevalence of obesity doubled between the early 1970s and late 1990s in the UK and the US as well as Canada, Germany, Chile, Finland, France, Australia, Brazil, Greece, and Japan (Wang & Lobstein, 2006).

In 2015 in the UK, it was reported that 26.2% of 4 and 5 years olds measured were either overweight or obese (HSCIC, 2015). It was also reported that a third of children aged 2 to 15 were overweight or obese (HSCIC, 2015), with younger generations becoming obese at earlier stages and staying obese for longer (Johnson, Li, Kuh, & Hardy, 2015). Furthermore, obesity 4-5 year olds living in London has been reported to be at 13% compared to 6% out of London and for 10-11 year olds, it is reported to be at 27% compared with 10% for those children living outside of London (Baker, 2017). Moreover, some scientists suggest this could be an underrepresentation of the

true magnitude of the crisis, and argue that using BMI to measure obesity may underestimate the true scale of the increase in the adiposity of children in the UK (Rennie & Jebb, 2005).

1.5 Ethnic and race disparities in childhood obesity

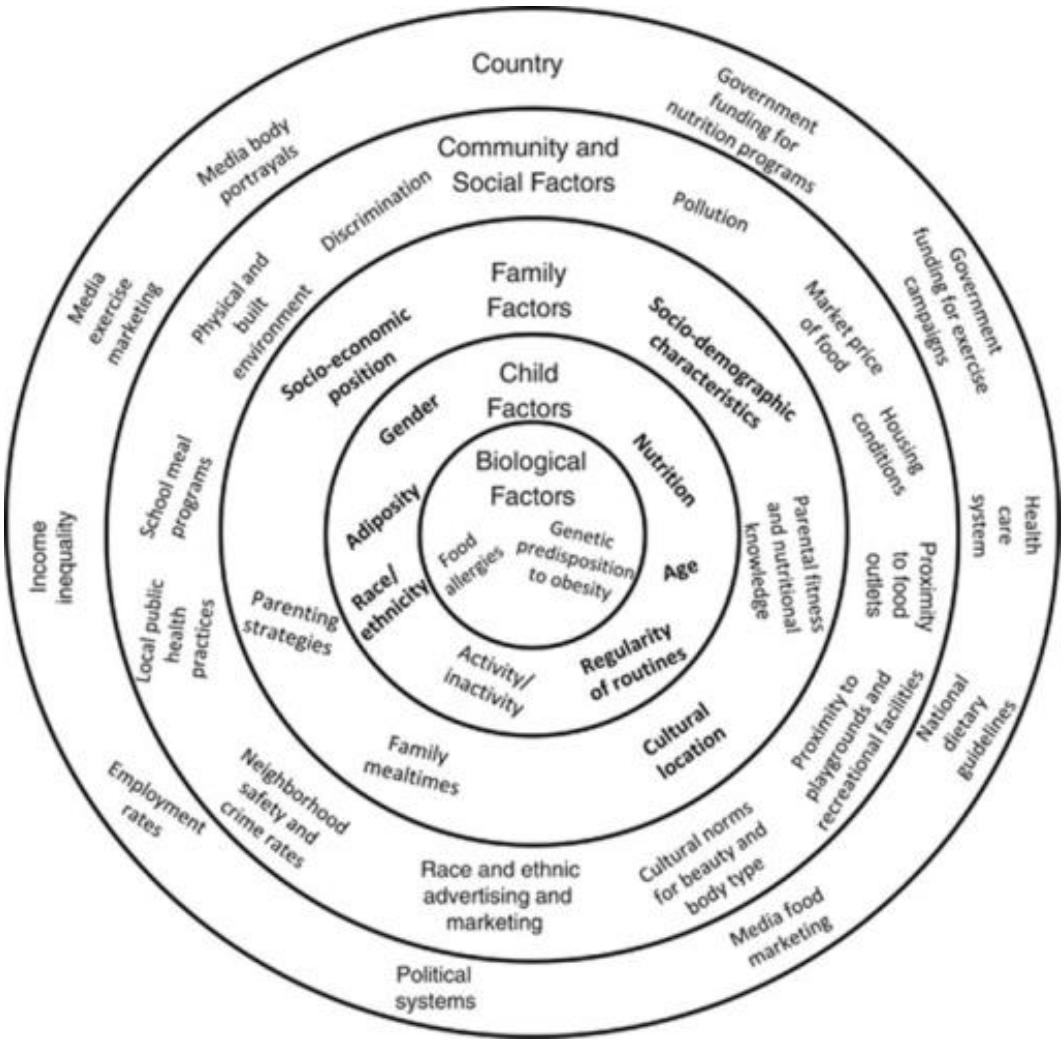
Research indicates that there are clear ethnic and race disparities in childhood obesity. In the UK; Black Caribbean, Black African, and South Asian children are more likely to be overweight or obese compared with White children (Martinson, McLanahan, & Brooks-Gunn, 2012; Hawkins, Cole, & Law, 2009; Harding, Teyhan, Maynard, & Cruickshank, 2008; Balakrishnan, Webster & Sinclair, 2008). Zilanawala, Davis-Kean, Nazroo, Sacker, Simonton, & Kelly, (2015) also found that in the UK, Black Carribbean, Black African and Bangladeshi children were most likely to be obese. This disparity is further supported by the UK parliament who recommend that initiatives to tackle obesity should target school children, lower socioeconomic groups, and minority ethnic groups (The Committee of Public Accounts, 2001).

Research has emphasized the importance of understanding racial and ethnic disparities at early ages (Harding et al., 2008; Weden, Brownell, & Rendall, 2012). Studies have also linked socioeconomic, cultural, nutritional and family routine factors to race/ethnic disparities in overweight and obesity (Weden et al., 2012; Griffiths, Dezateux, & Cole, 2011; Kimbro & Denny, 2012; Higgins & Dale, 2012).

Zilanawala, et al., (2015) created a diagram expressing the measured and unmeasured factors influencing race/ethnic disparities in child adiposity (see Figure 1.) further highlighting the complex nature of childhood obesity particularly for minority ethnic

children.

Figure 1. Diagram of factors influencing race/ethnic disparities in childhood obesity



1.6 Effects of childhood obesity

1.6.1 Physical

Childhood obesity often has serious consequences and adversely affects nearly every organ system in the body. This can lead to hypertension, dyslipidemia, insulin

resistance/diabetes, fatty liver disease, impaired glucose tolerance, and long-term consequences for cardiovascular and liver morbidity (Daniels, 2006; Weiss & Caprio, 2005). Pulmonary disorders, including obstructive sleep apnoea and reactive airway disease are seen more frequently among obese children (Gilliland et al., 2003). Many chronic conditions, such as hypertension and type 2 diabetes, begin their onset during childhood (Daniels, Jacobson, McCrindle, Eckel, & Sanner, 2009). Forty-five percent of newly diagnosed cases of diabetes in children and adolescents in the US, is Type II diabetes, which is an associated symptom of being overweight (American Diabetes Association, 2000). Childhood adiposity may also impact pubertal timing (DiVall & Radovick, 2009). Orthopaedic complaints, including fractures, musculoskeletal discomfort, impaired mobility, and lower limb malalignment are reportedly more common in obese compared to non-overweight children (Taylor et al., 2006).

Research has indicated a clear link between childhood adiposity and negative health factors in adulthood. Children who have a high BMI are more likely to be obese and therefore have obesity related diseases in adulthood (Nader et al., 2006). One study indicated that being overweight or obese between age 14 to 19 was associated with increased adult mortality (from age 30) from a wide variety of systemic diseases (Bjorge, Engeland, Tverdal, & Smith, 2008). High childhood BMI has also been associated with increased risk of cardiovascular disease in adulthood (Owen, Sharp, Shield, & Turner, 2009).

It is a clear government initiative and medical advantage to reduce levels of obesity as research indicates that obesity doubles one's risk of dying prematurely (Pischon, et al., 2008). This compelling evidence regarding the detrimental physical implications of

childhood adiposity highlights a strong motive for research to continue in this area.

1.6.2 Psychological

Psychological morbidity is likely to be the most widespread health impact in childhood (Dietz, 1998). Longitudinal literature has indicated a bi-directional relationship with obesity predicting the emergence of psychiatric symptoms (e.g. Anderson, Cohen, Naumova, Jacques & Must, 2007) and psychiatric symptoms predicting obesity (e.g. Franko, Striegel-Moore, Thompson, Schreiber, & Daniels, 2005). Furthermore, a systematic review of health consequences of obesity concluded that obese children are more likely to experience psychological or psychiatric problems than non-obese children, that girls are at greater risk than boys, and that risk of psychological morbidity increases with age (Reilly et al., 2003). Low self-esteem and behavioural problems were especially associated with obesity even after controlling for several other variables, including intelligence quotient (Reilly et al., 2003). However, it is of note that Reilly and colleagues (2003) review of the literature only included five articles that incorporated psychological implications of childhood obesity out of 29 journals in the total review. Nevertheless, they report stringent inclusion and exclusion criteria and state that the journals they included were of a high methodological quality (Reilly et al., 2003).

Being obese/overweight is a highly-stigmatised condition, and these individuals face social exclusion and discrimination in many areas of their lives (Puhl & Brownell, 2001; Wardle & Cooke, 2005). Furthermore, children, as well as adults have been reported to stereotype the obese as ‘stupid’, ‘lazy’, and ‘ugly’ (Wardle, Volz & Golding, 1995; Latner & Stunkard, 2003). Research has highlighted that weight related

teasing is common (Puhl & Brownell, 2001; Boutelle, Neumark-Sztainer, Story & Resnick, 2002) and as a result, it has been anticipated that obese people, particularly children and adolescents, will experience poor psychological health and well-being (Wardle & Cooke, 2005). Literature indicates that the psychological areas thought to be most severely impacted by overweight/obesity are; body image, self-esteem and emotional well-being (Wardle & Cooke, 2005).

1.6.2.1 Body dissatisfaction

Excessive weight concern and dieting, and its continual publication in the media has driven extensive literature on body image in children and young people to be conducted. In a review of the literature published in 2001, it was concluded that there are consistent findings of a relationship between increased BMI and body dissatisfaction in children, predominantly in girls (Ricciardelli & McCabe, 2001). However, few studies include clinical populations seeking treatment for obesity – possibly indicating an assumption that those seeking treatment for obesity are self-selecting as having body dissatisfaction and therefore it is not necessary to investigate. In one clinical population study it was found that body dissatisfaction was significantly reduced in 7–17 year olds during 10 months of inpatient treatment for obesity, and remained significantly lower than at baseline at a 14-month follow-up (Braet, Tanghe, Decaluwé, Moens, & Rosseel, 2004), suggesting an association between obesity and body-dissatisfaction within clinical samples.

There is an overwhelming body of community-based studies which document greater body dissatisfaction in heavier children and adolescents (Muris, Meesters, Vande &

Mayer, 2005; Presnell, Bearman & Stice, 2004; Eisenberg, Neumark-Sztainer & Story, 2003; Vander Wal & Thelen, 2000; Vander Wal, 2004; Thompson et al., 2007). However, it is important to consider the methodological limitations of these studies when interpreting the findings. Many of the studies are correlational in nature, and cross-sectional, making it impossible to infer causality, thus it is unknown if overweight causes greater body dissatisfaction or body dissatisfaction causes weight gain in children and adolescents. Furthermore, much of the studies relied solely on self-report data. Although adolescents are generally considered to be the best reporters of internalising symptoms (e.g. negative affect and body dissatisfaction) (Presnell, Stice, Seidel, & Madeley, 2009), reports from friends or family members could provide additional objective information. Another limitation of these studies is the homogeneity of the samples with small numbers of minority ethnic groups, which limits the generalisability results.

Nevertheless, this literature generally reflects the belief that body dissatisfaction is a greater problem for heavier children and adolescents, particularly, girls; however, many studies included only female participants. Research has indicated that females are more likely than males to describe themselves as fat, to weigh themselves often, and to diet frequently (Thompson et al., 2007). Women have also been found to be more generally dissatisfied with their physical appearance compared with men (Cooper & Fairburn, 1983; Furnham & Calnan, 1998). The most noticeable difference in body-image perceptions between the sexes is dissatisfaction with weight and, to a smaller extent, with shape (Berscheid, Walster, & Bohrnstedt, 1973). Franco, Tamburrino, Carroll, & Bernal, (1988), and Miller, Coffman, & Linke (1980) have shown that men are also dissatisfied with their weight and shape, although somewhat less so than women; yet

other studies that examined gender differences found none (Eisenberg et al., 2003; Hill, Draper & Stack, 1994). This discrepancy may be linked to body dissatisfaction often being operationalised in relation to seeing oneself as overweight rather than underweight. Researchers comparing male and female dissatisfaction with their weight need to consider the direction of the dissatisfaction. Dissatisfaction with body image in women is usually described by their desire to lose weight, whereas as equal proportions of males wish to gain weight as lose it (Furnham, Badmin, & Sneade, 2002).

Race and ethnic differences in body dissatisfaction have been neglected in the literature, particularly within the UK. However, Schreiber et al. (1996) found that even though African American 9- and 10-year-old girls were heavier than their Caucasian counterparts, they were less dissatisfied with their weight, body shape, and body parts. Furthermore, a review of research in the US showed that African-American girls consider themselves to be attractive and socially acceptable at a higher BMI than Caucasian girls (Padgett & Biro, 2003). These findings suggest that African American children may not be exposed to the same attitudes and messages about dieting and thinness from their family, peers, and the media, as are Caucasian children (Lawrence & Thelen, 1995). To more fully explore the cultural differences around body image concerns among children, we need to examine the types of messages children receive from parents, peers, and the media about weight-related attitudes and behaviors. Researchers have begun considering the role and influence of both parents and peers on young children's body image concerns, but this research has largely been confined to the study of Caucasian children.

1.6.2.2 Self-esteem

Self-esteem reflects a person's overall subjective emotional evaluation of his or her own worth. Self-esteem encompasses beliefs about oneself, (for example, "I am capable", "I am worthy"), as well as emotional states, self-pride, and shame (Hewitt, 2009). Smith and Mackie (2007) defined self-esteem as the self-concept; and stated that it is the positive or negative evaluation of the self.

Literature has supported that self-esteem is adversely effected by childhood obesity (Allon, 1979; Sallade, 1973; Strauss, Smith, Frame, & Forehand, 1985; Strauss, 2000). However, the literature is inconsistent across clinical and general-population samples. Within clinical samples, lower self-esteem is reported compared with obese and normal-weight general population controls (Erermis et al., 2004; Braet, Mervielde & Vandereycken, 1997; Pierce, & Wardle, 1997). It has been hypothesised that those who seek treatment are more adversely affected psychologically by their obesity than those who do not. Alternatively, being singled out for treatment could induce feelings of lower self-worth because it suggests personal responsibility for obesity or personal failing in not controlling it (Wardle & Cooke, 2005).

Overall, prospective studies within the general population do support the idea that higher BMI leads to lower self-esteem. Studies have reported that higher BMI in 5-10-year-olds at baseline predicted lower self-esteem 4 years later (Hesketh, Wake, & Waters, 2004). Further research has supported this and highlighted that this relationship has been observed even in very young children (Strauss, 2000; Brown et al., 1998). One study followed over 180 5-year-old girls for two years and found that higher BMI at age 5 was associated with lower self-esteem at ages 5 and 7 (Davison & Birch, 2001; Davison & Birch, 2002). Nevertheless, some argue that body dissatisfaction is the

mediator for self-esteem in obese children, as some work has found that low self-esteem reported among overweight adolescent female children was no longer significant after body image is controlled for (Pesa, Syre, & Jones, 2000).

Ethnic differences in self-esteem are often neglected as an area for study, nevertheless, where they are investigated, effects appear robust. Strauss (2000) found that self-esteem in obese Hispanic and Caucasian girls decreased significantly more over time compared with their healthy weight peers, however, this effect was not observed in African-Americans. Again, these findings imply that African American girls may not be exposed to the same attitudes and messages around weight and thinness from their family, peers, and the media, as are Caucasian and Hispanic girls (Lawrence & Thelen, 1995). Still, research into self-esteem, and minority ethnic communities in the UK is deficient.

1.6.2.3 Depression

As reported with self-esteem, rates of psychological disorders in clinical populations are much larger compared with the general population (Vila et al., 2004). Further research has indicated that the resulting body dissatisfaction of overweight/obese girls, is found to be associated with the development of not only depression but also eating disorders (Daniels, 2006). However, the relationship between adiposity and depression is complex, as depression itself is linked with changes in eating patterns and can lead to obesity and obesity can lead to psychosocial problems resulting in depression. Some research has found that depression in childhood is a risk factor for the development of obesity (Goodman, & Whitaker, 2002). Other studies have documented that obese

adolescents seeking treatment for their obesity have more depressive symptoms than community based obese or non-obese control groups (Britz et al., 2000). In general, researchers have been unable to conclude whether differences in depressive symptoms in children and adolescents are based on the severity of obesity. Published studies have been based on relatively small samples, raising questions about the conclusions' validity. Nevertheless, in a study by Erermis et al., (2004) more than half of their sample of obese adolescents had a clinically significant psychological diagnosis, most commonly; major depressive disorder.

Nevertheless, a causal pathway between obesity and depression remains to be established (Bardone, 1998; Pine, Goldstein, Wolk, & Weissman, 2001; Pine, Cohen, Brook, & Coplan, 1997; Richardson et al., 2003). However, adiposity and depressive symptoms appear to be linked and can have serious negative implications, with research indicating that being overweight combined with depressive symptoms significantly increased suicidal thoughts and attempts in adolescents (Eisenberg, Neumark-Sztainer, & Story, 2003)

1.6.2.4 Anxiety

Literature indicates that the most frequent disorders observed in obese/overweight children and adolescents were anxiety disorders, particularly separation anxiety and social phobia (Vila et al., 2004). Further research has suggested that adolescent females who are obese may be four times as likely to develop anxiety disorders compared with obese adolescent males (Anderson et al., 2007). These findings indicating that obese females would be more vulnerable to anxiety disorders may not be unanticipated, given

the relatively greater social pressure of thinness for girls and women in Western society (Flynn, 1997).

Nevertheless, as seen across the research investigating the psychological impact of obesity, quality of these studies has been criticised. Very few studies examined the longitudinal effect of obesity on anxiety disorders and the findings have been contradictory. Much of these studies were undermined by methodological limitations (such as small sample sizes and only using self-report measures) and the observed associations were weak and often nonsignificant. Moreover, evidence was mainly cross-sectional and therefore other reasonable justifications for the apparent association of obesity and anxiety cannot be ruled out (Gariepy, Nitka, & Schmitz, 2010).

1.6.2.5 Behavioural difficulties

Behavioural difficulties amongst overweight children has been frequently reported in the literature. One study conducted in the US, reported more than 81% of overweight female children had an increased likelihood of their teachers reporting substantial externalising behavioural difficulties, compared with non-overweight girls (Datar & Sturm, 2004). However, determining the causality of this relationship is difficult as some studies suggest behavioural difficulties may be as a result of overweight children defending themselves in response to bullying or due to poorly developed social skills (Sullivan, Joshi, Ketende, & Obolenskaya, 2010). However, literature has reported that clinically meaningful behavioural problems in a sample of 8-11-year-old children was independently associated with an increased risk of coexisting overweight, as well as an increased risk of becoming overweight (two years later) in previously healthy weight children (Lumeng, Gannon, Cabral, Frank, & Zuckerman, 2003). This suggests that

behavioural difficulties may precede overweight. A greater extent of externalising behaviour can eventually result in an overall poorer performance at school. Furthermore a higher percentage of missed school days has been correlated with poorer school performance in obese children (Fogelholm et al., 2007).

1.6.2.6 Critical appraisal of Psychological literature

It is of note that, although numerous studies have highlighted a relationship between obesity and psychopathology (i.e. depression and anxiety), the causal nature of this relationship remains inconclusive (e.g. Brewis, 2003; Erermis et al., 2004; Zeller & Modi, 2006). Although some researchers have found modest links between obesity and psychopathology, as described above (Erermis et al., 2004; Franko et al., 2005), other studies have failed to replicate these associations (Goodman & Whitaker, 2002). In contrast, some studies using clinical samples have found that obesity was in fact inversely associated with psychopathological symptoms in adolescence (Zeller & Modi, 2006). Further studies have demonstrated modest differences in additional global psychological concerns (e.g. emotional well-being and peer concern) between overweight and normal-weight adolescents (Falkner et al., 2001; Mond, van den Berg, Boutelle, Hannan, & Neumark-Sztainer, 2011).

Thus, despite several studies demonstrating the association between psychopathology and obesity in adolescence, there is inconsistency regarding the extent of those clinical problems. It is therefore arguable that the relationship between obesity and psychological problems is not well established, and when the effects are observed, they typically are not clinically significant (e.g. Mond et al., 2011).

These inconsistencies in the literature regarding the relationship between obesity and psychopathology could be related to poor methodological practices observed throughout the research which have been highlighted above. Namely, the majority of studies using self-report measures and a lack of objective data, cross-sectional and correlational methodologies being favoured which leave causality inconclusive, and small samples that are not culturally diverse and thus leading to a lack of generalisability. These limitations could also be linked with the complex nature of mental health with its many mediating factors, and additionally the difficulty of objectively measuring abstract concepts such as 'self-esteem' and 'body dissatisfaction'. Therefore, the findings from the literature must be interpreted with careful consideration.

1.6.3 Social

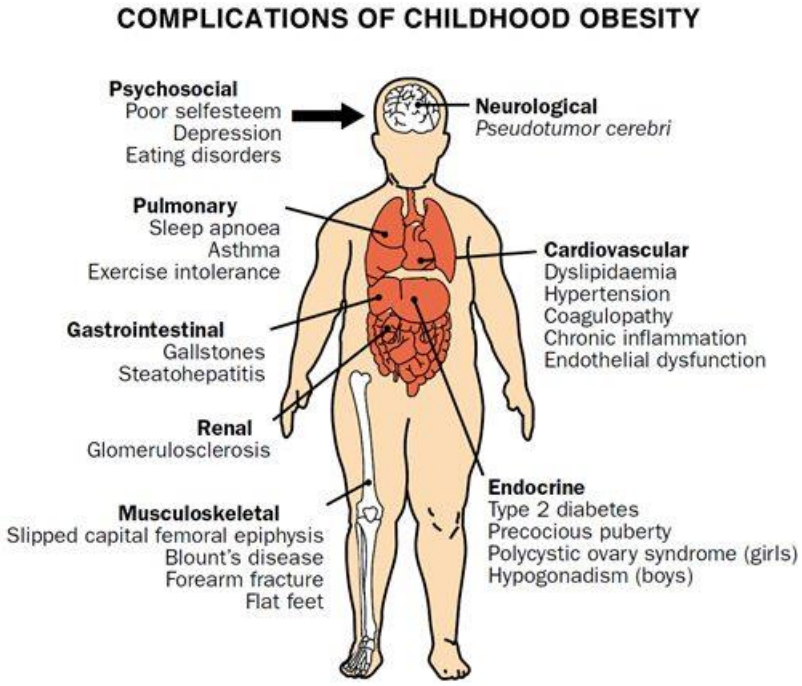
Friendship is a crucial means for the social and psychological development of adolescents (Youniss & Haynie, 1992; Buhrmester, 1990; George & Hartmann, 1996). Literature indicates that obesity and overweight adversely affect peer relationships of children and adolescents. Strauss and Pollack (2003) reported that overweight children are socially marginalized and on average have fewer friends. They stated that on various measures of social relationships, overweight adolescents were more isolated and more peripheral to social networks compared to healthy-weight peers (Strauss & Pollack, 2003). Obese/overweight adolescents were significantly less likely to be selected as friends compared to healthy-weight peers. Furthermore, healthy weight adolescents who nominated overweight peers as their friends tended to be less popular themselves (Strauss & Pollack, 2003). It is also reported that the stigma and stereotyping attached

to obese children can often lead to them becoming victim to bullying from peers (Sullivan et al., 2010).

Childhood and adolescence is a crucial time to form adaptive social relationships, which aid healthy social and emotional development during these periods, therefore issues relating to stigma and stereotyping amongst peers is particularly relevant (Pearce, Boergers, & Prinstein, 2002). Through peer interactions children learn valuable social skills (e.g. turn taking, sharing and competition) and how to form and maintain close relationships (Rubin, Bukowski, & Parker, 1998). Children and adolescents who are stigmatised for their weight may, as a result, fail to achieve normal social developmental competences and have difficulties with peer relationships, which may be indicative of poorer psychological well-being in the future (Parker & Asher, 1987); including the development of internalising symptoms, low self-concept and peer rejection (Hymel, Rubin, Rowden, & LeMare, 1990; Rubin, Chen, McDougall, Bowker, & McKinnon, 1995). These early experiences of marginalisation and stigmatisation may detrimentally impact on adulthood, affecting areas including job performance and the formation of intimate relationships (Bagwell, Newcomb, & Bukowski, 1998; Roisman, Masten, Coatsworth, & Tellegen, 2004).

As described above, childhood obesity appears to have a negative effect on all aspects childhood health. Figure 2 offers graphical representation of how the body as a whole is affected.

Figure 2. Diagram of complications of childhood obesity



1.7 Causes of obesity: nature vs nurture

It is widely accepted that obesity is a multifactorial disease caused by the interaction of genetic, lifestyle and environmental factors. A sedentary lifestyle, high-fat and high-energy diet, and genetic predisposition to obesity all contribute to the epidemic (Yamada et al. 2006).

1.7.1 Genes

Previous genetic research estimates that more than 70% of adiposity in 10-year-olds is due to genetic factors, and approximately 20% is due to socioenvironmental contributions (Wardle, Carnell, Haworth, & Plomin, 2008). Further studies have

located common genetic variations associated with fat mass, weight, and susceptibility to obesity, isolating several genes through these studies (Haworth, 2008; Loos et al., 2008). These findings may eventually help scientists to explain the biological mechanism for the heritability of obesity in families (Koehly & Loscalzo, 2009).

More recent genetic research has estimated that around 40-70% of individual variability in BMI scores can be attributed to genetic factors (Locke et al. 2015). However, all genes that contribute to genetic susceptibility to obesity remain to be definitively identified. In addition, given the ethnic differences in lifestyle and environmental factors, as well as in genetic background, it is important to examine gene polymorphisms related to obesity in each ethnic group (Yamada et al. 2006).

1.7.2 Environmental

Environmental factors refer to all that is available in one's environment, such as nutrition and physical activity. With regards to nutrition, studies have long been implicating high dietary fat intake with the development of obesity (Bray, Nielsen, & Popkin, 2004). Research indicates that dietary habits formed in childhood are likely to persist into adulthood, so an unhealthy diet in childhood has implications for health throughout the life course (Birch & Fisher, 1998).

Likewise, low levels of physical activity have also been linked to obesity in children. However, earlier studies examining the effects of physical activity on health in children have been criticised for relying on self-reported measures of physical activity which are subject to biases (Ku, Gower, Hunter & Goran, 2000; Schmitz et al. 2002; Ness et al. 2007). More recent studies have addressed this issue by using objective physical

activity assessment methods such as movement sensors, which have substantially greater validity in children (Sallis, Buono, & Freedson, 1991). Owen et al. (2010) reported strong evidence that low levels of objectively measured physical activity are associated with increased overweight and higher cardiac risk in childhood, these findings reportedly did not differ in boys and girls. Furthermore, Owen et al. (2010) reported that such associations were similar among children of different ethnic origin. This suggests that physical activity in children is highly important in relation to their weight, irrespective of gender and ethnicity.

Locard et al. (1992) highlighted further environmental factors which contribute to childhood obesity as snacks, excessive television viewing, and short sleep duration. This was supported by research done on European adolescents which found that short sleep duration was associated with higher levels of adiposity, this appeared to be linked with a combination of increased food intake (e.g. snacking more and eating fewer balanced meals) and more sedentary habits (e.g. TV watching) (Garaulet et al., 2011). However, this research did not include participants from the UK and due to its cross-sectional methodology cannot address the causal relationship between sleep duration and obesity.

Another key environmental factor linked with obesity is socio-economic status (SES). Research has indicated that in developed countries, females of low SES (i.e. low education, unemployment, lack of material possessions) had higher levels of obesity (McLaren, 2007). Maternal weight, knowledge of healthy food choices and children's activity levels have been linked to parental education and income (Costa-Font & Gil, 2013). Further research supports that being educated and having a stable income are associated with a decreased risk in childhood obesity in the UK and US (Ogden, Lamb,

Carroll & Flegal, 2010; Hawkins et al., 2009; Weden et al., 2012). However, much of this evidence is based on Caucasian samples. When focusing on SES status within minority ethnic families the findings are contradictory. Studies report that children in minority ethnic households with low income, and whose parents have low educational attainment, may be less likely to be overweight then their socioeconomically advantaged minority ethnic equivalents (Ogden et al., 2010; Martinson et al., 2012; Van Hook & Stamper Balisteri, 2007). Research in the UK has highlighted that SES disadvantage is highly linked with minority ethnic communities, particularly so for Black Caribbean, Black African and Bangladeshi children (Zilanawala et al., 2015). Contrarily, some research has concluded that, in the UK, SES measures completely explained the health disadvantages for Bangladeshi children but could only explain part of the disparities for Black African and Black Caribbean children (Zilanawala et al., 2015). This suggests that not only does ethnicity contribute to differences in the risk of childhood obesity, but that ethnic background and country of residence interact with other environmental factors such as SES, therefore a Black African child for example, with low SES may have different health outcomes depending on if they live in the US or the UK.

Literature from the US has outlined cultural beliefs and practices, and levels of acculturation as environmental factors that may contribute to racial/ethnic disparities to obesity in childhood and adolescents (Peña, Dixon, & Taveras, 2012). It is reported that culture may influence parental perceptions of their children's health status and behaviours and furthermore that minority ethnic mothers may have distinctive views of what they consider to be a healthy weight for their child (Peña et al., 2012). This is further supported by the literature which states that in some cultures, mothers may view

thinness as a reflection of poor health and malnutrition (Crawford et al. 2004; Kimbro, Brooks-Gunn, & McLanahan, 2007; Contento, Basch, & Zybert, 2003; Lindsay, Sussner, Greaney, & Peterson, 2011), and some minority ethnic parents may have inaccurate perceptions of their child's weight or obesity status (Young-Hyman et al. 2003; Hackie & Bowles, 2007). It is of note that this research has primarily been conducted in the US focusing on Hispanic and African American communities and therefore the results are difficult to generalise to the UK.

These findings highlight the complex nature of environmental factors and childhood obesity and stress the need for more culturally diverse research in this area.

1.7.3 Parenting

Parenting has been linked to the parent-child attachment relationships, but is also influenced by attachment experiences from a parents' childhood, in their own families of origin (Belsky & Pensky, 1988). Attachment theory states that by the end of the first year of life, infants are thought to form working models of the self and of others as a result of their interactions with relevant attachment figures (Bowlby, 1973; Bretherton, 1987). It is suggested that this formation of stable internal working models accounts for the connection between early attachment relationships and later parent-child relations (Bowlby, 1973; Crittenden, 1990; Main, Kaplan & Cassidy, 1985; Stern, 1989). The literature has highlighted that for mothers and fathers, adult attachment classification (using the Adult Attachment Interview (AAI); George, Kaplan, & Main, 1984). is associated with parenting behaviors (Cohn, Cowan, Cowan, & Pearson, 1992). Specifically, it was noted that parents whose AAI classifications were 'insecure' were

less positively engaged with their children and provided less structure with them than parents classified as 'secure' (Cohn et al., 1992). This is supported by Crowell and Feld-man (1988) who described associations between mothers' working models of attachment relationships and maternal behaviour.

Research has also identified one theory of importance when forming attachments is the learning / behaviourist theory (e.g. Dollard & Miller, 1950) which suggests that attachment is a set of learned behaviors. The basis for the learning of attachments is the provision of food. Therefore, an infant will initially form an attachment to the primary feeder. Infants learn to associate the feeder (typically the mother) with the comfort of being fed and through the process of classical conditioning, come to find contact with the mother comforting. They also find that certain behaviors (e.g. crying, smiling) bring desirable responses from others (e.g. attention, comfort), and through the process of operant conditioning learn to repeat these behaviors in order to get the things they want (Bowlby, May, & Solomon, 1989). Thus, highlighting the reciprocal attachment relationship and its link to not only parenting practices but the important connection with the act of feeding one's child.

Research on parenting and child outcomes originates from developmental psychology, which emphasises that parenting styles and parenting practices are related but distinct and have different implications for child outcomes (Darling & Steinberg, 1993). The term parenting style describes differences among parental attitudes and styles of interacting with children that could result in individual differences among children in key outcomes. In contrast, the term parenting practice describes a specific behavioural strategy employed by parents to socialise their children (Darling & Steinberg, 1993).

Hughes et al. (2006) have narrowed the definition of parenting style to focus solely on child feeding behaviours. They classify caregivers as having an authoritative, authoritarian, indulgent or uninvolved child-feeding style based on their use of demanding or responsive child feeding behaviours and attitudes (Hughes, Power, Orlet Fisher, Mueller, & Nicklas, 2005). Parenting practices in relation to feeding include behaviours such as pressuring children to eat, using food as a reward, restricting access to select foods or groups of foods, modelling or use of food to appease or control their child (Patrick, Nicklas, Hughes, & Morales, 2005).

Parenting practices have been studied specifically looking at availability of foods at home, and specific feeding strategies (e.g. restriction vs. covert control) (Boots, Tiggerman, Corsini, & Mattiske, 2015). The literature indicates that parents who restrict food availability at home can unintentionally cause weight gain in their children (Clark, Goyder, Bissell, Blank, & Peters, 2007). Research has suggested that applying a moderate level of control (e.g. monitoring unhealthy snack intake) is an adaptive and healthy strategy for parents to adopt to manage their child's food intake appropriately. However, high levels of control over children's food intake have been linked with subsequent disinhibited eating (i.e. a pattern of behavior that involves eating too quickly and a repeated lack of success when dieting) (Fisher & Birch, 1999; Birch, Fisher & Davison, 2003) and child increased weight or BMI (e.g. Faith et al. 2003; Farrow & Blissett, 2006). Although there have been some inconsistent findings in this area (e.g. Clark et al. 2007; Montgomery, Jackson, Kelly & Reilly, 2006), longitudinal studies indicate that highly restrictive feeding practices have been most consistently associated with child weight gain (e.g. Clark et al. 2007). Monitoring feeding practices on the contrary have been linked with lesser weight gain (e.g. Faith et al. 2004). Many

factors such as; genetic risk, ethnic and cultural practices, SES, and education, have been indicated to moderate the effects of feeding practices on weight outcome (e.g. Clark et al. 2007; Faith et al. 2003; Faith et al. 2004). In general, parents who find it difficult to control their own dietary intake, who are highly invested in their child's eating and who perceive that their child is at risk of developing weight problems have been identified as markers for when excessive parental feeding is likely to occur (Costanzo & Woody, 1985). Furthermore, it has been found that, although multiple factors are thought to influence parental food choice, parents with a good understanding of nutrition and a healthy balanced diet are more likely to make healthy food choices for their children (Clark et al. 2007).

Parenting style has also been reported to be associated to child feeding practices (Hughes et al., 2005). One study found that children with either 'authoritarian' or 'permissive parents' were twice as likely to be overweight compared to children of 'authoritative parents' (Rhee, Lumeng, Appugliese, Kaciroti, & Bradley, 2006). However, the study had limitations by the fact that incomplete data from child participants was excluded and researchers noted that these participants were more likely to be of a lower SES and from minority ethnic groups; compromising the generalsability of the results to these populations.

Nevertheless, several other studies have supported a relationship between parenting style, diet and activity in children and adolescents (Kremers, Brug, de Vries, & Engels, 2003). However, overall there has been mixed results from studies attempting to look only at the relationship between parenting style and child weight status. For example, Agras, Hammer, McNicholas and Kraemer (2004) did not find a significant relationship

between parenting style and child weight status, however researchers reported that this may have been due to a small sample size. A systematic review conducted by Sleddens, Gerards, Thijs, de Vries and Kremers (2011) concluded that children raised in more authoritative homes tended to have a healthier diet, were more physically active and had lower overall BMI levels. This was in comparison to children who were raised by parents with other styles such as, authoritarian, permissive/indulgent, uninvolved/neglectful.

As highlighted above, it has been recognised that general parenting styles and feeding practices are linked with child weight. However, Maccoby and Martin's (1983) elaboration of authoritarian, authoritative, indulgent, and uninvolved parenting styles was developed with a focus on Caucasian European-American parents and like much of the literature in the field often excludes parents from minority ethnic groups, whom, in the UK are more likely to be of low SES and thus more at risk of obesity. Hughes et al. (2005) attempted to address gap in the literature by investigating 231 primary care-givers of African-American and Hispanic ethnicity, using questionnaires such as The Child Feeding Questionnaire (Birch et al. 2001) to assess parents' use of authoritarian feeding practices and the Parenting Dimensions Inventory (PDI-S) (Power, 2002) which is a self-administered parenting instrument that assesses parental support, control, and structure in a general parenting context. This research was then used to create a valid and reliable instrument (Caregiver's feeding styles questionnaire - CFSQ) to identify feeding styles specifically for parents with low SES from a minority ethnic backgrounds (Hughes et al., 2005). This research demonstrated that Hispanic parents were more likely to be 'indulgent' in their feeding practices, whilst African-American parents were more likely to be 'uninvolved'. 'Uninvolved' parents used fewer child-

centered parenting techniques (i.e. support, structure, and following through on discipline) and more physical punishment. In contrast, 'indulgent' parents used a variety of child- centered parenting techniques and very little physical punishment. More importantly, children of 'indulgent' parents had higher BMI scores compared with 'uninvolved' parents (Hughes et al., 2005).

Further research in the US has supported that culturally defined perceptions of body image as a possible influence on parenting strategies and decision making regarding eating and physical activity habits (Peña et al., 2012). Other research has also shown a change in health status with acculturation and more time spent in the United States, which has been linked to changes in traditional diet compositions across generations (Allen, Elliott, Morales, Diamant, & Hambarsoomian, 2007). This indicates that parenting style and practices differ amongst different ethnic groups and furthermore may be influenced by acculturation over generations and need to be examined further. This complexity of the experience and process of acculturation has been discussed extensively in previous literature (Padilla & Perez, 2003). Research has also evaluated the relationship between ethnicity and acculturation in determining risk for obesity (Wojcicki, Schwartz, Jiménez-Cruz, Bacardi-Gascon, & Heyman, 2012). The underlying dynamics of the complex relationship between migration and migrant obesity may be further clarified with a theoretical perspective which takes into account the forces of acculturation and enculturation (Renzaho, Swinburn, & Burns, 2008; Renzaho, 2009). It is reported that the majority of people who migrate from low-income to high-income countries eventually adopt obesogenic behaviours, experience weight gain, and record higher body weights than their local counterparts (Goel, McCarthy, Phillips, & Wee, 2004). This change occurs as their immersion into the host culture

increases over time (Gadd, Sundquist, & Johansson, 2005) and is indicative of the broader and more complex process of acculturation – that is, the gradual exchange between immigrants' original attitudes and behaviour and those of the host culture (Redfield, Linton, & Herskovits, 1936). This literature supports the importance of considering cultural heritage and acculturation when addressing childhood adiposity.

The importance of understanding parenting style for successful intervention with child feeding practices have been stressed in literature (Hubbs-Tait, Kennedy, Page, Topham, & Harrist, 2008; Blissett, & Haycraft, 2008). Nevertheless, as emphasized above, much of the research has been conducted with white American or European participants with very little nationally representative data on obesity, causes and consequences in minority ethnic populations in the UK (Boots et al. 2015).

1.7.4 Family Factors

Family factors and the family food environment have been documented to impact on childrens eating habits and weight (Klesges, Stein, Eck, Isbell, & Klesges, 1991; Jingxiong et al., 2007) and it has been reported that dietary habits acquired in childhood often persist throughout adulthood (Nicklas, 2001). It has been argued that childhood obesity adds additional stress and management needs to the lives of families (Barlow & Dietz, 1998; Rippe, Crossley & Ringer, 1998). Rhee (2008) further investigated family functioning as a whole and its influence on child weight status, finding that parents may influence a child's weight through specific feeding and activity practices (as highlighted above under 'parenting') as well as, through parenting style and management of family functioning. Family functioning refers to exchanges between various family members and the effect that these have on the relationships and

functioning of the family as a whole (Kitzman-Ulrich, Wilson, George, Lawman, Segal, & Fairchild, 2010). Family functioning is theoretically born from Family Systems Theory (Bowen, 1994), which states that families are systems made up of connected and interdependent individuals. Therefore, in order to understand any individual, we must first try to understand their family system (Bowen, 1994). Families characterised by open communication, well-regulated affect and clearly defined roles are considered to be well-functioning. Well-functioning families tend to achieve family tasks whilst encouraging well-being and individual growth for its members. Whereas, poorly functioning families are thought to show unclearly defined or rigid roles, disorganisation and poor communication patterns (Kitzman-Ulrich et al., 2010).

Berge, Wall, Larson, Loth and Neumark-Sztainer (2013) have further investigated the role of family functioning in relation to childhood obesity, highlighting the importance of the interpersonal relationships occurring within families of obese children. Their study suggested that poorer family functioning (e.g. less structure/rules, warmth/communication, problem-solving skills) is associated with higher BMI in adolescents. However, the study was limited by its cross-sectional design, making it difficult to determine causality of the association between family functioning and adolescent BMI.

Most research on family factors and childhood obesity originates from a Western cultural context where parenting most commonly exists within a 'nuclear' family. Given that the social structure in minority ethnic families is often quite different with extended family having greater involvement in child upbringing, it is plausible that additional or other culture-bound risk factors play a role in the growing rate of

childhood obesity (Jingxiong et al., 2007). This is indicated by one qualitative study, conducted in China which highlighted the importance and influence of grandparents on several aspects of children's eating behavior (Jingxiong et al., 2007). They reported that grandparents were the primary caretakers and the ones providing the immediate family food environment for their grandchildren. Grandparental views and principles of healthy child nutrition were shaped by their own experiences of poverty, the conception that obesity is a sign of health, and that their fostering duty comprised providing the family's only child with ample amounts of food of the kind the child likes and which are thought to be nutritious. The grandparents in this study believed that overweight children where happy, strong and healthy (Jingxiong et al., 2007). These findings have been replicated further in Chinese populations by Li, Adab, & Cheng (2015).

Further research has highlighted that the extended family plays an important role in Latino and African-American families (Peña et al., 2012). As shown above with Chinese families it has been reported that in Latino and African-American families, grandparents or other extended family members are typically involved in the upbringing and care of children and may influence parenting strategies and beliefs (Lindsay et al., 2011; Bentley, Gavin, Black, & Teti, 1999). Extended family may also influence children's eating and physical activity behaviors, particularly sedentary parents in Native-American and African-American families appear to facilitate children watching more hours of television and being less active (Lindsay Sussner, Greaney, & Peterson, 2009; Polley, Spicer, Knight, & Hartley, 2005). However, research into extended family factors in minority ethnic communities in the UK is absent.

1.8 Current treatments of childhood obesity

1.8.1 Behavioural approaches

Strategies that are based on Bandura's social cognitive model (1986) that focus on changing dietary habits to lower calorie diet are most widely used. These strategies are based primarily on the notion that cognitively driven, intentional behaviours such as self-monitoring, goal setting, and rewarding successful change will ultimately lead to lifestyle changes. Behavioural approaches refer to nutritional and physical activity components, as well as teaching parents behavioural change strategies (Graves, Meyers, & Clark, 1988). Behavioural change strategies include: self-monitoring (Kazdin, 1974); diet information; exercise information; stimulus-control strategies (Epstein & Wing, 1987); family support (Epstein, Valoski, Wing, McCurley, 1990); cognitive restructuring (Meichenbaum & Goodman, 1971); peer relations (Shure, 1982); and maintenance strategies (Marlatt & Gordon, 1985). Behavioural strategies use puppets, stories and games to increase accessibility to the child and family.

A recent systematic review analysed seventy RCTs comparing behavioural treatments to a variety of control groups delivered to over 8000 overweight or obese children aged 6 to 11-years-old (Colquitt et al., 2016). The control groups delievered were reported as primarily being multicomponent interventions (different combinations of diet and physical activity and behaviour change). Four control groups were physical activity interventions and two were dietary interventions compared with no intervention or

'usual care'. The children in the included studies had an average age of 10-years-old, and were followed up between six months and three years (Colquitt et al., 2016). The key findings from this systematic review report that on average children's weight was 0.53kg to 1.45kg lower in the intervention groups compared with the control groups. However, dropout rates for the included studies were reported as being from 15% to over 25%. Additionally, the overall quality of the evidence was criticized for being low or very low, mainly because of limited confidence in how studies were performed, and the results were inconsistent between the studies (Colquitt et al., 2016).

Furthermore, only 38 studies clearly reported the ethnicity of their participants, within these studies six studies reported that all of their participants were white (Colquitt et al., 2016). In 23 studies participants were of mixed ethnic groups, but the majority ethnic group was white and the remaining studies who had more diverse ethnic representation reported minority ethnic groups such as African Americans, Hispanic, Latino and Mexican Americans, Hong Kong Chinese and Malay ethnicities (Colquitt et al., 2016). It is of note that these studies do did not take place in the UK and therefore do not appear to be representative of minority ethnic communities in the UK.

1.8.2 Motivational Interviewing

Motivational interviewing (MI) has also been advocated as a useful technique for those who may not feel ready to make changes in managing their own, and their children's, weight and diet (Miller & Rollnick 2002). MI refers to an empathetic "way of being", including reflective listening, shared decision making, and agenda setting (Resnicow, Davis, & Rollnick, 2006). Guidelines from the American Heart Association

recommends MI as an intervention for parents for paediatric weight management (Daniels et al. 2009). However, the efficacy of this approach versus other behavioural approaches is not known (Han et al. 2010).

Few studies have investigated the efficacy of MI for Pediatric Obesity. One of these studies focused on prevention of overweight among children 3 to 7 years old (Wasserman et al, 1998). Wasserman and collegues (1998) enrolled 93 patients from 14 practices in their Healthy Lifestyles Pilot Study. Clinicians participating in the study completed a self-evaluation rating form as a measure of MI fidelity. At 6 months' follow-up, there was a decrease of 0.6, 1.9, and 2.6 BMI percentiles in the control, minimal, and intensive groups, respectively (Schwartz et al, 2007). However, the differences in BMI percentile change between the 3 groups were not statistically significant. It is of note that the patient dropout rates were highest for the intensive intervention group (50%), compared with 10% for control and 32% for minimal intervention groups. 94% of the parents reported that the intervention helped them think about changing their family's eating habits (Schwartz et al, 2007).

Another study was a multicomponent intervention for overweight African-American adolescents aged 12 to 16 years, which included motivational interviewing as a key intervention element (Resnicow, Taylor, & Baskin, 2005).

Resnicow and collegues (2005) conducted a church-based nutrition and physical activity program designed for overweight African-American adolescent females which included MI telephone calls over the course of the treatment. From 10 churches, 123 girls completed the baseline and 6-month follow-up assessments. The primary outcome was BMI. The 6-month assessments indicated a mean difference of 0.5 BMI units

between the high and moderate intensity intervention groups. This difference was not statistically significant. In addition, there was no association between change in BMI and the number of MI calls completed in the high-intensity group (Resnicow, Davis, & Rollnick, 2006).

Insufficient research has been conducted to determine the efficacy of MI for the prevention or treatment of childhood obesity or other domains of behavior change in children. Results from adult studies suggest that MI can be effective in modifying diet and in the short-term physical activity (Resnicow, 2006). However, direct evidence of efficacy for weight control in adults is lacking. It should be noted that none of the adult studies targeted weight as the primary outcome.

1.8.3 Family based interventions

The literature suggests family interventions for childhood obesity to be the most effective (Berry et al. 2004). Currently, the main focus of family interventions is the use of behavioural strategies to support weight loss (Berry et al. 2004). However, research has identified how complex it can be for a family to intervene in a child's diet, with many different factors playing a part, such as; parenting style, child-parent relationship, availability of fruit and vegetables and feeding strategies (Blissett, 2011).

Family Systems Theory has considered the complexities of families in general and has moved interventions away from focusing on parenting, and child/parent interaction alone to think of the family more broadly (Flodmark, Ohlsson, Rydén & Svenger, 1993). Distinguishing features of Family Therapy (FT) for obesity is the focus on

familial interactions as an important source for implementing and maintaining lifestyle changes (Flodmark, 1997; Flodmark & Ohlsson, 2008). Inclusion of parents in the treatment of childhood obesity is widely used (Kitzmann & Beech, 2006; Young, Northern, Lister, Drummond, & O'Brien, 2007). However, specific FT is the only treatment model for obesity that relies on coherent integration of family systems theory and therapy that is developed and evaluated in a medical setting. Some randomised control trials (RCT) have been conducted to assess the efficacy of FT for obesity, which have shown promising results whereby FT appears to be more effective than conventional treatment (i.e. dietary counselling and regular appointments with a peadiatrician) (Flodmark et al, 1993). It is of note, however, that Flodmark and colleagues (1993) study in particular evidences prevention of childhood obesity developing into severe obesity in a one year period, not the treatment of obesity. In their research children in the FT group, conventional treatment group, and control group all remained obese with small increases in their BMI post treatment and at one year follow-up, however FT provided the smallest increase in BMI but this was not significantly different to the conventional treatment group at 1 year follow up (Flodmark et al. 1993). Berry and collegues (2004) reviewed literature to critically evaluate the evidence related to family-based interventions designed to treat childhood obesity through an examination of nutrition, exercise, and behavioural interventions, including behavioral modification, behavioral therapy, and problem solving. The interventions for children and adolescents and their families were varied in relation to age group; child, adolescent, or parent target; length of intervention; and length of follow-up (Berry et al, 2004). All of the interventions included some form of nutrition education, exercise, and behavioral intervention (Berry et al, 2004). The review results stated that behavioral modification interventions targeting children and parents together or separately and

were relatively successful in improving weight-loss outcomes in both parents and children (Berry et al, 2004). Problem-solving interventions that targeted parents of children improved the outcomes (Berry et al, 2004). However, when problem solving was used with both parents and children together or children alone, weight outcomes did not improve.

Nevertheless, the majority of the studies included in the review were reportedly methodologically inadequate, such as none of the studies reporting power calculations in their study design (Berry et al, 2004). Seventy percent of the studies did not report either the socioeconomic status or ethnicity of their participants. Studies that did report these factors included participants who were predominately caucasian and from middle to upper socioeconomic groups (Berry et al, 2004). The majority of family-based interventions have been conducted with middle-class caucasian families, whereas the highest obesity rates are with African American, Hispanic, and American Indian children (Ogden et al., 2002). Furthermore, children living in lower socioeconomic groups are reportedly the most affected by obesity (Dietz, 1998).

1.8.4 Community-based Interventions

International recommendations agree that paediatric obesity interventions should involve the whole family and include nutrition education, behavior modification and promotion of physical activity (Summerbell et al., 2003; NICE, 2006; Spear et al., 2007; Oude Luttikhuis, 2009). In the UK predominantly, efforts have gone into developing interventions that encompass these elements but are designed to be delivered in community and primary care settings. A popular example of this is the 'Mind, Exercise, Nutrition, Do it' (MEND) Programme (Sacher et al. 2005). The MEND intervention is

an integrated, multicomponent healthy lifestyle program based on the principles of nutritional and sports science plus, from psychology, learning, and social cognitive theories and the study of therapeutic processes. The program engages families in the process of weight management by addressing the three components necessary for individual-level behavioral change; (a) education (b) skills training, and (c) motivational enhancement (Fisher & Fisher, 2002), while maintaining an overall understanding of the need to engage multiple, interacting systems of influence within the family context (Christensen, 2004). In a RCT where the MEND programme was compared with a treatment waitlist control group, results indicated that the MEND group had significant improvements in weight loss as well as indicators of cardiovascular health and psychological well-being compared with the controls (Sacher et al, 2010). The authors suggest a key strength of the MEND programme was its acceptability to families as seen by low attrition rates (Sacher et al, 2010), and furthermore the mean 86% attendance was higher than reported for other childhood obesity interventions (Denzer, Reithofer, Wabitsch, & Widhalm, 2004; Golley, Magarey, Baur, Steinbeck, & Daniels, 2007). However, the study did have methodological limitations such as lack of blinding for measurement outcomes, selective drop out possibly influencing the results and the relatively short follow up time (12 months from baseline), making it difficult to conclude the long-term effects of the intervention.

1.8.5 Evaluation of childhood obesity treatment

Despite many seemingly efficacious interventions for childhood obesity, it continues to increase as a global health issue. Systematic reviews of satisfaction of paediatric

obesity treatment have highlighted general negative outcomes (Skelton, Irby, & Geiger, 2014). Considering the current paediatric obesity epidemic, research indicates that high attrition rates from treatment programs represent a stark failure of treatment (Skelton et al., 2014). Furthermore, treatment programs are considered to involve great time commitment from patients and clinicians, and require extensive resources that are seemingly wasted when attrition is high (Skelton et al., 2014).

Qualitative studies have identified an appeal from parents and adolescents for more long-term interventions (Murtagh, Dixey, & Rudolf, 2006; Stewart, Chapple, Hughes, Poustie, & Reilly, 2008). Furthermore, that parents want guidance in dealing with conflicts that arise due to resistance from the child and extended families during treatment (Stewart et al., 2008). Research also indicates that some families find dietetic advice and dietitians too rigid in their approach, whilst other families want more structured advice (Owen et al., 2009).

There remains little specific evidence of successful interventions among minority ethnic groups, and theories of health behaviour only identify a limited subset of cognitive factors that are assumed to be most proximal to the general population's behaviour. This is particularly so among minority ethnic populations in the UK, specifically London. (Lucas, Murray, and Kinra, 2013).

1.9 Parental experiences

1.9.1 Negative experiences of services

Some non-culturally specific research into parental experiences of having an overweight/obese child has been done. Much of the literature has highlighted negative experiences of parents with obese or overweight children. Qualitative research by Turner, Salisbury and Shield, (2012) highlighted that parents had a lack of confidence in their General Practitioner's (GP) abilities regarding their child's weight management; parents reportedly felt practitioners did not have the knowledge, time or resources to effectively treat childhood obesity. Furthermore, parents were reluctant to consult their GPs due to a fear of being blamed for their child's overweight and parents even described how they had worried social services would become involved (Turner et al., 2012). Parents also expressed a concern about their child being 'labelled' as overweight and the affect this could have on their child's mental well-being (Turner et al., 2012). However, Turner and colleagues (2012) interviewed parents who were attending one of the few UK hospital-based childhood obesity clinics and therefore this may explain the limited and dissatisfying input they experienced from their GPs. Nevertheless, other research has also highlighted that parents report not wishing to consult a health care practitioner for similar reasons (Stewart et al., 2008; Cote et al., 2004).

Other qualitative research in this area has highlighted the following themes: vulnerability in parents - particularly through perceived dealings with 'prejudiced' health professionals. Parents reported that some health professionals were described as using words like 'fat' and 'big belly', which they found offensive (Turner et al., 2012).

Other parents felt they were not respected or were not believed as telling the truth about the family's diet (Cote et al., 2004). Further research states that parents have remarked that GPs and school nurses did not understand their situation, for example, the extent to which they could afford healthy food, as well as a reluctance from parents to consult their GPs due to a fear of being blamed for their child's overweight (Turner et al., 2012). They also reported feeling stigmatised and that their parenting skills were being questioned. These feelings have been linked with decreased motivation to; diet, exercise and lose weight (Vartanian & Smyth, 2013).

1.9.2 Parental ambivalence to weight as a problem

Another key finding in parental experiences is that of not recognising their child's weight problem (Turner et al., 2012; Edmunds, 2005; Eckstein et al. 2006; Hackie & Bowles 2007). Haugstvedt, Graff-Iversen, Bechensteen & Hallberg's (2011) reported that in general parents accepted their children whilst hoping for change however they also felt ambivalent to acknowledging their child's weight as being a problem. Further literature states many parents do not recognise that their children are overweight and, tended to be unconcerned or unaware of the issue of childhood obesity (He & Evans, 2007). Furthermore, parents did not perceive their children as being overweight, if they perceived their children to be active and have a healthy diet and good appetite (Jain, et al. 2001). This finding has been replicated amongst minority ethnic groups in the US, for example with African-American mothers whom reported that a child's size is due to a fixed inherited growth pattern with little that can be done to prevent excess weight gain (Jain et al. 2001). In other studies of Latina and African-American mothers, it was

commonly expressed that a child would eventually "grow out of" obesity (Crawford et al, 2004; Rich, DiMarco, Huettig, Essery, Anderson, & Sanborn, 2005).

1.9.3 Guilt and parenting

Guilt has been defined as an interpersonal moral emotion that aims to repair or inhibit behavior that causes harm to others (Rotkirch & Janhunen, 2010). It occurs in relationships in which the other's welfare is of interest to the actor, such as reciprocal relationships and familial relations. Guilt focuses on unjust behaviour and is connected to a concern for others and how they are affected by one's behavior. Empathy is a necessity for feeling guilt (Jones, Schratter, & Kugler, 2000; Tangney, 1998).

Guilt has been reported to have some useful functions in parenting; it may serve to inhibit aggression, impulsive actions and neglect in parenting. There is evidence that girls and women experience both empathy and guilt to a higher degree than boys and men do (Hoffman, 2000; Kochanska et al., 2002; Korabik & McElwain, 2005; Preston & de Waal, 2002; Silfver & Helkama, 2007). There is, however, very little research on guilt in the parenting context.

A small body of literature has begun to emerge highlighting parental experiences of guilt when parenting an obese child. Among adults, nutrition knowledge has been related to guilt, with feelings of guilt commonly increasing when less nutritious foods are consumed (Wansink & Chandon, 2006). These feelings reflect the conflicting goals individuals face when making food choices where long-term health goals clash with short-term pleasure (Kivetz & Keinan, 2006; Chandon & Wansink, 2007). This suggests that parents focusing on their children's short-term pleasure when selecting

foods may experience more guilt than parents who make food choices for their children based on longer term health effects (Pescud & Pettigrew, 2014).

Parents have reported that they have experienced negative emotions around their child's overweight such as anger and guilt (Haugstvedt et al., 2011). Research has indicated that some parents felt guilty about their children having a poor diet or watching TV (Haugstvedt et al., 2011). However, others saw TV viewing as educational and so there was little guilt or desire to restrict viewing because they felt the child was benefitting (Pocock, Trivedi, Wills, Bunn, & Magnusson, 2009).

In a study by Noble, Jones, & McVie (2005) participants were required to provide explanations relating to the motivations behind a mother's food choices for her child which were either 'healthy' or 'unhealthy'. The results showed that parents viewed the mother's food decisions in the case of unhealthy snacks as being motivated by expediency which included keeping the peace, being in control, having multiple chores to complete in a timely fashion and feeling guilty. Jackson, Wilkes and McDonald (2007) found that mothers of over-weight and obese children felt guilty that their children were not within a healthy weight range, and although they wanted to help their children and felt partly responsible for their children's weight, they lacked knowledge of how to deal with the situation. It is of note that this study focused on experiences of parenting overweight or obese children, so their discussions of guilt occurred in the context of mothers who were aware of their children's weight status. However, as highlighted above, it is often the case that parents of overweight children do not recognise their children's weight status (Eckstein et al. 2006; Hackie & Bowles 2007),

therefore, it is unclear whether guilt would play a role in the experiences of parents who are unaware that their children are overweight.

Other research has found that some mothers report feeling guilty for passing on a perceived genetic susceptibility to obesity to their children (Hughes, Sherman & Whitaker, 2010). In addition, those who were working outside of the home felt guilty for not spending enough time with their children, which sometimes led to them overindulging their children, including acquiescing to requests for unhealthy food (Hughes, Sherman & Whitaker, 2010). Given the role of guilt as a behavioural motivator, it is important to investigate the emergent role of guilt to better understand the implications for the design and implementation of child obesity interventions (Pescud & Pettigrew, 2014).

1.9.4 Parental views on prevention

A systematic review of qualitative studies looking into parental views of preventing overweight and obesity has been done (Pocock et al., 2009). However, out of the 21 studies included in the review only one included a UK sample. Furthermore, the authors found that reporting of study methodologies was variable and frequently incomplete. The scope and purpose of studies was often inadequately described and even where study rationales had been stated, there was commonly no outline of theoretical or conceptual frameworks or frames of reference. However, the studies were considered to have adequate sample sizes and ultimately no studies were excluded on grounds of serious flaws in quality.

Nevertheless, this review highlighted that parents felt pressure to be positive role models. Parents in several studies recognised that their own behaviour potentially influenced their children's and expressed the belief that it was important for parents to act as positive role models, in relation to diet and exercise, however, this often did not happen because of a perceived lack of time (Pocock et al., 2009). Some parents also reported that it was sufficient to encourage their children to be active, without being active themselves (Pocock et al., 2009). This systematic review also highlighted various opinions about responsibility for child weight management. Some parents felt it was a family responsibility within their sphere of control and others that schools and other childcare providers were largely responsible, which took matters out of their hands. In this respect, the idea of overweight being inherited and beyond parental control was also cited (Pocock et al., 2009). Still, parents have generally been reported to be concerned about their parent/child relationship and fear conversations around their childs overweight will breed low self-esteem or eating disorders; that saying 'no' to their child will cause problems in their relationship (Toftemo, Glavin, & Lagerlov, 2013). This may partially explain why some parents feel the responsibility of weight management should lie with external agencies such as schools, as it would be less threatening to the parent-child attachment. Further research has also indicated that parents considered physical activity and nutrition of children aged 10–12 years a responsibility to be shared with school. Grandparents, however, were not always described as helpful by participants (Van Lippevelde et al. 2012). Similarly, Stewart et al. (2008) noted that the extended family often undermines and fails to support lifestyle changes initiated by parents and the health care system.

1.10 Adopting a Qualitative Approach

Given the absence of research that focuses on minority ethnic parental experience of having an overweight/obese child, a qualitative approach with exploratory aims was selected. A qualitative approach was deemed appropriate to prevent imposing constraints on the data by using hypothesis testing or quantitative methods. Additionally, a qualitative method was felt important to enable the emergence of salient idiographic experiences and their subjective meanings. Furthermore, a qualitative exploration permits a detailed examination of the evident complexity inherent in parental experiences of this nature (Clark, 2009), which is currently absent from the literature base. Moreover, a qualitative approach was felt to be appropriate as it would move beyond a distress or impairment focus and capture the wider experiences and perspectives of parents within a broader social, emotional and psychological framework.

The qualitative method of Interpretative Phenomenological Analysis (IPA) focuses on participants' perceptions, with the aims to understand how individuals make sense of their experience, using a subjective and reflective process of interpretation (Smith, Flowers, & Larkin, 2009). The inductive and iterative procedures of IPA help the researcher develop an "insider perspective" on the topic being studied, whilst also providing an interpretation of what this means to the participant. IPA is grounded in phenomenological epistemology and was thus considered suitable for exploring the parental lived experience and how parents make sense of these experiences (Holloway & Todres, 2003). The specific rationale for using IPA is discussed extensively in the methodology chapter.

1.11 Rationale for current study

As the above literature suggests, there is much research into the childhood obesity epidemic which has enabled some understanding into aetiology and treatments. There has been a shift towards furthering knowledge in parental experiences to enhance treatment effectiveness, however, much of the research has focused on Caucasian families and where culturally diverse communities have been included, it is primarily in the US with Hispanic and African-American individuals. Culturally specific research in this area is lacking in the UK. Given the health inequalities of minority ethnic groups within the UK, particularly in London, and considering the discrepancy between white Europeans and minority ethnic groups in many lifestyle factors, such as socio-economic status, it is vital that lifestyle modification programmes are developed that are suitable for implementation in multi-ethnic settings and can respond to the specific needs of minority ethnic groups.

NICE (2014) guidelines recommend advice on lifestyle change is tailored for different groups, particularly minority ethnic groups as their uptake of health information is lower than other groups, and under researched. Due to the lack of minority ethnic populations accessing interventions, the large attrition rates in childhood obesity interventions, the continuing rise of childhood obesity in the UK and the largely negative experiences of parents with obese or overweight children (as highlighted above), a need for research in the area of parental experiences in minority ethnic groups is indicated. Given this, qualitative research can be used to inform intervention and is especially appropriate for understanding individuals' subjective experience whilst

being sensitive to the contextual, social, economic, and cultural factors which influence health beliefs and behaviours (Strauss & Corbin, 1998).

The fidelity-adaptation tension involves two competing aims: (a) to develop universal interventions and implement them with fidelity, and (b) to design interventions that are responsive to the cultural needs of a local community. By implication, interventions that are "culturally blind" will fail to attract community participation, likely reducing program outcome effects (Kumpfer Alvarado, Smith, & Bellamy, 2002). The current study aims to use qualitative methods to help in firstly understanding the specific lived experience of minority ethnic parents living in the UK, which may then lead onto interventions being adapted to avoid "cultural blindness".

1.12 Study summary and research aim

This study will aim to increase the understanding of parental experience of having a child who is overweight or obese within a minority ethnic community to inform the development of interventions to enable services to meet the needs of this unique but increasing population. In-depth insight and understanding may enhance prevention, engagement, and intervention strategies and may thereby mitigate negative effects on the parent and child. Furthermore, the data may facilitate more effective targeting of psychosocial interventions to improve parental experience and the quality of care provided to children and their parents, particularly in minority ethnic communities, whilst making a valuable contribution to the limited evidence base.

The study will aim to answer the following research question:

What are the lived experiences of minority ethnic mothers of children who are considered overweight / obese?

Chapter 2: Method

2.1 Research design

A cross-sectional qualitative design was used. Semi-structured interviews were completed with parents who had a child who was overweight, to explore their experiences of their child's overweight within their family structure and specific culture.

2.2 Epistemological position

This research is concerned with lived experiences of parents who are from minority ethnic groups and who have a child who is overweight or obese. It is especially concerned with the meanings parents make of these experiences from their own individual perspective (Larkin & Thompson, 2012). This study assumes a critical realist stance within a hermeneutic phenomenological epistemological position. The critical realist position states that there are associations between ones' subjective reality and their individual account. The researcher can never have comprehensive access to an individual's experience (Nightingale & Cromby, 1999), however, through interpretations made of their accounts, understanding can be inferred within the context. IPA is consistent with this epistemological position and the exploratory aims of the study, which is to understand the experience of minority ethnic parents with an overweight or obese child.

2.3 Interpretive phenomenological analysis: theoretical underpinnings

IPA is a qualitative methodology developed by Jonathan Smith (1996) to systematically explore individuals lived experiences. IPA focuses on participants' perceptions in an attempt to understand how individuals make sense of their experience, by using a reflective process of interpretation which is subjective (Smith et al., 2009). The logical and repetitious procedures of IPA help the researcher develop an 'insider perspective' on the topic being examined, simultaneously providing an interpretation of what this means to the participant. IPA is informed by three philosophical principles: phenomenology - the study of lived experience and being; hermeneutics - the theory of interpretation underpinning the interpretative element of IPA and; idiography - the study of the discrete at an individual level. A more detailed examination of these principles is outside the scope of this research, for further details see Shinebourne (2011) and Smith and colleagues (2009).

2.4 Rationale for choosing interpretive phenomenological analysis

Researchers have long been utilizing qualitative approaches to examine perspectives and meanings about little known or understood phenomena (Marshall & Rossman, 1999). Due to the unique and "difficult to reach" population to be studied, and specific and understudied topic area, qualitative analysis methods were considered appropriate.

The exploration of parental experiences within the context of parenting an overweight/ obese child is especially well suited to IPA as one of the key epistemological elements of IPA is that of idiography as highlighted above. In contrast to most psychological

research which is looking for patterns, or for data to be generally applied to groups or larger populations, IPA is concerned with the individual detail of lived experiences, within a particular set of circumstances (Smith et al., 2009). From a phenomenological perspective, IPA can also help research move beyond an objective and observable conception, to consider subjective and lived experiences. Furthermore, IPA also has particular utility in examining experiences that provoke reflection, not only by the individual having the experience but also for those the experience is being relayed to, this is due to another key epistemological element of IPA; interpretation, or hermeneutics, also noted above (Smith et al., 2009). This aspect of IPA was influenced by Heidegger (1962/1927) who stated that it is impossible to escape using an interpretative approach when considering any lived experience. Heidegger (1962/1927) specified that there is a context in which experience is interpreted and that this context will be different for each individual. IPA demands an open acknowledgment of interpretation within an analysis as the way to understand how sense and meaning is applied to an experience, but also includes a 'double hermeneutic' of reflexive interpretation whereby the researcher reflects on their own interpretations, sense and meanings, of the original, interpreted, lived experience (Smith et al., 2009). Furthermore, studies have successfully used IPA to examine parental experiences of having children with a variety of psychological and/or health related challenges (Daniel, Kent, Binney & Pagdin, 2005; Glasscoe & Smith, 2011). However, very little qualitative exploration has been done examining parental experiences of having an overweight/obese child specifically. Qualitative examination that has been done primarily uses thematic and narrative techniques in order to identify similarities between experiences and is not interested in unique parental experiences (e.g. Jackson et al., 2007). Furthermore, the minimal qualitative literature that investigates parental

experiences of having a child who is obese/overweight often focuses on Caucasian families, neglecting minority ethnic populations and therefore minority ethnic parental experiences are still considered to be an under-researched topic area.

IPA is considered appropriate for under-researched topic areas as it captures the perspective of untold narratives, which is especially applicable in the case of minority ethnic parents with a child who is overweight. Predetermined hypotheses are not held when using IPA, and thus participants' voices are unconstrained, allowing novel and unexpected features of a phenomenon to be exposed (Shaw, 2001). IPA allows insight into processes such as decision-making, the experience of a parent feeding a child within societal, familial, ethnic, and cultural contexts, and the experiences of "overweight"- these features would be lost through quantitative methodologies. Moreover, IPA provides a theoretical framework that can be applied to exploring the processes through which people make sense of, and attribute, meaning to their experiences (Brocki & Wearden, 2006). Finally, IPA offers clear guidelines, training and support groups to help ensure production of a high-quality piece of research, for a novice researcher.

2.5 Excluding other qualitative approaches

IPA was selected after excluding many other qualitative approaches. This was done through careful consideration during the development of the study and the research aims to determine the most appropriate analytical method.

Thematic Analysis (TA) (Braun & Clarke, 2006) takes a nomothetic stance, concerned with the generalisability of findings, and typically employs larger samples to do so. Less significance is placed on the reflexivity of the researcher and the analysis is focused at a more descriptive level. It was decided that this approach would not produce an idiographic or sufficiently rich understanding of parental experience. Furthermore, it would not adequately attend to the role of social and cultural context through interpretations.

Discourse Analysis (DA) was also considered. DA examines the way language is used to create the reality of one's world (Forrester, 2010). It assumes that multiple realities exist which have been shaped by prior knowledge and assumptions known as 'discourses'. DA's emphasis is on the way in which these discourses structure the creation of narratives through interactions. DA is primarily interested and motivated by pressing social issues, which it hopes to better understand through discourse analysis (Van Dijk, 1993). It was felt that this sociopolitical focus of DA on the broader societal narratives would perhaps limit the extent to which the individual experience can be explored in depth and understood, as is the aim of the current study. Therefore, focusing on individual meanings was thought to provide a better starting point from which to compare with pre-existing research of families in relation to childhood obesity.

Grounded Theory (GT) (Glaser & Strauss, 1967) is a sociological methodology used to describe and generate theories/models of social processes. GT is most suited to research which aims to develop a theoretical model using a large sample of individual accounts over a substantial amount of time (Lingard, Albert & Levinson, 2008). GT was considered to be inconsistent with the broader, exploratory focus on capturing

previously unheard experiences of minority ethnic parents who have a child who was overweight (Harper, 2012). Consequently, IPA's emphasis on individual experience was considered most compatible with the study's aims.

2.6 Procedural and ethical considerations

The study was granted self-certified ethical approval by the Royal Holloway University of London Ethics Committee prior to proceeding with recruitment (Appendix 1). Following the initial approval, one amendment to the original application was made. This was based on the stipulations made in the initial research proposal that "Should recruitment of Bangladeshi participants prove difficult in the given time period the study should be opened up to minority ethnic communities and reviewed again by the ethics committee", thus the ethical approval was amended to consider minority ethnic communities and not only Bangladeshi parents, and was re-submitted and later approved by the Royal Holloway University of London Ethics Committee in November, 2016 (Appendix 1).

Thorough consideration and care was given to possible ethical implications of the study for participants, as this project involved interviewing parents around a potentially sensitive topic. Several ethical considerations were addressed via the Participant Information Sheet (Appendix 2), these included:

2.6.1 Informed consent

All parents were over the age of 18 years and deemed to have capacity to consent to their participation. All participants received an information sheet (Appendix 2) at least 24 hours in advance of the interview. The researcher only contacted the participants following their consent to do so, either by email, or via confirmation from the children's centre managers.

The information sheets were checked for content and accessibility by supervisors and given in support of ethical approval. Prior to the interview, participants were reminded of the details outlined in the information sheet and provided a further opportunity to ask any questions. All participants signed the consent form (Appendix 4) prior to the interview, which was countersigned by the researcher.

2.6.2 Confidentiality and anonymity

Confidentiality and anonymity was outlined in the information sheets and reiterated by the researcher when gaining informed consent prior to the interview and before the interview took place. Data collected was held in accordance with the Data Protection Act (Great Britain, 1998). All identifying information was removed and participant's anonymity protected through assigning each participant with a number identifying audio files and interview transcripts. Pseudonyms were allocated to each participant and their child to protect their identity and improve readability. Paper data, including the consent forms and demographic information sheets, were stored securely in a locked cabinet. Electronic data was stored securely on an encrypted USB memory stick and

audio recordings deleted following transcription and analysis, adhering to NHS confidentiality standards. Participants were able to access to their data upon request and could withdraw their information from the study should they so wish.

2.6.3 Participant distress and well-being

It was not anticipated that the interviews would cause harm to the participants, and previous research suggests that families of children with health conditions may find it beneficial to discuss their experiences (Murphy, Christian, Caplin & Young, 2007). However, it was recognised that participants could become distressed when participating in interviews focusing on their child's health, the impact of their feeding practices, and possibly cultural food norms. This is consistent with Brinkmann and Kvale (2008) who assert that human interaction, integral in qualitative studies, can emotionally impact the participant.

The researcher adopted a sensitive approach to enable the participant to feel comfortable and build rapport. Interviews were conducted in a private consultation room at the relevant children's center or within their own home to ensure the participant felt as comfortable as possible when discussing sensitive issues. If any distress was observed by the researcher, they responded sensitively and empathetically and reminded participants of the support options available. Brinkmann and Kvale (2008) state that qualitative interviews can negatively impact the researcher themselves. Throughout the data collection process the researcher had access to supervision to reflect on the interview process.

2.6.4 Service-user involvement

Managers from the children's centres and one self-selected parent of minority ethnic background, with a child who was overweight, was consulted on the development of the interview schedule (Appendix 6), information sheet (Appendix 2) and information flyer (Appendix 3). The managers and parent were provided with a draft copy of the schedule, information sheet and flyer and asked for feedback on; relevance of the questions and information, the readability and accessibility. The interview schedule, information sheet and flyer were amended as described above. It was felt that many parents would welcome the opportunity to share their experiences and that it would be important to elicit both positive and negative experiences.

2.7 Sample size

IPA guidelines suggest a small sample is most appropriate to allow for close consideration of each individual's experience and elucidate meaning (Smith et al., 2009). Additionally, Smith and colleague's (2009) recommend, a sample size of four to ten interviews in the context of professional Doctoral research and is consistent with other relevant qualitative studies in health psychology (Hale, Grogan & Willott, 2010). It is generally regarded that data saturation, i.e. the point at which no new information/themes are see in the data, is the gold standard. However, the concept of saturation is difficult to operationalise. Nevertheless, Reid, Flowers and Larkin (2005) stated that less is more in IPA: fewer participants examined at a greater depth is always preferable to a broader, shallow and simply descriptive analysis of many individuals. Smith and colleague's (2009) highlight the fact that sample size is contextual and must

be considered on a study-by-study basis. However, they have argued that more than six participants may de-emphasize IPA's commitment to idiography.

A sample of six was considered feasible given the constraints of the "difficult to reach" group, the sensitivity of the topic and time frame for recruitment and analysis within a Clinical Psychology Doctorate (Muhib et al., 2001). It was anticipated that six accounts would be sufficient to permit integration of the lived experiences across the parent group whilst preserving individual differences.

2.8 Inclusion and exclusion criteria

The research used purposive homogeneous sampling. It is recommended in IPA literature to use a 'fairly homogeneous sample', and this advice is especially endorsed for researchers who are novice to the approach (Smith et al., 2009). Homogeneity simply refers to a set of cells, or in this case people, who are similar to each other. In the current study, homogeneity also referred to the selection of participants who provide an idiographic perspective, in a specific given context, that of parents who are from minority ethnic backgrounds, living in London, with a child who is considered overweight or obese. Several inclusion and exclusion criteria were established prior to commencing recruitment;

Inclusion Criteria:

- Couples and single biological parents.

  It is important to include single parents, as research has indicated that single parent families are at greater risk of having an obese child (Gibson et al, 2007).

- Parent/s living in the UK.

  The participants may or may not have been born in the UK

- Parent/s of children 0-10 years of age, children who are overweight/obese.

  This will be determined from parent reports of age, gender, height and weight, allowing the researcher to calculate a Body Mass Index (BMI) for the child using the most commonly used growth and BMI charts in the UK which produced by the Royal College of Paediatrics and Child Health (RCPCH) and are based on the WHO Child Growth Standards (Wright et al., 2002). Using the RCPCH growth charts; ≥91st centile is considered to be overweight, and ≥98th centile is considered to be very overweight/obese.

- Able to speak English fluently.

  Assessed by asking participant directly if they feel they are able to be fully understood/express their views in English without the use of an interpreter.

Exclusion Criteria:

- They were unable to provide informed consent.
- Mothers who are actively suicidal, self-harming, or presenting in mental health services for severe parental mental health difficulties. This is in order to reduce the possibility of risk situations occurring during the research process for a lone researcher.

2.9 Sampling and Recruitment

The study focused on the geographic area of Haringey. Haringey is an extremely

diverse borough, with a population of 254,900 according to the 2011 National Census. Two-thirds of the population in Haringey, and over 70% of the young people in Haringey, are from ethnic minority backgrounds. Over 100 languages are spoken in the borough and the population is considered the fifth most ethnically diverse in the country. According to the Census 2011, 65% of the Haringey population is not White British. This is higher than the London figure of 55% (Haringey council, 2013). Children in the borough of Haringey have higher than average levels of obesity. 39% of children in year 6 and 23% of children in reception year were reported as obese and overweight (Haringey Council, 2014). Furthermore, around half of some minority ethnic groups were reported as overweight and obese by year 6 compared to one in five White British children (Haringey Council, 2014). These statistics compelled the researcher to conduct the study in this specific area as the demographics of the area would aid access to the target population of the current research.

Participants were recruited from children's centers in Haringey. Links were made with the managers of the children's centers. Purposive sampling was employed to select a fairly homogeneous sample, thereby providing the researcher access to a particular perspective of a phenomenon (Smith et al., 2009). This sampling approach is theoretically consistent with IPA and its philosophy (Chapman & Smith, 2002). Potential participants were given flyers (Appendix 3) and information sheets (Appendix 2) about the study from the children center staff team, and participants were asked if they would be willing to speak to the researcher. For those who agreed to participate, the researcher explained what the study would involve, answered any questions, obtained written informed consent (Appendix 4), and scheduled a convenient time to complete the interview.

Two out of six parents requested interviews take place at their respective children's centre where a private room was provided for this purpose. The remaining 4 interviews were conducted as home visits. This flexible approach opened the opportunity to recruit families unrestricted by the timings of children centre opening hours and room availability.

During the recruitment period 8 eligible families were approached. Two did not take part due to logistical difficulties and six consented. The study sample consisted of six interviews.

2.10 Sample characteristics

All participants self-identified as their child's main carer. All participants were mothers of the child who was considered to be overweight. Information was gathered from a demographic information questionnaire (Appendix 5) completed at interview. See Table 1. for demographic information.

Table 1.

*Parent	Relationship to child	Age bracket	Ethnicity	Child gender	Child age (y.m)	Child ethnicity	Child born in UK?	**Child BMI Centile
Chen	Mother	36-40	Chinese	male	2.5	Chinese/ Black African/ Turkish	No	91st centile (overweight)
Mia	Mother	31-35	Black Caribbean	female	5	Black Caribbean	No	98th centile (obese)
Sanaa	Mother	31-35	Black Caribbean	male	0.9	Black Caribbean	Yes	98th centile (obese)
Amira	Mother	31-35	Asian Pakistani	female	6.7	Asian Pakistani	Yes	91st centile (overweight)
Seren	Mother	31-35	Turkish-Cypriot	male	1	Turkish-Cypriot/ Black Caribbean	Yes	91st centile (overweight)
Leman	Mother	31-35	Turkish-Cypriot	female	7.10	Turkish-Cypriot/ Asian Pakistani/ Mauritian	Yes	91st centile (overweight)

* Pseudonym. ** As calculated using 'UK WHO Growth Charts – 0-4 years (Girls/Boys)' and the 'UK Growth chart 2-18 years (Girls/Boys)' (3rd edition – RCPCH)

2.11 Data collection

2.11.1 Semi-structured interviews

In accordance with recommendations by Smith and colleague's (2009) and Reid and colleague's (2005), face-to-face semi-structured interviews were conducted to obtain a detailed first-person account of each parent's experience guided by the researcher's exploratory questions. Prompt questions were utilized by the researcher to facilitate expansion of answers and enquire further into areas of interest or unforeseen areas (Robson, 2011). Interpersonal style and non-verbal cues were observed and noted to aid interpretation.

2.11.2 Interview schedule

An interview schedule was constructed to guide the interview process (Appendix 6). Relevant empirical base was reviewed and the schedule was developed initially to include themes extracted from this. A first draft of the interview schedule was developed during the initial stages of the research project and then refined following review by one self-selected minority ethnic participant who fit the inclusion criteria. The researcher also underwent discussions with research supervisor, peers and sought advice from the London IPA group to ensure questions were relevant, phrased clearly, sensitively and in an accessible format. It was of utmost importance that the interview questions be culturally sensitive and accessible, and this was the key area the reviewing participant was asked to consider. IPA guidance was also adhered to, ensuring

consistency with the theoretical framework and epistemological position (Smith et al., 2009). Closed interview questions were avoided in order to elicit an unbiased account of parents' perceptions and experience (Smith & Osborne, 2003). As recommended by the London IPA group, questions began very open, exploratory and felt to be less challenging, to help build rapport and provide a platform from which participants could share their experiences. Following recommendation by the reviewing participant, questions terms such as "obese" were removed and replaced with "thought to be overweight" as this was seen to be more sensitive.

A pilot interview was conducted with a parent to assess the content and clarity of the questions and its perceived flow. Upon review of this interview, prompt questions were further refined to ask about specific examples within participants' experiences. This pilot interview enabled the researcher to experience interaction with a parent in a research rather than a clinical context and to become more familiar with the interview schedule.

2.11.3 Interviewing procedure

All interviews took place between 02.12.16 and 30.03.17 Two interviews took place in a private room on children centre sites and the remaining four interviews took place as home visits. The researcher followed the NHS lone worker policy and discussed a safety plan with supervisors prior to each home visit. Interviews were conducted with the parent alone, at a time and date convenient to them, taking into account school or childcare hours to enable the participants to speak openly about their experience.

Prior to commencing the interview, the researcher reviewed the information sheet with the participant, providing an opportunity for them to ask questions and highlight any important ethical issues. Participants were reassured that the interview could be stopped at any time if they wished and that they could withdraw from the study at any time. Participants then signed the consent form (Appendix 4). Interviews varied in length from 40 minutes to 90 minutes, with an average of 65 minutes. All participants were verbally debriefed by the researcher following the interview (Appendix 7). Feedback about the interview process was requested and participants were reminded of the support services available to them.

Interviews were recorded on a personal audio-recorder and later transcribed verbatim by the researcher, removing all identifying information. Following this, the audio files and transcripts were downloaded onto a secure storage device, and kept in a locked cabinet pending analysis.

2.11.4 Measures

A demographic information questionnaire (Appendix 5) was developed by the researcher in conjunction with supervisors, which parents completed at the interview.

2.12 Data analysis

Interviews were analysed in accordance with the principles of IPA (Brocki & Wearden, 2006; Smith, 1996; Smith, Jarman & Osborn, 1999) and guidelines proposed by Smith

et al. (2009). Analysis was also guided through supervision with research and academic supervisors who were experienced in qualitative methodologies, and support from the London IPA peer support group.

All interviews were transcribed verbatim through a process of listening and re-listening (Tilley, 2003). Non-verbal communication (e.g. gesturing), significant fluctuations in volume or pitch and pauses were noted (Smith & Osborn, 2003) to aid interpretation and understanding. All transcripts were transferred into a landscape table in Microsoft Word to permit recording of exploratory coding and emergent themes. In accordance with recommendations by Smith et al. (2009), each transcript was subject to the following procedure:

2.12.1 Reading and re-reading

The researcher read the transcript several times to gain familiarity, and to actively engage and immerse in the data - entering the participant's world. The researcher remained open to the development of new thoughts and perceptions throughout this phase. Rich and conflicting areas were identified.

2.12.2 Initial exploratory coding

Remaining close to the data, initial notes were recorded, carefully reviewing the data line by line. The researcher recorded descriptive, linguistic and conceptual comments in the right-hand column. Descriptive comments focused on the content and subject of the participants' account. Linguistic comments attended to participants' use of language

(e.g. pronoun use, tense, repetition and metaphors) and non-verbal communication (e.g. hesitation). Conceptual comments included interpretive thoughts and abstract concepts requiring a higher level of abstraction and ability to question the underlying meaning of the experience. See Appendix 9 for example.

2.12.3 Developing emergent themes

Emergent themes were developed from the researcher's initial exploratory codes. The emergent themes captured the content salient to the participant and connections between exploratory codes were mapped and recorded in the left-hand column. These interpretations required a higher level of abstraction, whilst also remaining close to the data to ensure interpretations were grounded in the participants' experience. See Appendix 9 for example.

2.12.4 Clustering and collapsing emergent themes

Emergent themes were then listed chronologically, and patterns and connections between themes were noted to aid the organisation of clusters of related themes represented on mind maps. These subthemes were further refined and taken to a higher level of abstraction, discarding some themes. Subthemes were given a descriptive title to capture the conceptual nature of themes they represented. This process was iterative, checking that the subtheme and the group of emergent themes were connected and evidenced in the quotations.

2.12.5 Moving to the next case

The four previous stages were repeated for the remaining five transcripts. Each transcript was considered individually and the researcher tried to bracket out emerging ideas from previous transcripts, to retain idiographic focus.

2.12.6 Cross-case analysis

Subthemes were compared across cases, exploring convergences and divergences within the data (Smith, 2011). Subthemes were re-organised and superordinate theme labels developed to capture a more abstracted and synthesised overall representation of participant experience. A master table of themes (see Results chapter, Table 2) was created to depict the subthemes within superordinate themes. A coherent narrative of the findings is presented in the results chapter.

2.13 Validity and quality in IPA

Guidelines developed to assess the validity and quality of qualitative research (Elliot, Fischer & Rennie, 1999; Yardley 2000, 2008) have been reviewed and carefully consulted throughout the phases of the research to ensure its reliability and rigour. The researcher's consideration and efforts to preserve Yardley's criteria and their application to IPA (Smith, 2011) are detailed below.

2.13.1 Sensitivity to context

Sensitivity to context was carefully considered through extensive literature review. This ensured the researcher has a full understanding of the relevant theory the study was sensitive to relevant empirical base, which in turn informed the research aims and development of the study. Sensitivity to the participants' experience was fundamental and therefore service-user involvement was incorporated together with a flexible interview structure to encourage the participants to share their lived experiences. The iterative process of analysis ensured themes were grounded in the data, and transcript extracts were used to support subthemes - available both in the results chapter and Appendix 8. The researchers own characteristics and influence of the research process was also considered (see Owning one's perspective and personal reflexivity).

2.13.2 Commitment and rigour

In-depth understanding of the topic and attentiveness to the participants' account using prompt questions to enhance the richness of the phenomenological data enabled commitment to rigour. Furthermore, idiographic engagement and interpretive analysis was ensured through careful analysis of individual accounts, their convergences and divergences. The researcher consulted published IPA literature and the London IPA support group to ensure methodological competence. As recommended by Smith (2011), extracts from at least half of the participants were represented in each theme except for one subtheme, thereby ensuring rigour of the IPA (see Results chapter Table 2). A pilot interview was conducted to enhance the researcher's skill and competence.

2.13.3 Transparency and coherence

The analysis of the first transcript was independently coded by a fellow IPA researcher as a credibility check. Derived themes were compared with the original transcripts to ensure that interpretations were grounded in participants' accounts, thus reducing researcher bias in the selection of themes for analysis. A final list of themes was agreed with research supervisor following discussion of which themes best captured the data, to ensure the credibility of the final account.

A paper trail evidencing how the interpretation emerged was retained to ensure transparency of the development from the transcript to the finalised report. A coded extract from a participant's transcript (Appendix 9) and table of emergent themes is provided to allow the reader to follow the analytical process (Appendix 10) (Yardley, 2008). The researcher demonstrated transparency and reflexivity by presenting her prior experience (see 'owning ones perspective and personal reflexivity'). A reflective journal was recorded throughout the research process to promote reflexivity and identify how the researcher may have influenced data collection and analysis (Meyrick, 2006). A section of the reflective journal can be found in Appendix 11. The researcher also recorded reflections before and after each interview to enable identification of preconceptions, so bracketing could be used prior to analysis.

2.13.4 Impact and importance

Given the absence of relevant research exploring minority ethnic parental experience of having an overweight child, it was felt that this study held considerable importance, particularly as childhood obesity is a growing concern in the UK. In the discussion chapter, the findings are examined in relation to previous literature and theory, and implications for clinical practice and future research are made. The research will be submitted for publication and shared with the children's centres that took part to ensure its dissemination and clinical value.

2.13.5 Owning one's perspective and personal reflexivity

Reflexivity, central to the qualitative paradigm, recognises the complexities inherent in objectivity in qualitative research. Acknowledgement of the researcher's values and beliefs and how these may have influenced interpretations made was critical (Elliott et al., 1999). The researcher's position, relative to the phenomenon under investigation, was carefully reflected upon to facilitate consideration of factors unintentionally influencing data collection and analysis (Willig, 2008).

The researcher is a 29-year-old British female of Turkish-Cypriot ethnic background and is a Trainee Clinical Psychologist. She has no children but has had extensive experience of children through family members and work with child and adolescent services. The researcher has had personal and familial experience of childhood overweight, however not to a chronic degree.

The researcher had some professional clinical experience working with parents and children with a variety of chronic health conditions both prior to, and during, DClinPsy training. These professional encounters afforded the experience of working closely with parents, their children and systemic networks.

Participants were aware that the researcher was not part of the children centres team, which may have enabled participants to speak openly about their experiences, sharing both positive and negative aspects that may or may not have been linked with the children centre staff. The personal circumstances of the researcher were not disclosed which allowed the parents to take the expert position regarding their experience and facilitated curiosity in the researcher. The researcher's reflections were recorded in a reflective journal throughout the process to assist open mindedness and note preconceived ideas and assumptions (Coyle & Wright, 1996). The transparency of the researcher's fore understandings and the reflexive process is considered to increase the integrity of the research (Maso, 2003).

Chapter 3: Results

Interpretive Phenomenological Analysis revealed 11 subthemes, grouped into five superordinate themes as represented in Table 2 below. The essence of each superordinate theme is encapsulated within the subthemes, which can be found within a large proportion of participants' accounts. A summary table and representation of themes across participants is provided in Appendix 8, together with additional supportive quotations.

Table 2. Master table of themes

Superordinate Theme	Subtheme	Number of transcripts contributing to them
1. *Ambiguity towards 'fat'*	*Perceptions about weight*	6
	Female weight	4
	Babies need fat	5
2. *The complexity of food*	*Food isn't just sustenance – it's much more*	5
	Having control and balance over food is a difficult task	4
3. *Culture & Family: torn between worlds*	*Acculturation*	3
	Back home vs here	2
	My family's involvement with my child	4
4. *Dilemmas of Motherhood*	*Alone, responsible, and to blame for my child's weight*	5
	'Good mother'	5
5. *Managing my child's weight*	*Negative experiences*	2
	What helps and what doesn't?	3

The themes are translated into a narrative account of the data presented below. Descriptions of the parents' experiences and interpretative analytical commentary is interspersed with verbatim extracts from different participants to evidence each theme. These quotes aim to illustrate the theme and highlight convergences and divergences between the parents lived experience and demonstrate how the theme was evident in different ways. The quotations were selected as most representative of the theme to

allow the reader to evaluate the correspondence between the interpretation and the data (Elliott et al., 1999). Furthermore, consistent with Yardley (2008), themes were extracted that were relevant to the research aims to provide 'impact and importance'. Some quotations have been edited to ensure the confidentiality of the participants and pseudonyms have been used to maintain participant anonymity. To maintain clarity, some extracts have been edited and the omission of less relevant information is indicated by '……'. The researcher's explanatory notes are noted as [text]. Pauses are denoted as [..] with each full stop representing one second. Where the extract includes dialogue from the interviewer, it is denoted as 'I'.

3.1 Superordinate Theme 1: Ambiguity towards 'fat'

The first Superordinate theme 'Ambiguity towards 'fat'' is comprised of three subthemes entitled: 'Perceptions about weight', 'Female weight' and 'Babies need fat', each relates to a different aspect of an apparent ambiguity towards fat felt by all the parents.

3.1.1 'Perceptions about weight'. The account of all six parents were punctuated with evident perceptions or specific ideas about weight. These perceptions came from themselves or from others and was either directed towards their overweight child, to themselves or towards another individual's weight. These perceptions often linked to cultural perspectives about weight from both home and host cultures.

Parents described feelings of shock when they perceive their child has been judged and labelled as overweight. There was a strong sense of tension when parents discussed the

perceived judgment towards their child and when they felt their child was being compared with other children, as illustrated by Chen and Amira.

> I was quite shocked, '……' errr she was just saying how, yeah we were just at the house the other day and she said "he's getting a bit fat" and I was really surprised, because I don't think of him that way… at all. Erm. And actually, I have that stereotype that people from both our cultures, Turkish and Chinese want big fat kids. So I'm always feeling like, my mums always saying, My [emphasized] mums always saying (childs name) is skinnier then my niece was, so... there are always these comparisons. *(Chen)*

> They just say it's her belly, they're like, you know it's not all round, like you know if you look at some kids from the back as well their legs are chunky their arms are chunky, she's not like that. It's literally just her belly. *(Amira)*

Both Chen and Amira are talking about what family members have said about their children. These appear to be experiences of others describing an issue with their children which they do not see themselves or do not agree with.

Most parents described obesity in negative terms and these were linked to personality traits that implied blame, for example lazy. Whilst describing obesity as negative parents would also describe being slim as a more desirable state and attribute positive feelings towards a state of slimness.

It's not their fault, they just carry the family traits in them, they're not really that fat. But then people would look at them as fat. *(Mia)*

I've never been obese! I guess, I have gotten lazy. *(Sanaa)*

See I don't know, but in our family, they like us to have like a nice weight, to be slim and everything, slim is better '……' Coz I think the majority of our family we are not like overweight or anything, no like the immediate family, we are all quite slim and petite, so looking at (child's name) it's, we look at her totally differently because, she's the first child that's actually, seems to be overweight. *(Amira)*

But you can't be a chubby adult. Not really. [laughs] the Turkish cultures very much like slim is, is you know the nice way to look erm but for children, no, I think there's a lot of flexibility for children, definitely obesity is, is not in that category though. When you see a child is obese and is struggling, to us to see them struggling struggling to walk, maybe struggling to get up, you know, being, feeling overly lazy, a child, a little child should have energy running around and no matter, chubby kids can do that, my child does that, he's chubby, but when their obese there's that sense of… I dunno like reluctance in the child to do that, maybe they wanna sit more or watch tv more or so on. So there is a big wide difference between them. And I've got markers in my mind about what is a concern and what isn't. *(Seren)*

For Amira and Seren, the concept that slimness is superior to overweight comes from their families and cultural backgrounds, a view on appearance that is engrained in them through societal influence. This idea that society influences our beliefs and views about fat is further supported by Leman.

> This day and age as well I feel like health and fitness has become such a big thing as well so it's like a combination of the environmental factors as well like affecting our view on how we should treat our bodies. *(Leman)*

Despite the above extracts mostly illustrating that parents did not find it a positive experience having their child's weight or their own weight negatively judged by others, an almost polarization occurred when some of the parents themselves were discussing other's weight, using similar negative terms and a sense it was appropriate to be open and blunt to people who have weight concerns.

> We are not British in any way, we don't 'beat around the bush', it's just like "oh you look fat today", or you know, "you could use with losing some weight, or gaining some weight. *(Chen)*

> Weight… if your fat, we tell you your fat, yeah. We don't mix our words. Your fat, we don't want to be your friends. *(Sanaa)*

Although Amira appeared to agree with negative views of obesity, she reported that she would use a gentler, less blunt approach, but would still feel within her rights to express her opinions to the overweight individual.

> D'ya know what if you are overweight in my culture it is not a good thing, I think, I think they would take action. I would say something but in a nice way, or advise them, coz later on in life it's not good for you. *(Amira)*

Whereas Mia contradictorily opposed the idea of judging others weight and felt it was not her place to consider other's possible weight issues.

> We don't call someone skinny or fatty, no, we don't have that. Its less of a focus among the black people. *(Mia)*

Interestingly, Chen points out that it is perhaps it is more common in British culture to have a 'stiff upper lip' and not mention what they really might be thinking or feeling which sets her culture apart from British culture. However, Mia on the other hand focuses more on the fact that weight whether it be fat or skinny is less of a focus for 'back people' which contradicts her fellow Caribbean parent, Sanaa's ideas about what 'black people' think about weight.

3.1.2 'Female weight'. Four of the six parents made specific reference to female weight being judged and females having more pressure than males regarding weight. This was often relating to personal experiences from childhood or adulthood, particularly associated with cultural perspectives from their "home" culture around what is seen to be an acceptable weight for women and how this is different from men.

Chen, Amira and Leman focused on female weight during their interview, they described pressures and standards that they felt women are subjected to with regards to their weight. They highlight the idea that as a girl or a woman your weight is acknowledged externally and internally more so than if you are male and the pressures this can cause.

> fat baby but then especially as a little girl '……' growing up there was a lot of pressure for the girl then the boy '……' he's got like a really broad chest, and he's quite big, and I mean it's cool coz he's a boy, but, I mean it's all cool, anyways, but I know if he was a girl that would be considered as something, he would be considered big, '……' I just think it's really important for us to have good role models, and be able to talk about it openly, coz especially as a girl growing up, there's just so much negative publicity and, the pressure is unrealistic. *(Chen)*

> Yeah… so in Asian culture you should be womanly, not too muscular… I mean my sister used to be a bit chubby when she was younger. *(Amira)*

> for my daughter, especially as a woman I think, erm, there's sort of, there's, externally in terms of the environment, media and whatever, there's an image that women have to uphold, that they have to be skinny to be pretty or erm, have a certain body shape to be beautiful, I don't want my, and the thing is my sister is really obsessed with how she looks, or she was, she's actually improved quite a lot but she used to go on about her weight a lot and I know that as a Teyze [aunty] they look up to her a lot, so erm, I really really don't want my daughter

> to fall into having body dysmorphia and stuff, like my sister will go on about how her body shape isn't right and I'm like what is wrong with you? Just appreciate what you have, and, and, and love who you are, you're not just what you look at in the mirror, there's more to you then that, and I want my daughter to, erm, have that inner love for herself, not just erm, what she looks like on the outside. *(Leman)*

Chen and Leman note the need for 'good role models' and someone to 'look up to' for their children, highlighting the perceived lack of healthy examples for children. Contrary to this Mia expressed that not only is there no added pressure for women with regards to their weight but also that if there is any focus on female weight that it is in favour women being larger rather than slim.

> Black women are not really bothered about their weight that's one thing I've noticed. They always eat eat eat [laughs], I think they think, the bigger the breast the bum the better '……' I was really skinny everyone used to joke and say, "your too skinny" you understand, but now '……' I've put on weight for the past year and I'm pleased with myself, even with the extra tummy fat and all that [laughs]. *(Mia)*

Conversely Mia's laughter could be interpreted as a means to minimise her uncomfortable feelings about having gained weight since the birth of her twins and laughter is perhaps an expression that she does not in fact believe what she is saying and her words are ego dystonic.

3.1.3 'Babies need fat'. All but one parent's account conveyed an idea that fat is protective and that it is 'normal' for babies to be slightly overweight, but furthermore it is actually needed for survival. Many of the parents explicitly link this perspective of babies needing fat back to culturally and historically relevant themes from their home countries.

> There so small, they just need to eat, I don't, I don't think you can overfeed a baby, he's not so much a baby anymore, but I just think there storing it all up for when they grow, right, you know, if he's four or five and he's really over weight I think I would think about it more. I think there's more of a case of being underweight then anything '……' you've got to put the food in when you can because when they get sick it just drops off them, so it's kind of like storing it in the bank, for the day, those three days when they don't eat, coz they are so small '……' I think there was that idea, you know, that the fatter your child was, the more chance they would have to survive. So, even as, even from old thinking, its still there…So yeah, they think we just want to make them as fat as possible. Because babies died! *(Chen)*

> We're happy to see chubby babies, 1 year old/ 2 year old, but if your chubby at 3 you need to do something. That's what we say. I mean, she's too fat she can't walk, but you want to see a chubby baby! I mean it's a joy to see a chubby baby! You know that baby is healthy. *(Sanaa)*

> So I'm not stopping her from eating, because she needs to eat, because she's growing. *(Amira)*

> In a Turkish culture its not a bad thing for a baby to be chubby, where as possibly in another culture I'm not sure, I won't name any but maybe it is, maybe its an issue. In our culture, no, its not an issue. Babies chubby they say he's healthy, to us chubbiness is healthy. Don't mistake that for obese, obese is not healthy, we can clarify the difference, but to have a chubby baby it makes you reassured that if they become ill, there's some leeway, there's some, you know you're not worried if they're not gonna eat for that one or two days. *(Seren)*

Above each mother highlights the need to feed their baby and that a child putting on weight is a positive sign for them. Seren also notes that it is related to her Turkish culture, she is unsure if it is exclusive to Turkish culture, however Chen in her extract above states that her view is from "old thinking" suggesting it goes back to historical cultural views and she later goes on to clarify this.

> Chinese want big fat kids. *(Chen)*

3.2 Superordinate theme 2: The complexity of food

This theme reflects the notion that food itself took on many different meanings and purposes for the mothers within this study. It is composed of two subthemes; 'Food isn't just sustenance – it's much more' and 'Having control and balance over food is a difficult task'.

3.2.1 'Food isn't just sustenance – it's much more'. Five out of six parents experienced that food could mean something other than sustenance. Three of these mothers noted how culture and food were linked and expressed an importance for eating food from their own cultures as opposed to traditionally British cultural food.

> He definitely likes to share meals with (childs name), I know that. He likes to cook and share the foods that he likes with him. Coz again I think food is a big part of his, identi…like cultural identity, so he likes to share. Like he's really proud when (childs name) asks for more yoghurt, or something, like a Turkish thing. *(Chen)*

> We have celebrations with food, like our national day, then there is certain dishes, that you prepare… and erm, my kids so used to already eating these ones, and in my country where I was brought up we normally have three meals for the day and they are all cooked, we don't put food in the fridge. Whatever they have for lunch, they don't have it for dinner, I always cook twice. And I will ask them "what do you want" they will tell me "mummy do you have this mummy do you have that" so they have two cooked meals for the day. Plus the breakfast. They don't eat ready made food, they don't like the taste. (laughs) they will start throwing up. *(Mia)*

> Like [sister-in-law's name] would prepare like meat and two veg, coz that's how your English people cook '……' coz I cook proper food, well Caribbean food, curry goat. *(Sanaa)*

Chen, Mia and Sanaa talk in a way that suggests superiority of their own cultural food compared with British food

Half of the parents also linked food and feeding with the act of care giving, using food to gauge if their child is unwell, or to keep them well by giving them food.

> Because I mean like, I take care of him, a lot, so I know what he will eat, but it's just, its, its, again, I think everyone's looking at it as a way of taking care of him. *(Chen)*

> If she don't eat then I know she's not well. *(Mia)*

> I think I saw her as vulnerable and so had to like really really look after her. Sometimes I feel like "I was just trying to be a really good mum and now I've over fed her" like "what did I do wrong" – it's a lot of pressure. *(Amira)*

Amira verbalizes the dilemma she faces currently with her child being called overweight as to her, feeding her premature baby was her way of caring for her child. This raises questions around dietary interventions for overweight children and the affect it may have on a mother to ask them to refrain from feeding their child, as it may feel to the mother that they are being asked not to care for their child, this is verbalized by Seren in response to when healthcare professionals advised her to give her child water instead of milk.

> But I'm not gonna starve him! So there's no real solution. *(Seren)*

Food has also been described by the parents as a communal activity, and a social activity. The mothers express that sharing food with their children and their family can bring them closer and strengthen their relationships.

> A communal thing, coz yeah I play with his trucks and stuff but I don't really wanna play with his trucks, but I wanna eat [small laugh], so, actually eating together is a very natural communing activity. '……' "I was, like my family didn't do that much together, we didn't, it wasn't like family activities or anything like there are now, but we ate together, so that was like a big thing to like eat together, so it was really important, food, and like I lived with my grandma and she cooked a lot and so food was a big part of our... identity in a way, you know? Like my family identity. (Chen)

> I'm pleased with myself because I want to eat the same thing as them. *(Mia)*

> So as a family it was a social thing, whenever we get together it was always about food, erm and that's, I think actually being Muslim and because, I mean not being, not because we're Muslim but, as [emphasized] a Muslim because we don't have going out clubbing or drinking alcohol or doing stuff like this sort of, I supposed an enjoyment that we do as a social thing is that we get together and we eat, we go out to restaurants, we, you know? So I find that we end up erm… making food quite important and that can be quite dangerous. *(Leman)*

Leman, like Amira, notices that there are consequences to food meaning more than just sustenance to her and her family and uses "dangerous" as a strong description of this. She also talks about food being a "social thing" in the past tense indicating that because of her child's weight difficulties she is now re-evaluating her and her family's relationship with food. Leman seems to have an uncertain personal relationship with food; thinking about food in a broader way then just nourishment, enhancing her social pleasure from food and on the other hand using food as a soother in times of emotional difficulty as described in the extract below.

> Yeah so that she is more connected with the reasons why we eat coz obviously we eat first as a source of nourishment, and then, food should be enjoyable but we shouldn't just eat because we want, you know, sort of, it shouldn't be attached too much to emotional eating, which unfortunately for me growing up it was totally emotional eating '……' it was always an excuse which I'm kinda falling into myself like "oh, I'm feeling down I'm gonna eat this whole cake" or whatever you know so. *(Leman)*

This idea that food is linked with our emotions is also seen in some of the other parents, however unlike Leman some of the other mother's link food and eating with positive emotions such as enjoyment.

> I think for all of us sharing food with him is a big source of pleasure and like '……' yeah I think I'm a feeder! Like, I like, I wanna see him eat, you know, it makes me happy to see him eat. '……' I enjoy to see (childs name) eat and I

> enjoy to prepare something where he likes to eat […] Yeah, it's like a basic necessity. *(Chen)*

> She enjoys eating. *(Mia)*

Both Mia and Chen describe pleasure being derived from food, and Chen goes further to highlight that seeing her child eat brings her happiness, suggesting that the affect food has on her as an individual comes from not only eating it herself but seeing her child enjoy something she has made, which is perhaps linked with her earlier comments about food being an expression of caring for her child.

Sanaa conversely expresses how food can be used to evoke negative emotions and be used as a punishment.

> When they used to give trouble at school that would be their punishment "do you want cod liver oil" even my big boy [name], if he gives it I say come and have some cod liver oil coz I can't talk to you! [laughs]. But it would shine their skin! If you want nice skin take cod liver oil. *(Sanaa)*

Again highlighting the complexity of food and the concept that parents may use food for many different purposes, not just for sustenance.

All the parents described food that is considered to be "junk" food, that is food that is high in fats and sugars to be in some way 'bad', which is in line with government dietary advice.

> And food, the fast food culture, and just the size of food... and you know, the thing is it's what is considered normal in your context […] coz they eat really unhealthily, they often eat lots of fried junk food and stuff. (*Chen)*

> Definitely like the other kids stuff like the sweets and the biscuits. *(Mia)*

> I can't go to their house and give [name] a packet of crisps, I can't give [name] like I dunno a coke, which you shouldn't give kids soda whatever. *(Sanaa)*

> Maybe change your oil, maybe not even use oil in your foods and fry food, and sugary foods cut all that down. *(Amira)*

> We have a healthy balanced diet, we eat a Mediterranean healthy balanced diet, we're not junk food family. *(Seren)*

> Thankfully my kids have never really been like that, they've never really sort of, asked for sweets or biscuits or anything, because I've made it, I don't make it as a treat. *(Leman)*

It was apparent that when the parents mentioned these "bad" foods they were eager to demonstrate that they understood nutrition and were not feeding their children the "wrong" foods, this gave the sense that they felt they were being judged, linking in with the subtheme of "Judgments about weight - especially female weight".

3.2.2 'Having control and balance over food is a difficult task'. Four out of six of the parents identified with the subtheme of struggling to have 'balance' and 'control' over their own food but also their child's.

All four of these mothers talked about how either themselves or their child not being able to stop eating, and perhaps not noticing when they are feeling full or satiety not governing how much is eaten.

> It's just eat eat eat all the time, I mean it's beautiful food so it's hard not to but, it is. *(Chen)*

> But I mean not over eating, I mean, my kids would probably eat the world, eat crisps and biscuits, I don't have that. They can have their snacks but you know you have to stop eating coz you know you need to eat your dinner. *(Sanaa)*

> "But with her, what it is, is she just constantly wants to eat. *(Amira)*

> I'm like "[childs name] I think you need to stop now", coz she, is as if she has a hole in her stomach bless her, sometimes if she enjoys her food she just doesn't know when to stop. *(Leman)*

The parents seem to be describing an uncontrollable element of food, which is linked with the previously explored enjoyment that can come from food. Furthermore Sanaa, Amira and Leman all appear to agree that their children perhaps should know when to stop eating but do not, explicitly stated by Leman in the above extract "she just doesn't

know when to stop". These mothers appear to feel that their children should be responsible on some level for when they stop eating, perhaps explaining part of the battle these parents have with managing their children's food intake daily.

This struggle to manage a child's food intake is expressed further by Chen when she describes having suffered with an eating disorder in her teens and feels the need to control her food intake, and again by Amira when she describes having to control her child's food.

> it was like a control thing, it happened for lots of reasons but I just didn't want to eat. *(Chen)*

> And they do blame me. But I'm like "you don't know what goes on at home" I said "you can say that now, but I know what I'm doing at home", the amount of times I have to control her. *(Amira)*

Leman adds to the concept of having 'control' over ones food in a converse manner, in that she reports her own marker of "really really out of control" as a description of when she would become worried and intervene in her child's food and eating.

> I dunno, put a bit of a stigma onto a child's weight unless it's really really out of control, but erm, and like see that their eating is really unhealthy and out of control. *(Leman)*

These ideas around constantly having to control what a child eats and be in control of ones eating, appears to be in contrast to the previous ideas around food being pleasurable, enjoyable and a social activity, as the concept of control puts constraints on this. Parents report having a dilemma and are torn between a deep enjoyment of eating and sharing food, with an underpinning concept that they should be "in control" of what they and their children are eating at all times.

Amira and Leman address this dilemma by discussing an attempt to find a balanced way of approaching food.

> like she'll want an apple, grapes, but then you can't give her too much of the fruit as well. I'm constantly thinking, I can't give her this, I shouldn't give her that… like balancing. '……' I think the right way is not to let her constantly eat, there should be a balance. *(Amira)*

> I'm just trying to encourage better habits, so when it comes to being, having more physical activity, and erm, balanced eating, and making her aware of it '……' in terms of being more conscious about what they're putting into their bodies through the day, erm, but at the same time they're still getting together to eat out sometimes and stuff, so, I'm thinking it's getting a bit more balanced. *(Leman)*

This appears to be an attempt at finding a compromise between loving food and all that it means culturally, socially and as a mother, but also considering health and quality of life and the impact food can have on the body.

3.3 Superordinate theme 3: Culture & Family: torn between worlds

This superordinate theme is comprised of three subthemes; 'Acculturation', 'Back home vs here', and 'My family's involvement with my children'. The first two subthemes relate to culture, difficulties in understanding ones culture and comparisons that can be made between heritage and host culture. The third subtheme focuses on family life for these mothers, how it holds a place of importance but also can come with difficulties and tensions.

3.3.1 'Acculturation'. Three of the parents strongly identified with the concept of acculturation and the difficulties with this. These parents describe not only the complexity of coming from mixed cultural backgrounds and then living in another cultural host country, but also the dilemma that poses when you feel you no longer belong "back home", and the practical dilemma of how to verbally categorise ones culture.

> "Yeah, my family, I'm from Hong Kong, so I'm Chinese, errrm yeah, so my personal heritage is Chinese, my little boy, erm, is born in Hong Kong, but he is half Chinese and his father is from Turkey… All [emphasized] Londoner, [small laugh] '……' so yeah, race and sex and gender and all those kinds of things really plays such a big part of it, yeah, yeah, so I think, I think it's just interesting to remember all of that is so, so culturally specific! *(Chen)*

> For me, I still don't know, coz I left 15 its still kind of bit young, I can't go back home I wouldn't know what to first thing to do, you know what I mean, that kind of thing?... I don't know I would not know. I would not know the first place to go, my house is, no the dads house is gone that's completely ash, so he doesn't have a house, my house… I guess I've got the foundation of a house but, not a home, dya know what I mean? *(Sanaa)*

> I'm not sure because growing up I haven't really associated with Turkish culture so much even though I am Turkish background I am very British '……' erm, like I said I don't really, I would hardly ever, I mean I remember when people would ask me where I was from I would find it difficult to know what to say coz I would be like well I'm Turkish but my dad's born here and my mum's born in Cyprus and she came, and I feel like I have to explain my whole life story [laughs], it's like I'm British but I don't know if I'm British, am I British? you know! So, erm, I think it's only as, sort of as I've grown up that I feel like I can actually identify who I am, I would say I'm more British and I've been brought up with some Turkish culture because of my background but, and we hardly ever speak Turkish at home and our food that we eat is Turkish but we also eat a lot of other stuff so I dunno. How funny! *(Leman)*

Chen uses the term "All Londoner" in a light-hearted manner, but is tapping into the concept of each city having its own cultural identity, and perhaps suggesting that she feels her son is more "Londoner" then "British". Leman questions her Britishness - "am I British?" – emphasizing the difficulty in defining British-ness. These points highlight

the complex nature of acculturation, indicating that it may include city cultures as well as whole countries.

Chen makes the particular point of highlighting the complexity of acculturation, and expresses that she has put a lot of thought into helping her son with his own acculturation, Leman also points out this importance of helping her children to acculturate as being a fundamental part of 'knowing who you are'.

> I'm teaching [child's name] different languages, and one of the reasons is because of that idea of context, you know, and that you know, not, it's not just that this thought can be expressed this way actually this thought can be conceived of all these different ways, and I think you know that is, hopefully that is more important than all the other things he's gonna learn. The words are the thing that construct the culture! So, when you learn a… and actually a culture is a way of thinking, way of perceiving a world. *(Chen)*

> I wonder what my children are gonna have to respond to the question! [laughs] coz their all mixed as well oh God! [laughs] but you know, making sure my children know who they are, that's really important to me, so I am really focused on making sure they understand each of the cultures that their background is from, so I hope that will help them to, sort of grow. *(Leman)*

3.3.2 'Back home vs here'. This subtheme not only refers to comparisons parents make between their home culture and their host culture specifically when thinking

about weight and diet, but also refers to differences over time, meaning when they were a child in the past in their home culture compared to their children now in British culture. Two parents convey how weight is relative and highlight the vast differences in weight "back home" compared to in the UK.

> I remember reading something about the BMI thing and how it's waist to hip, and how for a lot of Asian people, because they're more pear shaped then apple shape, it doesn't work, and they should have different measurements, so… all that sort of thing I'm very aware of, you know, I, I'm, I've got a slight frame and that's because of my… ethnic… makeup, you know so, I'm very aware of how those things are different in erm different cultures. '……' I have an aunty back home who's like always been considered fat, and here she would be considered normal, but her whole life, she has the mentality that she's obese, you know, coz, all the time she's considered the fat person, she thinks of herself as fat, and I know, if she were here, she would be average…So back home in Hong Kong, my aunty, who is not fat, but because in her context she is already considered so fat she wouldn't let herself go that much more. You know what I mean, there's sort of like, she's already way beyond normal out there, so at some point she needs to stop herself. '……' That's a big thing because, I could… erm.. well it's all relative, so like back home, I'm quite a big person. *(Chen)*

In this extract Chen mentions UK methods of measuring obesity and expresses that these are not culturally generalizable, furthermore how they do not consider the frame of the individual. These beliefs she holds regarding the inappropriateness of UK weight measurements perhaps contribute to how she regards her childs weight.

Sanaa also notes the difference in perspectives of her home culture and that of the UK. However, Sanaa's focus is on British culture perhaps contributing to obesity, and reports the experience of not really contemplating obesity until she arrived in the UK.

> Definitely. In the way that, what we eat. What we do. What we are expected to do, what we are taught to do, what's stuck in your head, like form growing up. You eat everything, unless you don't like it. You know, I've never known anyone to be obese, not personally, they've been fat but you see these people with the 16 stomachs, and their big stomachs, and their turtle neck. I never saw that. Ever. Until I came to England. (Sanaa)

Both parents consider their own childhood with regards to food and weight and the differences of this compared with the UK.

> Obviously because they are from other cultures and from other generations so how much do I think their points are valid or invalid, and then just like hoping for myself that I'm doing the right thing. Coz actually one thing I think about now, is like, there's so much modern food, you know, like, like, I try to get the healthy things but there's still like kid's organic juices and kids organic, nothing that we ate! And I try to wonder, I wonder like how much I should or should not feed him, what is right and what is wrong, and is modern, there's nothing to compare it to, because they didn't have it back then… Well see I try to do it with these healthy things, there like apple, pear and pumpkin, [laughs] you feel like "it's alright" yeah… but some, this didn't exist 5 years ago. (Chen)

> I used to be active, in the Caribbean to what I've got available to me in England, I'm very, like if I go back I don't think I could walk what I used to walk…yeah, definitely, and there's nowhere to go, kids in the UK, they don't have anything to do. Well for me, I wouldn't want my son, even though I say back home in the Caribbean is active, I wouldn't want my son to be out on the road. I prefer know that he's home and playing games then to be on the street, so that's a big contrast to what I want, to what I want him to do, and it's because of, I dunno, the killing, and I guess the area we live in, and what you see happening, like yesterday I was taking the dad home and they were fighting on the high road, and I don't want my son, he's never, he's fought once that I've heard of defending himself, but I don't want him out there getting in a fight coming home with a black eye. He's got too much going to be doing these kinda, you know, crap. (Sanaa)

Chen focuses on the differences in food over time, and expresses the predicament of what her child should be fed, she obviously places some value on the foods she grew up with and asks herself if 'modern' food is as healthy for her child. Whereas Sanaa focuses more on the differences in physical activity, and specifically references her concerns about her child's safety. She seems to hold the view that children need to be outside playing and roaming the streets to live healthy lifestyles, however at the same time fears the level of violence in London, particularly in Haringey and for this reason would not allow her children to be outside. It appears that these mothers are struggling with the fundamental concepts of a 'healthy diet and exercise' with barriers to them

being the modern society they live in which differs from their own upbringing outside of the UK.

3.3.3 'My family's involvement with my children'. This subtheme encompasses some of the complexities that occur within families in relation to one's children that was expressed by four out of the six parents. These mothers have expressed that when weight, food and feeding of their child comes into play, family relationships can become more tenuous and often conflicts can arise.

> Yeah, actually just the other day, like his grandmother, what were we saying... his grandmother, I was cooking something for him and his grandmother was like "oh no he would never eat that", I'm like, "ok", I mean, he will, because I mean like, I take care of him, a lot, so I know what he will eat, but it's just, its, its, again, I think everyone's looking at it as a way of taking care of him, and you sort of just have to bite your tongue and be like "alright, sure..", like you can say that, but I'm gonna cook it now and he's gonna eat it. Erm, but yeah, I think what, what, what the child eats, like if I had decided for [childs name] to be vegetarian that would have been a big problem, you know, coz, people want to feed them, give him the stuff they wanna feed him, like his grandmother brings home, brings round frozen food for me to cook for him. *(Chen)*

> I was like well when I had [first child] you lot [family] were in my ears, you can't do this, you can't do that, feed that child, go and eat, make sure you eat before you feed him, you know always telling me what, coz you've feed before you've, eat before you breast feed, so you lot were always on my case. *(Sanaa)*

> Especially the family, their like constantly, like their worried as well. And they do blame me '……' Yes because everybody is worried about it, and they're always at me. So yeah it has, the whole family, literally, like my parents, and my siblings, everyone. They are quite concerned about it as well. Yeah and the thing is, they do feed her, but obviously, now they've realised and they are sort of like "ok", they sort of like feed her properly. *(Amira)*

> We had a big argument about it, and I dunno if he is understanding my perspective coz he sort of goes on that I'm too lenient with them, when I really don't see that, I mean, he doesn't see how much, erm, you know I plan my weeks meals and stuff. *(Leman)*

These four mothers express an almost over involvement of some family members in the feeding of their child and seem to be expressing feelings of being judged and blamed for their child's weight problems, possibly pushing these mothers in a position where they have to defend their 'mother' status and show they are in charge of their childs food. Despite tensions that arise when family members become involved in their childs eating, these mothers expressed that grandparents hold a unique position, and in some way, are there to be respected and listened to, but also who are governed by different rules then them as parents when it comes to feeding of their grandchild.

> But erm, obviously because I'm his primary care taker, and I feel very responsible to like my elders, especially as, the culture I come from, it's a big thing to sort of respect your elders and so, I do somehow feel the pressure, that

> I have to… make him… I dunno, like I'm taking care of their grandchild I guess, so I'm aware of that. '……' I think my mum and [partner's] mum have been mothers for a really long time, so I do value their opinion, erm and then again because they are the grandparents. *(Chen)*

> when they had their first child they read a book 'how to be a parent', I never had that my mum just told me what to do and I got on with it, and my nan was like how we grow up. *(Sanaa)*

> But I try to say to them, right you only have this when you go to your grandparents house because I know at their grandparents house they always spoil them with that, they see it as spoiling them which I get a bit irritated with, erm, it's like, let them, their little, spoil them, give them all the chocolates in the world, erm, which is, I try not to interfere with that because that's just what grandparents do and let them be grandparents in a way, unless its, unless it's like really detrimental to them, but at the moment it's not too bad, but I try not to get involved on that side, so erm, yeah. *(Leman)*

For these mothers, perhaps the slightly over involved stance of their families with regard to their child's feeding and the fact that grandparents appear to have a different relationship with their grandchild's food, could create a difficult environment for a parent to have agency in changing their child's diet when they are recognised to have a weight problem.

3.4 Superordinate theme 4: Dilemmas of Motherhood

This Superordinate theme is comprised of two subthemes; 'Pressures of a mother' and 'good mother'. The subthemes are used to delve deeper into the experiences of motherhood in general, but more so, the pressures and demands of motherhood that lead to dilemmas and question and ultimately leave a mother wondering "am I a good mother?".

3.4.1 'Alone, responsible, and to blame for my child's weight'. This theme was prominent across the accounts of five of the mothers. Specifically, one pressure that came across was a sense that mothering happens somewhat alone, and is very much a full-time job that comes with a lot of responsibilities, and mothers often feel blamed for their child's weight difficulties.

> So erm, just me here. *(Chen)*

> It's just me. *(Mia)*

> To me, just feels like, I should do something about it. I wanna take action. *(Amira)*

> I am a stay at home mum, although I have worked part time, on and off, whenever I am not pregnant or having a new born [laughs] '……' that's my full time…. Hobby? [laughs]. *(Seren)*

> I'm a homeschooling mum so I'm really busy at home with them. *(Leman)*

Chen and Mia use the word "just" which both belittles and elevates their personal status, on the one hand the child is left with "only them" which may seem insufficient, but on the other hand they are expressing that they are able to do all that entails mothering without perhaps a partner's support. Chen further develops this concept of motherly responsibility and the pressures that only a mother bares.

> But erm, obviously because I'm his primary care taker, and I feel very responsible… I do somehow feel the pressure" '……' I think that's one thing, especially being a mum, like everything, err, you constantly feel guilty about everything [small laugh], but it's just you putting it on yourself really, yeah ok, you're getting glimpses of it maybe from your family, but its, its, you know, you put it on yourself. *(Chen)*

Amira, Seren and Leman also resonate with the huge responsibility as a mother, and express that even with husbands, mothers can still very much feel responsible and when it comes to their childrens weight blamed.

> She said I have to look at her diet, like maybe the things you're putting in her food" '……' And they do blame me. But I'm like "you don't know what goes on at home" I said "you can say that now, but I know what I'm doing at home", the amount of times I have to control her. *(Amira)*

> Of course I am responsible, I'm the one feeding him aren't I? nobody else is, he's not able to feed himself, I'm feeding him, so I am re- ultimately responsible no matter if he was skinny, fat, medium, doesn't matter. *(Seren)*

> I think I'm probably not a great example for that, coz I actually am putting on a lot of weight '……' I know I need to be a bit, try to be a good example. *(Leman)*

Chen and Amira go on to express that with this responsibility and blame, you can begin to question your mothering, which can lead to blaming yourself for your child's weight difficulties.

> And I try to wonder, I wonder like how much I should or should not feed him '……' but it's like that line between like where, how much do I trust myself, my own instincts, and then how much do I listen to somebody else? '……' I guess it makes me feel like, erm, well for one, questioning my own ability as a mother. *(Chen)*

> I thought ok maybe what she is saying is right, because we don't realise sometimes, that's just how we cook, then I thought maybe ok, she's a child and sometimes we don't realise '……' Sometimes I feel like "I was just trying to be a really good mum and now I've over fed her" like "what did I do wrong" – it's a lot of pressure. *(Amira)*

Amira explicitly uses the word "pressure" and the sense from these mothers is that with this responsibility and pressure mothers can often feel isolated in their parenting, being

blamed and made to question themselves, especially in relation to their child's health, it does not appear that these mothers feel that the father has the same experience of pressure and responsibility whether they are together in a couple or not.

3.4.2 'Good Mother'. Again, five of the six mothers related to the concept of a 'good mother'. Four of the parent expressed the want to be a good mother. Being a good mother for these parents involved trying hard, being motivated and being evaluated externally, for example someone telling them they were a good parent.

> I feel like I'm a good mother, I mean I try to be a good mother, you know, but I'm new to it […] just like hoping for myself that I'm doing the right thing. *(Chen)*

> Normally they say I have good parental skills. *(Mia)*

> I was just trying to be a really good mum '……' Mind you a lot of people have said to me, you know, I'm a good mum, I look after my kids really well, I take care of them, and as a whole we are a really good family. *(Amira)*

> Erm […] (laughs) erm […] well I've had, it's really quite surprising to say this, erm, sort of loudly, like out loud, erm but I've actually had a lot of people say that er, that I look really calm and I look really erm, like I've got everything under control and, everything's cool. '……' Because I have a lot of people say that to me, that like I'm doing a really good job as a mum or you know my family's got this and this so. *(Leman)*

All the parents struggled with speaking positively about themselves and appeared to find it easier to report back on positive things others had said about their mothering. This difficulty is expressed in Leman's extract above with the number of times she pauses and says "erm" but also explicitly when she notes that she hasn't said these things "out loud".

For Mia and Seren, 'good mothering' also includes an element of fighting and advocating for your child.

> The doctor said everything was ok everything is ok, but I'm saying "no" she's not eating she's not, even if she is sipping, this is not her, she would normally finish this… and then, after 5 days when, I stayed in the hospital, I refused to leave, because they said I should leave they wanted the cubical for someone else and I said no, and then I stayed and after a while another paediatric came… But I always know if my daughter don't eat, something is not right. *(Mia)*

> Like I'm not doing anything, but I'm not gonna starve him! So there's no real solution. At the end of the day I am not willing to let him cry. *(Seren)*

This expresson of strength as a mother appeared to be something both mothers were proud of when discussing it. For these morthers, their expert knowledge of their child overruled medical advice.

> She eat, I dunno, she just stopped eating, she just sipped on her bottle, and I said "no this is not my [name]. *(Mia)*

> All my babies are generally chubby when I breast feed, but as soon as I stop breast feeding they lose that, that baby, that baby chub. '……' I've decided within myself that erm he doesn't have to average and he doesn't have to be in a graph, he doesn't look abnormally fat, he doesn't have any problems, he walked at an early age, he walked at 9 months actually which is really uncommon for babies, so I think he's doing, all the milestones he's meeting, even though he's in this "unchartered" territory of overweight in this graph. *(Seren)*

This concept of 'I know my child best', and knowing ones child better then medical professional also resonated with Chen and stood as an important point for her.

> I think that I would be concerned if I thought that he was overweight… he's like above the 100th percentile, (laughs) but he seems fine! So I just think, you know you just have to make the judgement for you own child '……' I just think, I think, you know, I know him better than the doctors would, and obviously if he had a broken arm I would listen to the doctors but on like a sort of general base note, I, I, I would just have to trust myself, hopefully. *(Chen)*

Another key factor for all five of these mothers in being a 'good mother' was having a close and special relationship with their child.

I'm his mother I guess, that's our relationship, he's my child. *(Chen)*

I'm happy, I'm pleased with them. I love them, no complaints whatsoever, they well behaved. *(Mia)*

Oh we have a really good relationship. Yeah, she's like a friend to me, she's like "mum you're my friend" it's like a mother and friend relationship, like little buddies. *(Amira)*

Our family is, erm, you know complete now, so yeah, we're having a lovely, he's a lovely character and he's basically completed our family. *(Seren)*

Yeah we've got a really good relationship, bless her, she's erm, I would say we're very close, she's, she is comfortable, there's been times when she's actually shocked me, she'll come and she'll open up to me on an emotional level and she'll tell me like if she's upset about something or she wants to share something that's happened you know to her, and, erm, yeah we get on really well, she's erm, I think being a first child as well there is a different relationship, there's always a slightly different relationship so, erm, she's like my, my little confidant, I even open up to her and stuff sometimes you know [small laugh] so yeah, we've got a good relationship. *(Leman)*

The way in which the mothers express this differs; for Chen the uniqueness of the relationship is self-explanatory, whereas for Leman she derives pleasure in talking

about the intricacies of her intimate, emotional and unique relationship with her daughter.

3.5 Superordinate theme 5: Managing my child's weight

Four parents in total contribute to this theme, it's appropriateness comes from its links to the main aims of this study, which were to learn in detail about these parent's experiences of their child's overweight. This superordinate theme is comprised of two subthemes; 'Negative experiences' and 'What helps and what doesn't?'.

3.5.1 'Negative experiences'. This subtheme relates particularly to two of the parents who have had negative experiences with health care professionals and this has lead them to disengage from services.

> what about the social… health visitors on our neck. And I said "well I won't take him to the health visitor if we feel like that, just won't go". I would just say to them I'm gonna feed my child and that's that. Like the doctors did say before I left the hospital "you have to feed every 4 hours before we can release you", coz I lived in hospital with him, and then I just started to lie on the charts [laughs], I couldn't stay on the ward anymore!... so I said he was doing 4 hours, to go home! I needed to be at home… so taking into those considerations they should have been a bit more lenient. Dya know what I mean! Like change it up! Each child is different. *(Sanaa)*

> It meant a lot actually, because I didn't actually go back to the, the center again to get him weighed. I felt that every time I went it would be a case of "oh he's still putting on too much weight, it was a big put off, it was a big put off and I didn't want to be judged as well, because you know, oh you're, I didn't want to be seen as overfeeding my child '……' so that's why I'd much rather just refrain from going, I don't want to be like criticized. '……' but the issue is, that's not the reason I feel embarrassed, because I'm responsible, I'm embarrassed because they told me, look he's getting too big, do this, and next time I go there they will say it again and say it again and they'll think that I'm not making a differ- like I'm not doing anything '……' but I'm still nervous and worried to go back there, I probably won't, until he's lost the weight '……' I was really really put off, and I didn't feel that the advice they gave would help me in anyway, I mean, how is feeding a crying baby water gonna help anything other than make the baby persist in crying. *(Seren)*

Both mothers appear to feel judged by health care professionals in the situations they describe. Furthermore, these extracts speak to the notion that perhaps the health care services and professionals are not acknowledging a fundamental need for a mother, especially a new mother, which is to feel like a 'good mother' as discussed previously. By not acknowledging this and making the parent feel judged and inadequate the parent may then isolate themselves from future support and refrain from help seeking, which could do more damage for the child's health in the long term.

3.5.2 'What helps and what doesn't?'. As so few of the parents had sought any support for the management of their childs weight, much of their experiences of what

has helped or not helped comes from things that were imposed upon them, however both Mia and Amira reported feeling comfort and seeking reassurance from their doctors.

> I went to the GP, so he said to me, if both of the girls are eating, they're both healthy girls, he doesn't have any problem with that… he said to me, as long as she is eating, then that's not a problem. *(Mia)*

> It is a bit worrying, so I've got an appointment with the peadiatrician in a couple of weeks, I'm gonna go back to him and speak to him about her belly as well and see like, and see what her weight is like. *(Amira)*

It appears for these mothers having a good relationship with their doctors, being able to make appointments, ask questions and be reassured by them was an important and positive experience with regards to their children's weight.

Mia and Amira also both note their childrens school's involvement or lack of involvement with their childs weight and health.

> I feel that the kids doesn't do enough exercise at the school (laughs) I mean although I know they have the P.E. time, I know they run around at thing, but I dunno, like maybe, during the summer time, when they would be before you could be taking them for walks, you would walk round with them, but then after school there's nothing really to do until summer time and like during the winter they have from school back home, unless there's like simple activities like

> drama or singing, that's it. Except for afterschool sports or unless you pay for special classes for football or things like that. You always have to pay extra for the sporting activities. '……' She says the teacher says to eat all but the teachers are not even bothered. *(Mia)*

> She was at school and there was like a nursery nurse there, and they were, they like do checkups on the children, with their heights and weights and everything. *(Amira)*

For Mia, it is a lack of input from the school particularly in relation to physical activity that is of importance to her, whereas Amira first learnt that her child was overweight due to nurse checkups that were conducted within school. Amira appears to value the input from the school and Mia appears to encourage further involvement from the school. It seems that parents are willing to make an allegiance with school where their child's health is concerned.

Only Seren reports openly about what she feels didn't work with managing her child's weight.

> I am not willing to let him cry, and I think a lot of cases health visitors want them, like even if you speak to them about sleep, like you go to them and say my child doesn't sleep, they will say leave him, change his nappy, feed him, put him in the bed and let him cry! And I'm not willing to do that. So that to me, to go there and them tell me again and again, don't feed him, don't do this, let him cry, I'm not gonna do that and that's against my mothering, my parenting

> techniques. '……' I thought it was ridiculous because when a baby is crying for a feed after its been many hours since having a feed, waters not sufficient, waters gonna… fill him up for maybe 5 minutes and then he's just gonna cry again, so it was just, it was an impractical piece of advice. I understood where they were coming from, because they saw he's putting on quite a lot of weight, but there was no way around it at this point because he was on, just on milk. I didn't really listen to be fair. I just continued as I was, tried to space out the hours a little bit more, maybe pushing on half an hour for the next feed or so on, and trying to spread them out better, but it was still, it wasn't, it wasn't a practical way to go around it, so I just continued as I was already. *(Seren)*

She specifically has trepidations regarding the "cry it out" method that she was advised to use and believes this is "impractical" advice for parents.

Chapter 4: Discussion

4.1 Overview of Discussion

This study explored parental experiences of six minority ethnic mothers of children who were considered to be overweight or obese. Data were analysed according to the principles of IPA (Smith et al., 2009) and aimed to explore the following research questions;

> What are the lived experiences of minority ethnic mothers of children who are considered overweight / obese?

This chapter reviews the findings of the current study by considering the results in relation to each of the research question and reviews the findings in terms of the current literature. Following this, the strengths and limitations of the study will be appraised and the implications for research and clinical practice will be outlined. Finally, the researcher's personal reflections will be presented.

4.2 Evaluation of the findings

Due to the exploratory nature of this study and the breadth of the research question, it will be discussed following the pattern of superordinate themes. The analysis revealed five superordinate themes;

1. Ambiguity towards fat

2. The complexity of food

3. Culture & Family: torn between worlds

4. Dilemmas of Motherhood

5. Managing my child's weight

4.2.1 Research Question: What are the lived experiences of Minority Ethnic and Black mothers of children who are considered overweight / obese?

The maternal experience was marked across all superordinate themes. Within all the superordinate themes there appears to be an overarching concept of dilemmas. This leads to difficulty in summarising mothers' experiences in a linear fashion as these mothers tend to hold conflicting views and perspectives at one time, highlighting the complexity of mothering in general but furthermore of a child with particular health needs.

4.2.1.1 Ambiguity towards fat

In the current study, it was common for mother's to report feeling responsible, worried about the health and social implication of their child being seen as overweight, worry about the views of others (feeling judged), frustrated by the weight and trying to make

sense of it, particularly seen the in the subtheme 'perceptions about weight'. These findings are similar to those reported by Jackson and colleague's (2007) who found that overall mothers felt judged by others, they also reported that mother's felt blamed by their partners, worried about how best to help their child and pressure to be a positive role model for their child. The current study also emphasised the mothers experience of wanting 'good role models' and someone to 'look up to' for their children, highlighting the perceived lack of healthy examples for children. This was also found in a systematic review of the literature conducted by Pocock and colleagues (2009), who stated that parents not only wanted good role models for their children but also felt pressure to become these role models.

These findings went further in the current study as the mothers described the lack of role models, particularly for their female children. The mothers in the current study highlighted a difference between the perception of female and male weight within minority ethnic communities. This corresponds with the literature which reflects the belief that body dissatisfaction is a particular problem for girls; with many studies including only female participants. However, other studies that have examined gender differences found none (Eisenberg et al., 2003; Hill et al., 1994). This discrepancy may be linked to the way in which body dissatisfaction is operationalised. Literature often defines body dissatisfaction in relation to seeing oneself as overweight rather than underweight, therefore, researchers comparing male and female dissatisfaction with their weight need to consider the direction of the dissatisfaction. Dissatisfaction with body image in women is usually described by their desire to lose weight, whereas equal proportions of males wish to gain weight as lose it (Furnham et al., 2002).

The literature underlines that parents are concerned that conversations around their childs overweight will breed low self-esteem or eating disorders (Toftemo et al., 2013). Furthermore, that the psychological areas thought to be most severely impacted by overweight/obesity are; body image, self-esteem and emotional well-being (Wardle & Cooke, 2005). The concept of Self-esteem was not explicitly mentioned by the mothers in the current study. This may be related to the relatively young age of their children, or alternatively be linked with language and culturally equivalent concepts of 'self-esteem' perhaps not being present. However, many of the mothers in the current study made reference to their children's emotional well-being being impacted and one mother in particular linked focussing on weight at a young age leading to 'body dysmorphia'. This fear that mothers in the current study expressed is somewhat supported by empirical research as it has been found that restrictive dieting may act as a mechanism due to a preoccupation with food, which may trigger overeating leading to weight gain (Pietiläinen et al., 2012), and those who have restricted diets in adolescents are more likely to suffer weight gain and eating disorders into adulthood (Patton, Selzer, Coffey, Carlin, & Wolfe, 1999)

Another key finding in the literature is that of parents not recognising their child's weight problem (Turner et al., 2012; Edmunds, 2005). Haugstvedt and colleagues (2011) reported that in general parents accepted their children whilst hoping for change. However, they also felt ambivalent to acknowledging their child's weight as being a problem. This finding is supported in the current study and relates to the 'Babies need fat' subtheme. It was common for parents to ignore their child's weight due to the belief that their child would 'grow out' of their weight or that the child was too young for the parent to be concerned about their weight. This finding agrees with current literature

which states many parents do not recognise that their children are overweight and, tended to be unconcerned or unaware of the issue of childhood obesity (He, & Evans, 2007). Furthermore, parents did not perceive their children as being overweight, if they perceived their children to be active and have a healthy diet and a good appetite (Jain et al., 2001).

These findings of parents not recognising their child's overweight suggests that parents may be in the 'precontemplation' stage according to the 'Stages of Change' model (DiClemente & Prochaska, 1982). This stage is defined by a period where an individual is not thinking about changing their behaviour. Suggesting interventions could be developed to support parents in moving through the 'Stages of Change', to contemplation, preparation, action and eventually maintenance (DiClemente & Prochaska, 1982).

The current study highlights a difference between previous findings with Caucasian parents compared to the current findings with minority ethnic mothers. Caucasian parents tended to report feeling ambivalent to acknowledging their child's weight as being a problem (Haugstvedt et al., 2011), whereas, in the present study, mothers went further to convey that fat is protective and that it is 'normal' for babies to be slightly overweight, but furthermore it is actually needed for survival. Many of the parents explicitly link this perspective of babies needing fat back to culturally and historically relevant themes from their home countries.

The present study emphasized that cultural and historical stories and practices relating to child upbringing are brought with parents when they migrate. These practices from

'home' cultures appear to make it acceptable and even desirable to overfeed a child and have overweight babies. This concept has been supported by previous research (Bresnahan, Zhuang, & Park, 2014). This along with previous literature suggests that the history of a given country impacts on how one feeds their child. The cultural acceptability of overeating may be conditioned by past or recurrent economic deprivation, i.e., "feasting" whenever food is available (Mintz 1997). This was expressed clearly in the current study by one mother of Chinese descent, described that if the country has gone through times of poverty and famine, when food then becomes available people wanted abundance and to overfeed their children, not only to ensure their survival but also to show to the external world that they are wealthy and can afford to care for their children. Other research has supported this concept suggesting that older generations, especially Asians, are likely to think that a fatter baby is healthier (Cheung et al., 2011) and that the traditional Chinese belief equated being overweight with prosperity and health (Wu et al. 2005). This concept was directly referenced by a Chinese mother in the current study.

This concept of fatter babies representing health may be linked to evolutionary theory and survival (Buss, 2005). Attachment theory may also go some way in explaining this association between generations and cultural influences on child feeding. Literature has supported that parenting has been linked to the attachment relationships of parent and child, but are also influenced by attachment experiences from parents' childhoods, in their own families of origin (Belsky & Pensky, 1988).

Interestingly these "old thinking" ways did not translate to other findings around judgment of female weight. The majority of mothers in the current study expressed that

women were judged more negatively if overweight within their culture, expressed in the subtheme 'Female weight'. However, historically it is suggested that rounder women were considered more fertile and thus more attractive (Dixson & Dixson, 2011). One mother in the current study, of African Caribbean ethnicity did support this stating that it was desirable for women to have 'curves' particularly bigger hips and breasts as this related to 'womanly-ness'. This is supported by Davis, Sbrocco, Odoms-Young, & Smith, (2010) who found that Caucasian women emphasize a slender (i.e., absence of fat) body as most attractive, whereas African American women, conversely, describe attractiveness in terms of shapeliness, the fit of clothing, having hips, and femininity. This finding in the current study mirrors ideas posed by Lawrence and Thelen (1995) that African American children may not be exposed to the same attitudes and messages about dieting and thinness from their family, and/or peers.

4.2.1.2 The complexity of food

In the current study the complexity, importance, and the meaning of food was marked. This has not been a focus in previous studies on parental experiences with Caucasian participants suggesting that food and minority ethnic cultural identity are importantly related. These results were highlighted in the subtheme 'Food isn't just sustenance – it's much more'. The mothers express that sharing food with their children and their family can bring them closer and strengthen their relationships, feeding represented a form of care giving, and also an emotional link between food and feeding ones child, with many of the mothers feeling 'joy' when seeing their children eat. This link between positive emotions and the act of feeding may be related to learning theory and theories of attachment (Bowlby, May, & Solomon, 1989). Research indicates that babies learn

to associate the feeder (typically the mother) with the comfort of being fed and through the process of classical conditioning, come to find contact with the mother comforting. Thus, highlighting the reciprocal attachment relationship and its link to not only parenting practices but the important connection with the act of feeding one's child and the positive feelings of comforting and possibly joy that develop during this time (Bowlby, May, & Solomon, 1989).

The mothers reported that food from their own cultures held important links back to their heritage, often being considered as 'better' then British food. Interestingly, although three of the mothers expressed the superiority of their own cultural food compared with British food, two of the mothers used language that suggested they did not want to appear biased towards their own cultural foods. One mother emphasizing the amount of oil in her cultural food and another accentuating that they eat a variety of foods, not just their own cultural foods. This may be linked with the process of acculturation, as these two mothers were both born in the UK and therefore they may feel more allegiance to British culture as well as their own culture. The complexity of food has also been examined within the realm of 'food studies' which is an interdisciplinary field of study that examines the complex relationships among food, culture, and society from numerous disciplines in the humanities, social sciences, and sciences (Almerico, 2014). Kittler, Sucher, & Nahikian-Nelms (2012) addressed the influence of food habits on an individual's self-identity by stating that eating is a daily reaffirmation of one's cultural identity. Many people affiliate the foods from their culture, and their childhood with warm, good feelings and memories. This general association between one's cultural food and positive affect and memories could perhaps lead parents to overfeed their children despite their overweight, as part of learnt

behaviour and positive reinforcement that may result (Bowlby et al., 1989). This reinforcement associated with feeding may also serve to strengthen the parent-child attachment as suggested by behaviourists and learning theory (e.g. Dollard & Miller, 1950).

4.2.1.3 Culture & Family: torn between worlds

Within this superordinate theme, a key finding for some of these mothers was the difficulty of acculturation as highlighted in the 'Acculturation' subtheme. They described not only the complexity of coming from mixed cultural backgrounds and then living in another cultural host country, but also the impasse that poses when you feel you no longer belong "back home". These ideas were also highlighted in the subtheme 'Back home vs here' where mothers in the current study made comparisons between their home cultures and their host culture. Furthermore, they reported a practical dilemma of how to verbally categorise ones' culture. This complexity of the experience and process of acculturation has been discussed extensively in previous literature (Padilla & Perez, 2003). Research has also evaluated the relationship between ethnicity and acculturation in determining risk for obesity (Wojcicki et al., 2012). It is reported that the majority of people who migrate from low-income to high-income countries eventually adopt obesogenic behaviours, experience weight gain, and record higher body weights than their local counterparts (Goel et al., 2004). This literature supports the importance of considering cultural heritage and acculturation when addressing childhood adiposity.

Another key experience for these mothers was of the prominent involvement and importance of their families. Literature underlines that connectedness to extended family members and direct involvement of grandparents or elders in child rearing (Bentley et al., 1999), is apparent to a greater extent in minority ethnic families compared to Caucasian families (Kumanyika, 2008). With regards to the current study, mothers described a slightly over involved stance of their families regarding their child's feeding. They also described a unique grandparent/grandchild relationship, one where parents want to please grandparents and grandparents are free to 'spoil' their grandchildren with usually restricted foods. This could create a very difficult environment for a parent to have agency in managing their childs diet and weight. Previous research has also highlighted the distinctive relationship of grandparents, who have not always been described as helpful by parents (Van Lippevelde et al., 2012). Similarly, Stewart et al. (2008) noted that the extended family often undermines and fails to support lifestyle changes initiated by parents and the health care system.

This is also supported by other qualitative research with black adolescent mothers conducted in the US which suggests a strong role of grandmothers in deciding what infants should eat (Hannon, Willis, Bishop-Townsend, Martinez, & Scrimshaw, 2000; Bentley et al., 1999) and in shaping the young mothers' overall parenting style. (Black & Nitz, 1996). This is also supported by research in China which found that grandparents were commonly perceived to contribute to childhood obesity through inappropriate views (e.g. fat children are healthy and well cared for), knowledge (e.g. obesity related diseases can only happen in adults; the higher the dietary energy/fat content, the more nutritious the food), and behaviour (e.g. overfeeding and indulging through excusing the children from household chores) (Li et al., 2015). Furthermore, it

was found that conflicting child care beliefs and practices between grandparents and parents, and between grandparents and school teachers, were felt to undermine efforts to promote healthy behaviours in obese children (Li et al., 2015). Although the importance of family has been highlighted through Family Systems Theory which has considered the complexities of families in general and has moved interventions away from focusing on parenting, and child/parent interaction alone to think of the family more broadly (Flodmark et al., 1993), it is also important to consider some of these negative experiences of family over-involvement during child weight management intervention.

Other research in parenting and family interaction have been resulted in positive parenting theories (Sanders, 2003). Positive parenting is based on social learning theory (Bowlby, 1988). and developmental psychology (Shaffer, & Kipp, 2013). Its emphasis is on a harmonious parent-child relationship and on wellbeing of parents, children and the whole family (Sanders, 2003). Theories of positive parenting have led to interventions such as 'The Triple P-Positive Parenting Program' a comprehensive multilevel model of parenting and family support, which aims to better equip parents and families with support strategies (Sanders, 2003). Positive parenting theories highlight the need for an enhanced behavioral family intervention program for families where parenting difficulties are complicated by other sources of family distress (e.g. family conflicting values) (Sanders, 2003). It is of note that The Triple P parenting program in particular aims to enhance family protective factors and to reduce risk factors associated with severe behavioral and emotional problems however is not explicitly utilised for parents struggling with their child's eating behaviour (Sanders, 2003).

4.2.1.4 Dilemmas of Motherhood

A key finding was captured by the subtheme 'Alone, responsible, and to blame for my child's weight'. This was irrespective of paternal figures being involved in child upbringing, suggesting that the mothers in the current study embodied a classic 'primary care giver' position and with this came feelings of pressure and responsibility which ultimately lead to feelings of guilt when decision making. This is supported by Jackson and colleague's (2007) who agreed that mothers felt responsible for their child's weight, and also in other research where parents have reported that they have experienced negative emotions around their child's overweight such as anger and guilt (Haugstvedt et al., 2011). Parents in the current study also felt blamed for their childs weight, by external individuals (e.g. health care professionals and family members), but also internally blaming themselves. This is supported by previous literature that emphasizes that mothers hold strong perceptions that their child's weight reflects negatively on them as mothers, and that mothers feel that they are judged and blamed by others for their child's status as overweight or obese (Jackson et al., 2007). Research has also indicated that mothers have this sense of this blame and guilt, due to the responsibility for family decision-making about food and nutrition being on their shoulders (Jackson et al., 2007), which was very much echoed with the parents in the present study. These experiences of blame and responsibility that parents have expressed may be related to the problem focused approaches utilised in interventions with parents around childhood obesity (Rudolf, Christie, McElhone, Sahota, Dixey, Walker, & Wellings, 2006). Research has indicated that a motivational and solution focused approaches may be more affective (Rudolf et al, 2006). Motivational approaches are based on the degree to which behavioural change is

important to an individual, their confidence in their ability to achieve behaviour change, and the degree to which change is a priority. The solution focused model views the patient rather than the professional as the expert in order to identify "what works" (Rudolf et al, 2006).

Despite parents in the current study feeling blamed and owning the responsibility of their child's weight difficulties, it appeared that these mothers also expressed a sense of empowerment where advocating and fighting for their child's needs was part of the responsibility that they bore. That is, with the responsibility of being a mother comes a sense of "knowing my child best" and therefore being able to act within their child's bests interests, particularly when healthcare decisions are made.

Nevertheless, generally these mothers found it difficult to speak positively about themselves and appeared to find it easier to report back on what positive things others had said about their mothering. These results link with literature around positive parenting approaches whereby Parental Self-Efficacy is promoted. This refers to a parent's belief that they can overcome or solve a parenting or child management problem. Parents with high self- efficacy have more positive expectations about the possibility of change (Sanders, 2003).

4.2.1.5 Managing my child's weight

Both mothers who saw health care professionals regarding their child's weight reported negative experiences, feeling judged by the professionals, and ultimately refraining on returning to the services for ongoing support. One parent in the current study

specifically has concerns regarding the "cry it out" method that she was advised to use and believes this is "impractical" advice for parents. Although this mother is the only parent who overtly criticizes advice given to manage her child's weight, both parents who had input from health care professionals disengaged with these services. This may be linked with parents feeling judged and blamed for their child's weight as discussed previously, and may lead to them being highly likely to disengage with services. It is of note that the mothers in the current study were actively engaged in services to support them with managing their child's weight at the time of the study, highlighting a lack of accessible services for these mothers.

The experiences reported in the current study have been sustained in the literature which has highlighted negative experiences of parents with obese or overweight children. Research indicates that parents feel GPs and school nurses did not understand their situation, for example, the extent to which they could afford healthy food, as well as a reluctance from parents to consult their GPs due to a fear of being blamed for their child's overweight (Turner et al., 2012). Parents have also stated practitioners did not have the knowledge, time or resources to effectively treat childhood obesity (Turner et al., 2012). Other qualitative research in this area has highlighted vulnerability in parents - particularly through perceived dealings with 'prejudiced' health professionals; (Toftemo et al., 2013). They also reported feeling stigmatised and that their parenting skills were being questioned. These feelings have been linked with decreased motivation to; diet, exercise and lose weight (Vartanian & Smyth, 2013).

Two parents reported the particular importance of school involvement and it appears that these parents are eager to make an allegiance with school where their child's health

is concerned. One parent in the current study expressed that she felt school could be doing more for her child in regard to physical activity in particular. This is supported by Van Lippevelde et al. (2012) who indicated that parents considered physical activity and nutrition of children a responsibility to be shared with school. This is also reinforced by (Pocock, et al., 2009) who in a systematic review of qualitative literature found that parents felt it was schools and other childcare providers who were largely responsible for managing a child's weight. Involvement of schools and other agencies in management of childhood obesity may address some other parental concerns highlighted in previous qualitative studies. For example, parents and adolescents have identified a need for more long-term interventions (Murtagh et al., 2006; Stewart et al., 2008), this may not be feasible through health care services, however integration with schools may open avenues for interventions to continue for longer periods of time.

4.3 Critical Evaluation

4.3.1 Strengths

The main strength of this study is that it addresses a clinically significant gap in the literature. It provides a unique insight into minority ethnic parents in London, UK and their lived experience of having a child who is overweight or obese, through the collection of rich narrative data.

The study was subject to numerous measures to ensure the production of high quality IPA and thus the validity of the results. The service-user involvement and consultation with the London IPA group regarding feedback on the draft interview schedule ensured

questions were pertinent, clear and sensitive. Moreover, an initial practice pilot interview, permitted further refining of the researcher's interview style to ensure effective and sensitive collection of data. Furthermore, all participants were asked what the experience had been like for them at the end of each interview. This was in line with Kvale and Brinkmann's (2009) suggestion that asking participants about their experiences of being interviewed can help to strengthen the validity of a qualitative study. Feedback from participants suggested that the interviews had been positive, they had enjoyed talking to someone about the experiences associated with their child's weight, an opportunity they felt they rarely had.

Due to the stigmatisation of obese children and their parents, it may have proved difficult to recruit parents of obese children for research (Puhl & Latner, 2007). Furthermore, despite research indicating that that there are clear ethnic and race disparities in childhood obesity in the UK (Martinson et al., 2012), minimal research has been done examining parental experiences of having an obese child within minority ethnic groups. In the current study, six mothers from ethnically diverse backgrounds were recruited who were currently not engaging in any health care support for their overweight children. The sample therefore appears to be representative of diverse range of parents of obese children, and additionally the results may give insights into non-engagement with health care services.

A key strength of the study was the use of credibility checks to maintain the validity and quality of the final themes (Yardley, 2008), as outlined in the method section. Cross validation by supervisor, the London IPA group and peer-support from the Royal Holloway IPA Trainee support group ensured themes were grounded in the data,

mutually exclusive and coherent. The researcher conscientiously kept a reflective journal capturing preconceptions, concerns and thoughts throughout the process as recommended by Smith et al. (2009) and Morrow (2005). This reflexive process was found to be particularly helpful given the interviews were addressing a sensitive topic area and it enabled bracketing of biases, such as assumed parental reaction to their perceived 'blame' of child's weight, during the analysis.

4.3.2 Limitations

Participants in this study were all recruited from a children centres in one London Borough. These parents were also not actively involved in any weight management services for their children. This may therefore limit the external validity and generalisability of the findings to other areas in London and the UK; as well as to parents who are currently accessing a weight management program. In addition, parents were required to be confident in their ability to express themselves using the English language to be included in the study, therefore, parents who do not speak English were not captured. This may have had a limiting effect on the generalisation of the findings.

Moreover, some heterogeneity of both parent (ethnicity, marital status, occupation and number of children) and child characteristics (gender, age, access to previous weight management support) was present. However, this variability did not appear to result in divergent experiences. Although the introduction of some heterogeneity was required due to the small population size, this complicated the analysis of convergences and divergences within the sample and created challenges relating to the confidence in attributing findings to the shared lived experience, as opposed to variation within the

sample. It is probable that the findings best represent the experience of mothers who identify with the specific cultural backgrounds identified and living in the specific London Borough, thus further generalisation of the findings would not be well founded.

The methodology of data collection, together with the nature of the research, may leave a vulnerability for socially desirable responding from parents. Social desirability effects are possible (Durgel, van de Vijver & Yagmurlu, 2013), however the researcher attempted to minimise this risk by emphasising and reiterating participants anonymity throughout the study.

On reflection service user involvement in the project could have been used more throughout the development and execution of the research. For example, service users could have been involved in co-producing the interview schedule rather than consulting on a developed schedule. Furthermore, the participants could have been involved in the validations of the themes that emerged from the qualitative analysis, this would have ensured that the research was capturing their idiosyncratic lived experiences.

4.4 Research Implications

There are several implications for future research which arise from this study and warrant further investigation.

The parents in this study self-selected as being the main carer for their child. All participants were mothers with no fathers taking part in the study. This is in line with previous research as paternal perspectives are predominantly underrepresented in

parenting literature (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000). However, given the shift towards paternal caregiving roles in modern society, understanding paternal lived experience is essential. This would suggest that exploration of the paternal experience in future research would be a valuable contribution to the evidence base, as supported by Clark and Miles (1999).

One of the limitations of this study was the heterogeneity of ethnic background of these mothers and children. Though, all mothers shared the experience of having a different cultural background to their host culture, and lived in the same London Borough presently. Further research with homogenous ethnic groups within particular areas of the UK may provide more in depth cultural information regarding parent's experiences and benefit services in providing accessibility for minority ethnic groups.

The current sample is a community sample that is not currently accessing weight management programmes or support for their children. It would be useful to replicate this research with minority ethnic parents who have been or are currently accessing weight management support for their children, as this may give further insight into how services can adapt to best support these families.

Finally, collecting psychometric information such as a measure of health-related quality of life (QOL) such as PedsQL 4.0 (Varni, Seid, Kurtin, 2001) which has been used in previous research to indicate that severely obese children and adolescents have lower health-related QOL than children and adolescents who are healthy and similar QOL as those diagnosed as having cancer. Physicians, parents, and teachers need to be informed of the risk for impaired health-related QOL among obese children and adolescents to

target interventions that could enhance health outcomes. Using this in conjunction with qualitative exploration of parental and child experiences may aid contextualisation of the sample and facilitate inferences about the findings.

4.5 Clinical Implications

This study provides an understanding of the parental experience and meaning, previously absent from the literature, of being a minority ethnic parent with a child who is considered overweight. Several clinical implications for children's centres and NHS sites running weight management programmes are presented below.

Some specific barriers to behavioural change experienced by minority ethnic groups in general and the mothers in the current study are in the first instance a difficulty in minority ethnic groups being able to access services, due to language barriers, or stigma within a community. This could be addressed clinically by ensuring that interpreters and translated resources are readily available. Once services have been accessed, families have reported a lack of understanding by clinical professionals of cultural and religious requirements, but also behaviour change was obstructed by cultural and social norms, contrasting practices between generations and dietary change and physical activity being approached differently between cultures. These findings were supported in a systematic review by Johnson et al. (2011). Clinicians could engage in more preventative, outreach work, making links in culturally diverse communities with religious and community leaders, using psychoeducation and

motivational interviewing techniques to engage families in considering healthy habits in a culturally sensitive manner.

Mothers in this study have expressed negative experiences such as feeling blamed by health care professionals that have resulted in not returning to said services. this suggests that sensitive and non-blaming approaches should adopted by professionals when addressing a child's weight with a parent. These therapeutic techniques are widely advocated in clinical psychology, particularly in Systemic family therapy with children and their families (Lax, 1989). Furthermore, Rogers (2007) emphasizes the importance of unconditional positive regard and empathy as necessary conditions of therapeutic change.

Furthermore, it is important for both children's centres and NHS sites running weight management programmes to educate themselves on cultural food practices within a given family, as the importance of cultural foods and its relationship to self-identity have been stressed in the literature (Kittler et al., 2012) and in the results of the current study. This educating could be done by having open discussions with parents, and helping them to teach healthy eating habits to their children without excluding culturally important foods and feeding practices.

The current study also highlighted the importance in enhancing mother's self-esteem and belief in their capabilities as a mother, placing them as the expert of their child. This is a common therapeutic practice within psychological intervention (Goldfried &

Davila, 2005) and enables a strong therapeutic alliance, and furthermore allows clients to have agency which may lead to better health outcomes and change.

Supporting parents and children to have more in depth and open conversations about the child's weight including the various feelings and experiences, may help to ensure that attempts to manage weight are sought out at the earliest possible opportunity, a factor which is likely to enhance the effectiveness of intervention (Edmunds, 2005). One way of enhancing communication about weight may be through understanding what the cultural and historical influences are on the family (i.e. are grandparents championing an "old view" that grandchildren need to be "chubby"?).

In addition, it may be that giving families the opportunity to talk with a professional about their experiences would be helpful in them acknowledging the child's weight as being an issue; allowing them to then take action in an open, committed and realistic way. It is important that parents become aware of the potential difficulties associated with their child's weight as this helps to motivate them to start making changes (Ginger, 2006). Therapeutic techniques which aim to increase motivation toward health behaviour change (such as motivational interviewing; Rollnick & Miller, 1995) may be useful in supporting children and parents to become more aware of the need for change, as well as encouraging children to become more likely to engage with change.

4.6 Personal Reflections

Throughout this process, I have been struck by parents' readiness to willingly share their experience with a stranger. The sense of honesty and openness offered by these

mothers underscored the importance of reflective psychological support and follow-up. I was honoured that for many this was the first time they had reflected on and shared their experiences. At times, prompting parents to delve into difficult emotional experiences around concepts such as family expectations and blame, felt exploitative due to the vulnerability the parents conveyed however, all parents expressed that they derived benefit from the interviews.

This research experience has underscored the importance of systemically appreciating the needs of parents within a child health setting, which is frequently child focused and dominated by a medical model.

As a novice IPA researcher, my own experience and journey with the methodology was often difficult to navigate. During the analysis phase, I was aware of the striking parallels between my own feelings of wanting to be accurate and be a 'good researcher', and that reported by the mothers of wanting to be a 'good mother'. Having come from an ethnically diverse background myself, I have felt privileged to hear the stories and experiences of acculturation, and it has led to personal reflection about my own mother's experiences and the similar challenges she must have faced. Personally, their experiences highlighted the importance of appreciating our mothers and all the work that entails, but also the richness of culture and diversity and the positives of living in a culturally diverse society.

4.7 Conclusion

The current study aimed to explore minority ethnic parental experiences of childhood obesity. Interpretive Phenomenological Analysis (Smith et al., 2009) was used to identify themes and connections across six minority ethnic mothers' accounts. Five superordinate themes were identified: 'Ambiguity towards 'fat'', 'The complexity of food', 'Culture & Family: torn between worlds', 'Dilemmas of Motherhood', and 'Managing my child's weight'.

The findings highlighted the complex interactions between ethnicity, acculturation and parental feeding. The importance and meaning of food and its link with culture and heritage was also a key finding. The findings also expressed the significance of Family and their involvement parenting. Negative experiences of health care interventions for their overweight children were also highlighted. The findings advocate for cultural acknowledgment and sensitivity in child weight management settings.

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Appendices

Appendix 1: Self-certify ethics review details and declaration.

Ethics Review Details

You have chosen to self certify your project.
Name: Baykaner, Ozlem (2014)
Email: PBVA072@live.rhul.ac.uk
Title of research project or grant: Culture & Childhood Obesity: Investigating parental experiences
Project type: Royal Holloway postgraduate research project/grant
Department: Psychology
Academic supervisor: Afsane Riazi
Email address of Academic Supervisor: afsane.riazi@rhul.ac.uk
Funding Body Category: No external funder
Funding Body:
Start date: 01/06/2016
End date: 01/06/2017

Declaration
By submitting this form, I declare that the questions above have been answered truthfully and to the best of my knowledge and belief, and that I take full responsibility for these responses. I undertake to observe ethical principles throughout the research project and to report any changes that affect the ethics of the project to the University Research Ethics Committee for review.
Certificate produced for user ID, PBVA072
Date: 05/11/2016 11:11
Signed by: Baykaner, Ozlem (2014)
Digital Signature: Ozlem Baykaner
Certificate dated: 11/5/2016 11:36:30 AM
Files uploaded: Self-Assessment-317-2016-11-05-11-23-PBVA072.pdf
Volunteer information Sheet BME.docx
Consent Form.docx

Appendix 2: Participant Information Sheet

Information Sheet

Culture & Childhood Obesity: Investigating parental experiences

We would like to invite you to take part in a research study. We want to understand more about the experiences of minority ethnic UK residents who are parents of a child who is considered overweight or obese.

Taking part in the study is entirely up to you, before you decide whether to participate it is important for you to understand why the study is being conducted and what is involved. Please take the time to read the following information carefully, and discuss with others if you wish.

Why is this study needed?
Rates of child obesity have increased. Research has been conducted looking at treatment for childhood obesity, and this has resulted in Family Interventions being seen as most effective. However, we still do not know much about this research area, especially with relation to Black and minority ethnic groups.

This study aims to gain insight into minority ethnic parental needs, experiences and challenges associated with having an obese child. By understanding parental experiences interventions can be tailored in order to be most accessible and effective.

What does the study involve?
Once you have read this information sheet, the researcher will contact you to see if you would like to take part and to answer any questions you have.

If you would like to take part, you will be invited to meet with the researcher to take part in a face-to-face interview that will take roughly 1 hour. The interviews will take place somewhere that is private, but that is convenient for you. This may be your home, or an office space in London provided by Royal Holloway university. Your travel expenses should you have any will be reimbursed.

The interview questions will be looking at your experience of being a parent, having a child who is overweight or obese, how you feel about this, and what it is like for your family. All interviews will be typed up (transcribed). To help with this the interview will be audio-recorded, once transcribed the recording will be deleted. Unfortunately, we do not have interpreters available to aid you if English is not your first language, for this reason we ask

that you only take part in the study if you feel comfortable in talking in English, you don't need perfect English though.

We will ask you for some basic demographic information during this meeting e.g. age, gender, members in your family. You will not get a list of the interview questions before the interview, however it is ok if you do not want to answer some questions, or if you don't know what to say. It is not a test, and we just want to understand your personal experiences.

Approximately 6-8 people will be invited to take part in this study. Your interview will be 1-2-1 with the researcher, and it will be a one-off interview, that is, you will not be asked to take part in more research because you have taken part in this study.

Once we have recruited participants we will analyse the interviews and look for common themes. We would like to share the draft findings with you, to check that how we interpret the findings fits with your experiences.

What will happen to the results of this study?
The results will be published in recognised clinical journals. We will contact you if any publications are made and will supply you with a copy should you wish to have one. The identity of the participants who took part in the study will remain confidential and information about you will be kept anonymous at all times.

Do I have to take part?
No, it is completely up to you. If you decide to take part, you will be asked to sign a consent form. You are free to withdraw at any time, without giving a reason.

Are there any benefits for me in joining the study?
There will be no immediate direct benefits to you if you take part. However, there should be benefits to help develop services and interventions for children who are overweight and their families, to hopefully design more culturally sensitive intervention.

Are there any risks for me joining the study?
There are no immediate risks to taking part in this study. However, the topic of the research may bring up emotional reactions. If you become distressed during the interview you will be signposted back to your GP. We will inform you before any information is shared with your GP.

How will information about me be kept confidential?
We will protect your privacy at all times. The steps taken to ensure confidentiality are detailed below:

- Any information with your name or other identifiable details will be stored in a secure location.
- Your data will be stored using a unique, anonymous participant identification number. Only those conducting the current research will have access to the full data.
- If the research is published, direct quotes will be used, however these will all be anonymous.

Who is organising and funding the study?

This research forms part of a thesis project for a Doctorate in Clinical Psychology at Royal Holloway University of London.

Who has approved the study?
This research is approved by the Royal Holloway University of London Ethics Committee, which is there to protect your rights, wellbeing and dignity.

How can I get more information?

Please do not hesitate to contact Ozlem Baykaner, the principal researcher, via email should you need any further information about the study. You may also contact my supervisor, who is based at the Department of Psychology, Royal Holloway, University of London; Dr XXXX.

Ozlem Baykaner: ozlem.baykaner.2014@X.ac.uk

Dr XXXX: X.X@X.ac.uk

Appendix 3: Recruitment Flyer

Are you a parent from a Minority Ethnic group?

Are you concerned about your child's health?

Many children are overweight in the UK, however interventions do not consider culture.

Please volunteer to take part in our study!

All we need is 1 hour of your time, to ask a few questions to help improve services for children from Minority Ethnic groups.

For more information, contact;
Miss Ozlem Baykaner (Trainee Clinical Psychologist)
ozlem.baykaner.2014@X.ac.uk

Appendix 4: Consent form

Consent Form

Culture & Childhood Obesity: Investigating parental experiences
Name of Researcher: Ozlem Baykaner

Please initial box

1. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐

4. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix 5: Demographic information questionnaire

About me

1. Age (Please circle one):

   <20 20-25 26-30 31-35 36-40 41-45

   46-50 >50

2. Relationship to child
   _____

3. Marital Status_____

4. Ethnicity (Please tick one):

   Black or Black British
   Black Caribbean ☐
   Black African ☐
   Any other Black background……

   Asian or Asian British
   Indian ☐
   Pakistani ☐
   Bangladeshi ☐
   Any other Asian Background……

   Mixed
   White and Black Caribbean ☐
   White and Black African ☐
   White and Asian ☐
   Any other mixed background……

   Any **other** ethnic group……

5. Education level (Please circle one):

   Primary / Secondary / Graduate / Post-graduate

6. Occupation……
   ……
   (Please circle): Full time / Part time

About my child

1. Gender (please circle one): Male / Female
2. Date of Birth ……/……./…….
3. Position of child in the family (please circle one):

   Oldest youngest Middle/ Other only child

4. Attending nursery / School? Yes / No
5. If yes, what year is your child currently completing

   ……
   ……..
6. Weight

   ……
   ……

7. Height

   ……
   ……

8. Do you think your child's weight is something to worry about?

   ……
   ……

   ……
   ……

9. If yes, how old was your child when you started to become worried?

   ……
   ……

……
……

10. Have you ever spoken to your GP / pediatrician or another health care professional about your child's weight?

……
……

……
……

Appendix 6: Interview Schedule

Semi-structured interview schedule.

Introductions

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

Questions

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

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

2. **Who in the family is over weight or obese?**

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

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

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

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

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

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

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

6. **Do you think your culture has a 'role' in how you view X's obesity?**

Prompts: 'Role' meaning the culture has a specific slant on obestity? How do you feel about this?

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

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

Ending

8. **Is there anything else you think it would be important for me to know? Any thing you would like to add?**

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

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

Appendix 7: Debrief guidelines

Debrief:-

We have now reached the end of the interview. I would like to thank you for taking the time to talk to me. I have very much valued hearing your thoughts and experiences.

If distressed:

- Would they like to talk to a member of their children's centre about anything? If you
- aren't sure now you can always contact them later.
- Make a referral to Psychosocial Services?

Risk disclosed?

- Contact participants G.P?
- Contact Dr X to inform and make referral to Psychosocial Services?

Contacting me:

- Tell the participant that they can contact me by email (on Information Sheet) if they think of anything they would like to ask me, or if they are worried about anything related to the interview.

Report summary:

- Ask the participant if they would like to receive a copy of the main findings from the research and indicate on the Consent Form.

Thank you for taking part.
END OF INTERVIEW.

Appendix 8: Summary table and representation of themes across participants

Subtheme Theme	Participant	Quotation
Superordinate Theme 1: Ambiguity towards fat		
Perceptions about weight	CHEN	"I was quite shocked, '……' errr she was just saying how, yeah we were just at the house the other day and she said "he's getting a bit fat" and I was really surprised, because I don't think of him that way… at all. Erm. And actually, I have that stereotype that people from both our cultures, Turkish and Chinese want big fat kids. So I'm always feeling like, my mums always saying, My [emphasized] mums always saying (childs name) is skinnier then my niece was, so... there are always these comparisons." "because she is quite, is quite a big lady herself, and people from her family are a bit bigger, so I think she is maybe quite sensitive to it, or maybe aware of it" "We are not British in any way, we don't 'beat around the bush', it's just like "oh you look fat today", or you know, "you could use with losing some weight, or gaining some weight…"
	MIA	"…it's not their fault, they just carry the family traits in them, they're not really that fat. But then people would look at them as fat" "we don't call someone skinny or fatty, no, we don't have that. Its less of a focus among the black people."

	SANAA	"I've never been obese! I guess, I have gotten lazy…" "Weight… if your fat, we tell you your fat, yeah. We don't mix our words. Your fat, we don't want to be your friends…"
	AMIRA	"they just say it's her belly, they're like, you know it's not all round, like you know if you look at some kids from the back as well their legs are chunky their arms are chunky, she's not like that. It's literally just her belly" "see I don't know, but in our family, they like us to have like a nice weight, to be slim and everything, slim is better '……' Coz I think the majority of our family we are not like overweight or anything, no like the immediate family, we are all quite slim and petite, so looking at (child's name) it's, we look at her totally differently because, she's the first child that's actually, seems to be overweight." D'ya know what if you are overweight in my culture it is not a good thing, I think, I think they would take action. I would say something <u>but in a nice way,</u> or advise them, <u>coz later on in life it's not good for you.</u>"
	SEREN	"but you cant be a chubby adult. Not really. [laughs] the Turkish cultures very much like slim is, is you know the nice way to look erm but for children, no, I think there's a lot of flexibility for children, definitely obesity is, is not in that category though. When you see a child is obese and is struggling, to us to see them struggling struggling to walk, maybe struggling to get up, you know, being, feeling overly lazy, a child, a little child should have energy running around and no matter, chubby kids can do that, my child does that, he's chubby, but when their obese theres that sense of… I dunno like reluctance in the child to do that, maybe they wanna sit more or watch tv more or so on. So there is a big wide difference between them. And I've got markers in my mind about what is a concern and what isn't."

	LEMAN	"…but for her, I don't want her to struggle with worrying about her weight or feeling funny about her image or anything…" "…this day and age as well I feel like health and fitness has become such a big thing as well so it's like a combination of the environmental factors as well like affecting our view on how we should treat our bodies…" "I've never really been too conscious about my weight, which I'm not sure is a good or bad thing" "their weight is fine and they're young as well so I don't, I don't like to sort of erm, I dunno, put a bit of a stigma onto a child's weight unless its really really out of control"
Female weight	CHEN	"you know, there's this contrasting thing, you want a fat baby but then especially as a little girl, then they weren't, they considered me too fat. So there was all this like, pressure around my food" "growing up there was a lot of pressure for the girl then the boy…" "he's got like a really broad chest, and he's quite big, and I mean it's cool coz he's a boy, but, I mean it's all cool, anyways, but I know if he was a girl that would be considered as something, he would be considered big, you know…" "I just think its really important for us to have good role models, and be able to talk about it openly, coz especially as a girl growing up, there's just so much negative publicity and, the pressure is unrealistic"
	MIA	"Black women are not really bothered about their weight that's one thing I've noticed. They always eat eat eat [laughs], I think they think, the bigger the breast the bum the better…"

		"I was really skinny everyone used to joke and say, "your too skinny" you understand, but now '……' I've put on weight for the past year and I'm pleased with myself, even with the extra tummy fat and all that [laughs]"
	SANAA	Not represented
	AMIRA	"Yeah… so in Asian culture you should be womanly, not too muscular… I mean my sister used to be a bit chubby when she was younger."
	SEREN	Not represented
	LEMAN	"for my daughter, especially as a woman I think, erm, there's sort of, there's, externally in terms of the environment, media and whatever, there's an image that women have to uphold, that they have to be skinny to be pretty or erm, have a certain body shape to be beautiful, I don't want my, and the thing is my sister is really obsessed with how she looks, or she was, she's actually improved quite a lot but she used to go on about her weight a lot and I know that as a Teyze (aunty) they look up to her a lot, so erm, I really really don't want my daughter to fall into having body dysmorphia and stuff, like my sister will go on about how her body shape isn't right and I'm like what is wrong with you? Just appreciate what you have, and, and, and love who you are, you're not just what you look at in the mirror, there's more to you then that, and I want my daughter to, erm, have that inner love for herself, not just erm, what she looks like on the outside…"
Babies need fat	CHEN	"…there so small, they just need to eat, I don't, I don't think you can overfeed a baby, he's not so much a baby anymore, but I just think there storing it all up for when they grow, right, you know, if he's four or five and he's really over weight I think I would think about it more. I think there's more of a case of being underweight then anything '……' you've got to put the food in when you can because when they get sick it just

		drops off them, so it's kind of like storing it in the bank, for the day, those three days when they don't eat, coz they are so small '……' I think there was that idea, you know, that the fatter your child was, the more chance they would have to survive. So, even as, even from old thinking, its still there…So yeah, they think we just want to make them as fat as possible. Because babies died!" "Chinese want big fat kids" "… I mean when I was a baby, they wanted me to be fat"
	MIA	Not represented

	SANAA	"whenever a baby cry you feed them, regardless, so once they cry you give them food, so that was always my attitude, if they're hungry feed them…feed him every 4 hours" and I said "but he's red, he's hungry, he's hungry" and he was like no, coz when I went to the doctor he said that he's overweight and I've got to make sure I feed him at a certain time. I said so I'm gonna stay there, watch my baby cry, because the doctor said I'm not supposed to feed my baby, and then my sister-in-law would always say "yeeaah because you don't want to go back and have them say that he's putting on more weight", I said "so you prefer my baby to starve and lose weight, so that they are happy and your dealing with the stress"…" "see its probably just baby fat…" "we're happy to see chubby babies, 1 year old/ 2 year old, but if your chubby at 3 you need to do something. That's what we say. I mean, she's too fat she can't walk, but you want to see a chubby baby! I mean it's a joy to see a chubby baby! You know that baby is healthy" "A baby should eat. I mean, they're the doctors they know best, but at the end of the day I'm not gonna stop feeding my child, if he's overweight I'd make them eat salad, you have to, if to me he isn't fat."
	AMIRA	"but I didn't take no notice of it because everyone was like she's young, she's, when she gets older it will go away…their kids as they grow older the fat will go… But then again, see he's like, you know, she's still a child, she's still growing, you know, it'll just disappear, you know, as she gets older. "So I'm not stopping her from eating, because she needs to eat, because she's growing…"
	SEREN	"in a Turkish culture its not a bad thing for a baby to be chubby, where as possibly in another culture I'm not sure, I wont name any but maybe it is, maybe its an issue. In our

		culture, no, its not an issue. Babies chubby they say he's healthy, to us chubbiness is healthy. Don't mistake that for obese, obese is not healthy, we can clarify the difference, but to have a chubby baby it makes you reassured that if they become ill, there's some leeway, there's some, you know you're not worried if they're not gonna eat for that one or two days…" "…babies are, you know, erm babies should, in our opinion, obviously this is not from the medical stance but in our opinion babies should have a little bit of weight on them, obviously not overweight but a little bit of weight. As soon as they become ill, poorly, they have a virus, you know which my previous daughter did have and she couldn't eat for a week, we were thankful that she had a little bit of weight on her. So he wasn't worried and he's not bothered by it at all. And he's clearly, our boy is clearly a big boy in height as well, so he doesn't look, if it was clearly like oh dear, he like looks really really big then I think maybe he'd worry more. We obviously don't want our child to be "obese" but for a little child to have puppy fat as you'd call it in, or a little bit plump is not a problem, once that child is out, going to school, doing sports, that's gonna go." "he was a chubby baby because we were breast feeding and all my babies are generally chubby"
	LEMAN	"oh [childs name} is putting on quite a lot of weight" and erm you know "we should keep an eye on it" and like my response to that was like she's probably gonna go through a growth spurt and kids at this age… her body needs the extra fat right now, and she might stretch out and have you know a sort of, erm shoot up and it will spread out, like the weight will spread out, so erm, yeah…"
Superordinate theme 2: The complexity of food		
Food isn't just sustenance – it's much more	CHEN	"he definitely likes to share meals with (childs name), I know that. He likes to cook and share the foods that he likes with him. Coz again I think food is a big part of his, identi…like cultural identity, so he likes to share. Like he's really proud when (childs name) asks for more yoghurt, or something, like a Turkish thing."

		"because I mean like, I take care of him, a lot, so I know what he will eat, but it's just, its, its, again, I think everyone's looking at it as a way of taking care of him" A communal thing, coz yeah I play with his trucks and stuff but I don't really wanna play with his trucks, but I wanna eat (small laugh), so, actually eating together is a very natural communing activity. '……' I was, like my family didn't do that much together, we didn't, it wasn't like family activities or anything like there are now, but we ate together, so that was like a big thing to like eat together, so it was really important, food, and like I lived with my grandma and she cooked a lot and so food was a big part of our... identity in a way, you know? Like my family identity. "I mean sometimes I will bribe him with sweets! (small laugh), using food as a bribe! oh my gosh all the time, somebody else was telling me "oh I don't do that" but I must say I do, I don't even think I do, but I do. I do do it. Well see I try to do it with these healthy things" I think for all of us sharing food with him is a big source of pleasure and like '……' yeah I think I'm a feeder! Like, I like, I wanna see him eat, you know, it makes me happy to see him eat,…I enjoy to see (childs name) eat and I enjoy to prepare something where he likes to eat… Yeah, it's like a basic necessity." "So yeah, they think we just want to make them as fat as possible. Because babies died! Yeah… and I think it's like a sign of maybe, well definitely prosperity, you know, that you could afford just to take care of your child, you know, like your child could afford to be fat." "So you look like that your taking very good care of your kid if there fat and white."

		"and food, the fast food culture, and just the size of food... and you know, the thing is it's what is considered normal in your context… coz they eat really unhealthily, they often eat lots of fried junk food and stuff," "but its just like, it's a measure of how well you're doing, and I guess it comes again from that time when there wasn't any food, and if you've eaten your good, if your about to eat, your good, (laughs)"
	MIA	"if she don't eat then I know she's not well." "We have celebrations with food, like our national day, then there is certain dishes, that you prepare… and erm, my kids so used to already eating these ones, and in my country where I was brought up we normally have three meals for the day and they are all cooked, we don't put food in the fridge. Whatever they have for lunch, they don't have it for dinner, I always cook twice. And I will ask them "what do you want" they will tell me "mummy do you have this mummy do you have that" so they have two cooked meals for the day. Plus the breakfast. They don't eat ready made food, they don't like the taste. (laughs) they will start throwing up." "definitely like the other kids stuff like the sweets and the biscuits." "I'm pleased with myself because I want to eat the same thing as them, and I do not have them on a strict diet like vegetables this, they know they will always have vegetables with their food or some beans or thing with their rice but, its not something… I give them two broccoli and I say have your broccoli the person who eats all there broccoli will be the winner, and that's the first thing they eat (laughs). They do love their food, they don't love their school food but they do love their food."

		"she enjoys eating"
	SANAA	"I cant go to their house and give [name] a packet of crisps, I cant give [name] like I dunno a coke, which you shouldn't give kids soda whatever" "Like [sister-in-law's name] would prepare like meat and two veg, coz that's how your English people cook '……' coz I cook proper food, well Caribbean food, curry goat. "you lot were in my ears, you cant do this, you cant do that, feed that child, go and eat, make sure your eat before you feed him, you know always telling me what, coz you've feed before you've, eat before you breast feed, so you lot were always on my case…" "Coz for me, I think kids should eat. If im cooking lobster my kids are having lobster, there not gonna have crab.. (laughs) I don't know! Dya know what I mean, whatever I eat , I said I don't know how your gonna feed your man, and not feed your kids, and that's my attitude with them all the time…" "When they used to give trouble at school that would be their punishment "do you want cod liver oil" even my big boy [name], if he gives it I say come and have some cod liver oil coz I cant talk to you! (laughs). But it would shine their skin! If you want nice skin take cod liver oil." "Oh food, that's what my nan told me, "feed the child the childs crying", but I just fed him! (laughs)."
	AMIRA	"And she was premature. And that plays a part as well because everyone thinks maybe because she was premature, that's why she is like that, and I sort of, they think I over fed her. But I don't, hmmm… I don't feel guilty because I know I wasn't over feeding her. Coz I know I was giving her the right portions and stuff like that."

		"I think I saw her as vulnerable and so had to like really really look after her. Sometimes I feel like "I was just trying to be a really good mum and now I've over fed her" like "what did I do wrong" – it's a lot of pressure." you know like Indian foods or Asian foods a lot of oil goes in a lot of spices goes in, maybe change your oil, maybe not even use oil in your foods and fry food, and sugary foods cut all that down
	SEREN	but I'm not gonna starve him! So there's no real solution. We have a healthy balanced diet, we eat a Mediterranean healthy balanced diet, we're not junk food family
	LEMAN	"yeah so that she is more connected with the reasons why we eat coz obviously we eat first as a source of nourishment, and then, food should be enjoyable but we shouldn't just eat because we want, you know, sort of, it shouldn't be attached too much to emotional eating, which unfortunately for me growing up it was totally emotional eating '……' it was always an excuse which I'm kinda falling into myself like "oh, I'm feeling down I'm gonna eat this whole cake" or whatever you know so" so as a family it was a social thing, whenever we get together it was always about food, erm and that's, I think actually being Muslim and because I mean not being, not because we're Muslim but, as a Muslim because we don't have going out clubbing or drinking alcohol or doing stuff like this sort of, I supposed an enjoyment that we do as a social thing is that we get together and we eat, we go out to restaurants, we, you know? So I find that we end up erm… making food quite important and that can be quite dangerous" our food that we eat is Turkish but we also eat a lot of other stuff

		thankfully my kids have never really been like that, they've never really sort of, asked for sweets or biscuits or anything, because I've made it, I don't make it as a treat, "I think in my personal family, food has always been important." "it was always whenever family and friends are around we were just maxing it out with every type of food we could offer and erm, and so, it has been a focal point in our lives also being a practicing Muslim as well, we're like what do you do when your gonna go out and meet friends it was always meeting up to go to a restaurant, meeting up to go to a café, having lunch you know whatever, with my husband as well if we have a date night or whatever we are like "oh what are we gonna eat" erm and even if we go cinema or something we would always have food after or before or something so erm, yeah"
Having control and balance over food is a difficult task	CHEN	"but because in her context she is already considered so fat she wouldn't let herself go that much more. You know what I mean, there's sort of like, she's already way beyond normal out there, so at some point she needs to stop herself." "it's just eat eat eat all the time, I mean it's beautiful food so it's hard not to but, it is…" "it was like a control thing, it happened for lots of reasons but I just didn't want to eat…" "I don't know I'm much more focused on like the idea of eating regular meals, and having like a, I think I have a better relationship with food basically, his father doesn't eat regular meals as much as I do"
	MIA	Not represented
	SANAA	"But I mean not over eating, I mean, my kids would probably eat the world, eat crisps and biscuits, I don't have that. They can have their snacks but you know you have to stop eating coz you know you need to eat your dinner"

	AMIRA	"And they do blaim me. But I'm like "you don't know what goes on at home" I said "you can say that now, but I know what I'm doing at home", the amount of times I have to control her…" "Yes, with food it's the same thing every day. Yeah, same kind of argument. You see, sometimes I give up. And then I have to give it to her. Sometimes just to keep them quiet you know and I just have to make life a bit easier. Its just the same pattern everyday, it's a constant battle. Its hard." "But with her, what it is, is she just constantly wants to eat." "like she'll want an apple, grapes, but then you can't give her too much of the fruit as well. I'm constantly thinking, I can't give her this, I shouldn't give her that… like balancing. '……' I think the right way is not to let her constantly eat, there should be a balance." So I'm not stopping her from eating, because she needs to eat, because she's growing" "I think her being premature plays a big part in it as well, like… like I did treat her a bit differently. Like I took extra care of her. See but then, going back to like feeding wise, at that time babies like feed on demand isn't it, plus I was giving her my breast milk as well. So I was constantly erm giving her breast milk, then when she got to like 4 or 5 months, then I started feeding her 3 times a day but I think maybe, I was giving her a bit too much, portions, solids." "Because I won't give her anything and she will be like "you don't give me anything", (laughs) yeah but its not like, you know, I do feed her, but obviously, you gotta discipline them aswell, she cant eat all the time 24-7, no. and I think that's what she likes doing."

	SEREN	Not represented
	LEMAN	"I dunno, put a bit of a stigma onto a child's weight unless its really really out of control, but erm, and like see that their eating is really unhealthy and out of control" "I'm like "[childs name] I think you need to stop now", coz she, is as if she has a hole in her stomach bless her, sometimes if she enjoys her food she just doesn't know when to stop…" "I'm just trying to encourage better habits, so when it comes to being, having more physical activity, and erm, balanced eating, and making her aware of it '……' in terms of being more conscious about what they're putting into their bodies through the day, erm, but at the same time they're still getting together to eat out sometimes and stuff, so, I'm thinking it's getting a bit more balanced I don't want to make to much of a thing about it for her, so I've not really spoken to her about her but about being healthy and being balanced and stuff "like in the long run I don't want it to get out of hand, like I said, I, erm, in terms of, I know some parents that have, have actually had to lock their cupboards and fridges because their kids would sneak snacks and stuff" "but its only after having kids I think I make a lot of excuses for myself, im like aww I'm pregnant I can eat, aww I'm breast feeding I can eat, and I got cravings so I will actually just be stuffing my face until I cant breath. And… (laughs) and now, the thing is I've never been someone that exercises, the only exercises I used to do is yoga but I never really… erm… done it at such a strenuous level that I'm losing weight with it or, just more for stretches and relaxation and stuff…"

		"its really tricky for me to incorporate exercise into my life right now because I'm, I dunno, not motivated enough" "not be giving [childs name] a good example because he's constantly weighing himself, constantly going on about oh there's sugar in something or there's salt in something, there's calories in something, and I just don't like that approach because I really don't think it's the healthy approach…"
Superordinate theme 3: Culture & Family: torn between worlds		
Acculturation	CHEN	"Yeah, my family, I'm from Hong Kong, so I'm Chinese, errrm yeah, so my personal heritage is Chinese, my little boy, erm, is born in Hong Kong, but he is half Chinese and his father is from Turkey… All [emphasized] Londoner, [small laugh] '……' so yeah, race and sex and gender and all those kinds of things really plays such a big part of it, yeah, yeah, so I think, I think its just interesting to remember all of that is so, so culturally specific! "I'm teaching [child's name] different languages, and one of the reasons is because of that idea of context, you know, and that you know, not, it's not just that this thought can be expressed this way actually this thought can be conceived of all these different ways, and I think you know that is, hopefully that is more important than all the other things he's gonna learn. The words are the thing that construct the culture! So, when you learn a… and actually a culture is a way of thinking, way of perceiving a world" "…and his black grandmother from Turkey is here. On my side he's got one cousin in Hong Kong, and we recently went to visit my cousins kids, so their like cousins to me, there mixed race as well"

		"when I went to the States I arrived, I got out of the airport, I was like "oh my god, these people are like a different shape!" they're not just fat their tummys are bigger, you know coz, people here may be fat, but they're fat all over, but like the average person I saw in like America, I mean their tummys were just like, it was like Santa Claus size, I was so amazed!"
	MIA	Not represented
	SANAA	"for me, I still don't know, coz I left 15 its still kind of bit young, I can't go back home I wouldn't know what to first thing to do, you know what I mean, that kind of thing?... I don't know I would not know. I would not know the first place to go, my house is, no the dads house is gone that's completely ash, so he doesn't have a house, my house… I guess I've got the foundation of a house but, not a home, dya know what I mean?"
	AMIRA	Not represented
	SEREN	Not represented
	LEMAN	I'm not sure because growing up I haven't really associated with Turkish culture so much even though I am Turkish background I am very British '……' erm, like I said I don't really, I would hardly ever, I mean I remember when people would ask me where I was from I would find it difficult to know what to say coz I would be like well I'm Turkish but my dad's born here and my mum's born in Cyprus and she came, and I feel like I have to explain my whole life story [laughs], it's like I'm British but I don't know if I'm British, am I British? you know! So, erm, I think it's only as, sort of as I've grown up that I feel like I can actually identify who I am, I would say I'm more British and I've been brought up with some Turkish culture because of my background but, and we hardly ever speak Turkish at home and our food that we eat is Turkish but we also eat a lot of other stuff so I dunno. How funny! "I wonder what my children are gonna have to respond to the question! [laughs] coz their all mixed as well oh God! [laughs] but you know, making sure my children know

		who they are, that's really important to me, so I am really focused on making sure they understand each of the cultures that their background is from, so I hope that will help them to, sort of grow."
back home vs here	CHEN	"Coz I mean, I used to live there, so I didn't think I would have a culture shock, but because I hadn't been there for so long, just to see.. you know, obviously not everyone, but the average shape of a person, is SO different to what you see on the streets here… Unhealthy lifestyles '……' and food, the fast food culture, and just the size of food... and you know, the thing is it's what is considered normal in your context." "erm, driving everywhere, erm, sitting in front of TV's, computers too long, and yeah, and food, the fast food culture, and just the size of food... and you know, the thing is it's what is considered normal in your context." "because ever since I was quite young I moved around quite a lot, I learnt that is very relative term, you know, you can't just say, I mean obviously there's scientific measurements of it, but erm, there's different cultural contexts and then different races, I remember a friend of mine, who's black, he's like Nigerian, they told him he was obese, and like, he wasn't obese, he's a big guy, but there is no way he's obese, you know, but because of whatever measurements they do, he was considered obese, and then I remember reading something about the BMI thing and how it's waist to hip, and how for a lot of Asian people, because they're more pear shaped then apple shape, it doesn't work, and they should have different measurements, so… all that sort of thing I'm very aware of, you know, I, I'm, I've got a slight frame and that's because of my… ethnic… makeup, you know so, I'm very aware of how those things are different in erm different cultures." "I have an aunty back home who's like always been considered fat, and here she would be considered normal, but her whole life, she has the mentality that she's obese, you

		know, coz, all the time she's considered the fat person, she thinks of herself as fat, and I know, if she were here, she would be average…So back home in Hong Kong, my aunty, who is not fat, but because in her context she is already considered so fat she wouldn't let herself go that much more. You know what I mean, there's sort of like, she's already way beyond normal out there, so at some point she needs to stop herself." "[Culture's impact on food/weight] That's a big thing because, I could… erm.. well it's all relative, so like back home, I'm quite a big person." "you know so, yeah. And yeah, because we are like Chinese, you know? We are not British in any way, we don't 'beat around the bush', it's just like "oh you look fat today", or you know, "you could use with losing some weight, or gaining some weight"…" "so I think there's still, even though were not really in the third world as it were, we have that third world mentality, you know? And its still, from times when things were really bleak, and there wasn't any food. I dunno, there is a lot of focus on food…" "obviously because they are from other cultures and from other generations so how much do I think their points are valid or invalid, and then just like hoping for myself that I'm doing the right thing. Coz actually one thing I think about now, is like, there's so much modern food, you know, like, like, I try to get the healthy things but there's still like kids organic juices and kids organic, nothing that we ate! And I try to wonder, I wonder like how much I should or should not feed him, what is right and what is wrong, and is modern, there's nothing to compare it to, because they didn't have it back then… Well see I try to do it with these healthy things, there like apple, pear and pumpkin, (laughs) you feel like "its alright" yeah… but some, this didn't exist 5 years ago" "what is obese in one place is not obese in another, you know and yeah, what you see in Hong Kong to be considered healthy is actually unhealthy, well there BMI is fine but

		actually if you measured their whatever their muscle, body mass, I dunno what you call it measure, coz they eat really unhealthily, they often eat lots of fried junk food and stuff, because it is a modern life now, but they're tiny because that's the pressure. So they look tiny, but actually they're really unhealthy and yet there internal organs are like surrounded with fat."
	MIA	Not represented
	SANAA	"I guess, erm, his mum and dad are back home, coz their elderly and not a lot of people wanted to come to England. And then because of the cold and getting adjusting, they're quite old so they decided to stay there. Like his sister just went back home coz she had enough of England. Like the lifestyle of England." "I used to be active, in the Caribbean to what I've got available to me in England, I'm very, like if I go back I don't think I could walk what I used to walk…yeah, definitely, and there's nowhere to go, kids in the UK, they don't have anything to do. Well for me, I wouldn't want my son, even though I say back home in the Caribbean is active, I wouldn't want my son to be out on the road. I prefer know that he's home and playing games then to be on the street, so that's a big contrast to what I want, to what I want him to do, and its because of, I dunno, the killing, and I guess the area we live in, and what you see happening, like yesterday I was taking the dad home and they were fighting on the high road, and I don't want my son, he's never, he's fought once that I've heard of defending himself, but I don't want him out there getting in a fight coming home with a black eye. He's got too much going to be doing these kinda, you know, crap." "I'm still worried, like if we were back home, I guess I would be a bit more relaxed, but then I don't know back home no more, I'm not comfortable back home, so even if I was to take him back home and like other kids come and get you coz that's what normally

		happens, kids come and get you and you lot go, but you come back home at night, I don't know how I would cope with that." "I was working from early so I've never not worked, until I had the last one and now I cant stay at home no more, I cant do it. I really, I don't know how these people, and the benefit thing is, we don't have that back home. You have to work. So… I dunno… I guess its lazy, I find it lazy, coz I'm very lazy now being on it. But I've struggled. I've gotten quite lazy but now I cant stay at home and hoover every day, I need a life! (laughs)." "Yeah, you just do whatever you want. So I think my kids, I would love to take them home because they're missing something that erm, and like buying fruits which we've never had to done and buying these expensive foods that we cook that are just off the chart. Yeah so… Vegetables, we had our own trees, you'd climb your mango tree, you just did whatever. No one troubled you there, you didn't have no rapists, killing kids. Very seldom. No one locked their door ever. I guess now they do. But when I was growing up, that was not heard of. So it was hard to get, hard to adjust to. School was hard to adjust to as well, the talking back to the teachers, the disrespectful, I just like started to like not tell people hello. Coz its not heard of in the Caribbean to see someone and not say good afternoon or good, especially an elderly person, not greet them, you don't do that in England. I had to adjust, that was the first think I had to adjust to (laughs)." "Back home you wouldn't go to the doctor to be weighed, you never had any restrictions, with fruit you would just pick from the tree and eat it! Food was just food. You pick a mango you eat a mango. No one ever says "don't eat it" and your always active, we don't stop, you're up early. There is no pressure to eat your dinner, because you are eating all the fruit… in the summer. But I'm not like that with my kids! Now I don't like them being outside. I don't let them eat as much fruit as they want coz they

		spoil their dinner. I don't do lunch, breakfast is breakfast, dinner is dinner, whatever you eat in between is ok with me." "Definitely. In the way that, what we eat. What we do. What we are expected to do, what we are taught to do, what's stuck in your head, like form growing up. You eat everything, unless you don't like it. You know, I've never known anyone to be obese, not personally, they've been fat but you see these people with the 16 stomachs, and their big stomachs, and their turtle neck. I never saw that. Ever. Until I came to England." "Like [sister-in-law's name] would prepare like meat and two veg, coz that's <u>how your English people cook</u>"
	AMIRA	Not represented
	SEREN	Not represented
	LEMAN	Not represented
My family's involvement with my children	CHEN	"my family…on my side… my mums always saying, MY mums always saying…" "Yeah, actually just the other day, like his grandmother, what were we saying... his grandmother, I was cooking something for him and his grandmother was like "oh no he would never eat that", I'm like, "ok", I mean, he will, because I mean like, I take care of him, a lot, so I know what he will eat, but it's just, its, its, again, I think everyone's looking at it as a way of taking care of him, and you sort of just have to bite your tongue and be like "alright, sure..", like you can say that, but I'm gonna cook it now and he's gonna eat it. Erm, but yeah, I think what, what, what the child eats, like if I had decided for [childs name] to be vegetarian that would have been a big problem, you know, coz, people want to feed them, give him the stuff they wanna feed him, like his grandmother brings home, brings round frozen food for me to cook for him"

		"But erm, obviously because I'm his primary care taker, and I feel very responsible to like my elders, especially as, the culture I come from, it's a big thing to sort of respect your elders and so, I do somehow feel the pressure, that I have to… make him… I dunno, like I'm taking care of their grandchild I guess, so I'm aware of that. '……' I think my mum and [partner's] mum have been mothers for a really long time, so I do value there opinion, erm and then again because they are the grandparents…"
	MIA	Not represented
	SANAA	"I've got 3 boys, my nan, my mum, my dad, my brother, my sister, they are all here. Some of my family, like my dads side of the family is still in Montserrat but my mum is from Antigua so her family is from Antigua so Im kinda mixed, and erm, my grandad, grandma they passed recently" "I got a next job in a stationary centre, and you just work, coz you want your own money. And I give my mum money…" "when they had their first child they read a book 'how to be a parent', I never had that my mum just told me what to do and I got on with it, and my nan was like how we grow up…" "I was like well when I had [first child] you lot [family] were in my ears, you cant do this, you cant do that, feed that child, go and eat, make sure your eat before you feed him, you know always telling me what, coz you've feed before you've, eat before you breast feed, so you lot were always on my case" "I guess, coz I'm from a big family and we're always loud… It's different. Caribbean people, I dunno we're loud. We're talking normally and you probably think we are fighting."

	AMIRA	"especially the family, their like constantly, like their worried as well. And they do blaim me '……' Yes because everybody is worried about it, and they're always at me. So yeah it has, the whole family, literally, like my parents, and my siblings, everyone. They are quite concerned about it as well. Yeah and the thing is, they do feed her, but obviously, now they've realised and they are sort of like "ok", they sort of like feed her properly" "I think the majority of our family we are not like overweight or anything, no like the immediate family, we are all quite slim and petite" "He [father] is aware, and yeah, he does care."
	SEREN	Not represented
	LEMAN	"we're close with my family, so we see them very regularly at least once or twice a week erm, they have their grandparents near by they get involved with the family and takes them out as well, erm, yeah." "and I know that as a Teyze (aunty) they look up to her a lot" "we had a big argument about it, and I dunno if he is understanding my perspective coz he sort of goes on that I'm too lenient with them, when I really don't see that, I mean, he doesn't see how much, erm, you know I plan my weeks meals and stuff" "but I try to say to them, right you only have this when you go to your grandparents house because I know at their grandparents house they always spoil them with that, they see it as spoiling them which I get a bit irritated with, erm, its like, let them, their little, spoil them, give them all the chocolates in the world, erm, which is, I try not to interfere

		with that because that's just what grandparents do and let them be grandparents in a way, unless its, unless its like really detrimental to them, but at the moment its not too bad, but I try not to get involved on that side, so erm, yeah…" "Yeah, yeah. On me and my husband, yeah. Not external family so much but erm, yeah. We do still have discussions about it, but whereas previously it was quite heated whereas now I think we've come to a bit more of a balance, but I think he still doesn't appreciate sort of my side in terms of, for my daughter" "I think in that respect we still have those differences but I think he's sort of learning to sort of lay off her a bit because he did become quite harsh with her at one point, and erm, would just shout at her and say "no that's enough, your not eating no more" and she would start crying and he would be like "oh my god what is wrong with you" like how do I deal with that, so I called him into the kitchen and I said to him you just have to be a bit more reasonable and explained to him, like I didn't wanna make him wrong in front of her as well because I think that she should not see me and her father like disputing in that way, but erm, yeah but its hard, it could have been a lot of hard work, but I think we've come to some sort of middle path at the moment, I hope."
Superordinate theme 4: Dilemmas of Motherhood		
Alone, responsible, and to blame for my child's weight	CHEN	"so erm, just me here" "But erm, obviously because I'm his primary care taker, and I feel very responsible… I do somehow feel the pressure" '……' I think that's one thing, especially being a mum, like everything, err, you constantly feel guilty about everything (small laugh), but its just you putting it on yourself really, yeah ok, your getting glimpses of it maybe from your family, but its, its, you know, you put it on yourself…" "I don't know I'm much more focused on like the idea of eating regular meals, and having like a, I think I have a better relationship with food basically"

		"And I try to wonder, I wonder like how much I should or should not feed him '……' but its like that line between like where, how much do I trust myself, my own instincts, and then how much do I listen to somebody else? '……' I guess it makes me feel like, erm, well for one, questioning my own ability as a mother" "I met a friend the other day and like she only makes, she never buys anything prepared for her kid, you know she makes everything. And I remember I had like an organic juice packet, I still took it out, you know, but I did think, it gave me a "ohhh god" you know (small laugh) "I'm not as good as her" sort of, I had a moment where I felt like that…Yeah! But like, I mean, like my friend cares what I feed my kid, you know what I mean, but I couldn't help myself but compare myself, in that moment, thinking "ahh, you know, she only makes fresh compote and I bought like a compote" that sort of thing. I think at this point because hes so small, food is like a major thing, coz hes not like going to school or taking classes or whatever yet, but I think when that starts I will be comparing myself with that too."
	MIA	"It's just me" "unless you pay for special classes for football or things like that. You always have to pay extra for the sporting activities."
	SANAA	Not represented
	AMIRA	"they instructed me to maybe you know maybe start looking after her weight, and you know cut down on sugary foods and stuff like that." "I went in and she spoke to me, and she said, how do you feel about this, and I was like "yeah I am a bit concerned now obviously"

		"she said I have to look at her diet, like maybe the things your putting in her food" '……' And they do blame me. But I'm like "you don't know what goes on at home" I said "you can say that now, but I know what I'm doing at home", the amount of times I have to control her…" "To me, just feels like, I should do something about it. I wanna take action "I thought ok maybe what she is saying is right, because we don't realise sometimes, that's just how we cook, then I thought maybe ok, she's a child and sometimes we don't realise '……' Sometimes I feel like "I was just trying to be a really good mum and now I've over fed her" like "what did I do wrong" – it's a lot of pressure."
	SEREN	"I am a stay at home mum, although I have worked part time, on and off, whenever I am not pregnant or having a new born [laughs] '……' that's my full time…. Hobby? (laughs)." "Of course I am responsible, I'm the one feeding him aren't I? no body else is, he's not able to feed himself, I'm feeding him, so I am re- ultimately responsible no matter if he was skinny, fat, medium, doesn't matter"
	LEMAN	I'm a homeschooling mum so I'm really busy at home with them I think I'm probably not a great example for that, coz I actually am putting on a lot of weight '……' I know I need to be a bit, try to be a good example and that really upset me because that's the worst way to come to a 7 year old child and I could see she felt so rubbish he doesn't see how much, erm, you know I plan my weeks meals and stuff

Good mother	CHEN	I feel like I'm a good mother, I mean I try to be a good mother, you know, but I'm new to it…just like hoping for myself that I'm doing the right thing "erm yeah. I'm his mother I guess, that's our relationship, hes my child." "I think that I would be concerned if *I* thought that he was overweight… he's like above the 100th percentile, (laughs) but he seems fine! So I just think, you know you just have to make the judgement for you own child '……' I just think, I think, you know, I know him better than the doctors would, and obviously if he had a broken arm I would listen to the doctors but on like a sort of general base note, I, I, I would just have to trust myself, hopefully." "I take care of him, a lot, so I know what he will eat…"
	MIA	"she eat, I dunno, she just stopped eating, she just sipped on her bottle, and I said "no this is not my [name]…" the doctor said everything was ok everything is ok, but I'm saying "no" she's not eating she's not, even if she is sipping, this is not her, she would normally finish this… and then, after 5 days when, I stayed in the hospital, I refused to leave, because they said I should leave they wanted the cubical for someone else and I said no, and then I stayed and after a while another paediatric came… But I always know if my daughter don't eat, something is not right." "I always cook twice. And I will ask them "what do you want" they will tell me "mummy do you have this mummy do you have that" so they have two cooked meals for the day"

		"normally they say I have good parental skills" "I'm happy, I'm pleased with them. I love them, no complaints whatsoever, they well behaved."
	SANAA	Not represented
	AMIRA	"Oh we have a really good relationship. Yeah, she's like a friend to me, she's like "mum you're my friend" its like a mother and friend relationship, like little buddies." "I was just trying to be a really good mum '……' Mind you a lot of people have said to me, you know, I'm a good mum, I look after my kids really well, I take care of them, and as a whole we are a really good family."
	SEREN	"like I'm not doing anything, but I'm not gonna starve him! So there's no real solution. At the end of the day I am not willing to let him cry" "and all my babies are generally chubby when I breast feed, but as soon as I stop breast feeding they loose that, that baby, that baby chub. '……' I've decided within myself that erm he doesn't have to average and he doesn't have to be in a graph, he doesn't look abnormally fat, he doesn't have any problems, he walked at an early age, he walked at 9 months actually which is really uncommon for babies, so I think he's doing, all the milestones he's meeting, even though he's in this "unchartered" territory of overweight in this graph…" "our family is, erm, you know complete now, so yeah, we're having a lovely, he's a lovely character and he's basically completed our family"
	LEMAN	Yeah we've got a <u>really good relationship, bless her, she's erm, I would say we're very close,</u> she's, she is comfortable, there's been times when she's <u>actually shocked me,</u>

		she'll come and she'll open up to me on an emotional level and she'll tell me like if she's upset about something or she wants to share something that's happened you know to her, and, erm, yeah we get on really well, she's erm, I think being a first child as well there is a different relationship, there's always a slightly different relationship so, erm, she's like my, my little confidant, I even open up to her and stuff sometimes you know [small laugh] so yeah, we've got a good relationship Erm… (laughs) erm… well I've had, it's really quite surprising to say this, erm, sort of loudly, like out loud, erm but I've actually had a lot of people say that er, that I look really calm and I look really erm, like I've got everything under control and, everything's cool. '……' Because I have a lot of people say that to me, that like I'm doing a really good job as a mum or you know my family's got this and this so
Superordinate theme 5: Experiences of managing child's weight		
Negative experiences	CHEN	Not represented
	MIA	Not represented
	SANAA	"what about the social… health visitors on our neck. And I said "well I wont take him to the health visitor if we feel like that, just wont go". I would just say to them I'm gonna feed my child and that's that. Like the doctors did say before I left the hospital "you have to feed every 4 hours before we can release you", coz I lived in hospital with him, and then I just started to lie on the charts (laughs), I couldn't stay on the ward anymore!... so I said he was doing 4 hours, to go home! I needed to be at home… so taking into those considerations they should have been a bit more lenient. Dya know what I mean! Like change it up! Each child is different."
	AMIRA	Not represented
	SEREN	"it meant a lot actually, because I didn't actually go back to the, the center again to get him weighed. I felt that every time I went it would be a case of "oh he's still putting on

		too much weight, it was a big put off, it was a big put off and I didn't want to be judged as well, because you know, oh you're, I didn't want to be seen as overfeeding my child '……' so that's why I'd much rather just refrain from going, I don't want to be like criticized. '……' but the issue is, that's not the reason I feel embarrassed, because I'm responsible, I'm embarrassed because they told me, look he's getting too big, do this, and next time I go there they will say it again and say it again and they'll think that I'm not making a differ- like I'm not doing anything '……' but I'm still nervous and worried to go back there, I probably wont, until he's lost the weight '……' I was really really put off, and I didn't feel that the advice they gave would help me in anyway, I mean, how is feeding a crying baby water gonna help anything other then make the baby persist in crying."
	LEMAN	Not represented
What helps and what doesn't?	CHEN	Not represented
	MIA	"I went to the GP, so he said to me, if both of the girls are eating, they're both healthy girls, he doesn't have any problem with that… he said to me, as long as she is eating, then that's not a problem." "They didn't believe me, I went to the gp, I went to the hospital, they didn't believe me. Then by the time he saw what she had she was admitted, she spent 2 to 3 months there" "I feel that the kids doesn't do enough exercise at the school (laughs) I mean although I know they have the P.E. time, I know they run around at thing, but I dunno, like maybe, during the summer time, when they would be before you could be taking them for walks, you would walk round with them, but then after school there's nothing really to do until summer time and like during the winter they have from school back home, unless theres like simple activities like drama or singing, that's it. Except for afterschool sports or unless you pay for special classes for football or things like that. You always

		have to pay extra for the sporting activities. '……' She says the teacher says to eat all but the teachers are not even bothered."
	SANAA	Not represented
	AMIRA	"it is a bit worrying, so I've got an appointment with the peadiatrician in a couple of weeks, I'm gonna go back to him and speak to him about her belly as well and see like, and see what her weight is like." "she was at school and there was like a nursery nurse there, and they were, they like do check ups on the children, with their heights and weights and everything" "Especially with (childs name) when they look at her they say don't worry she's fine, she's growing, don't worry about her fat, if I'm like stopping her in front of people, like if we are all together and she's eating and I stop her they will be like look don't worry, she's growing, she'll grow out of it." "It's hard for me to know why she's got a belly, she doesn't eat that much over the top and she is active…" "I would say something but in a nice way, or advise them, coz later on in life it's not good for you."
	SEREN	"…and with him, I stopped breast feeding around the two month mark, due to issues that we had with breastfeeding, erm… but he didn't lose the weight, he actually started to gain more weight being on formula, hence why they told me to slow it down a bit." "I am not willing to let him cry, and I think a lot of cases health visitors want them, like even if you speak to them about sleep, like you go to them and say my child doesn't sleep, they will say leave him, change his nappy, feed him, put him in the bed and let him cry! And I'm not willing to do that. So that to me, to go there and them tell me again and again, don't feed him, don't do this, let him cry, I'm not gonna do that and

		that's against my mothering, my parenting techniques. '……' I thought it was ridiculous because when a baby is crying for a feed after its been many hours since having a feed, waters not sufficient, waters gonna… fill him up for maybe 5 minutes and then he's just gonna cry again, so it was just, it was an impractical piece of advice. I understood where they were coming from, because they saw he's putting on quite a lot of weight, but there was no way around it at this point because he was on, just on milk. I didn't really listen to be fair. I just continued as I was, tried to space out the hours a little bit more, maybe pushing on half an hour for the next feed or so on, and trying to spread them out better, but it was still, it wasn't, it wasn't a practical way to go around it, so I just continued as I was already."
	LEMAN	Not represented

Appendix 9: Coded extract from a participant's transcript

Emergent Themes	**Interview Transcript**	**Exploratory comments** *Descriptive* *Linguistic* *Conceptual*
Mothering alone *Race and culture* *Family "my side"*	Mmmhmmm, yeah, so my family live in Hong Kong, so erm, just me here, his, (childs name)'s father is here, and his black grandmother from Turkey is here. On my side he's got one cousin in Hong Kong, and we recently went to visit my cousins kids, so their like cousins to me, there mixed race as well, so they live in California, there father is black, and the kids are half Chinese and half black.	*'just me' doing it alone* *From her side of the family.* *'black grandmother' not just 'grandmother' labelling ethnicity and culture from the start.* *'my side' – we talk about families and heritage using possessive language* *"mixed race" "half...half"* *describing race/heritage in detail* *being "mixed race" is meaningful, she is not but her child is, cousins are "as well"*
	Interviewer: a lot of ethnic diversity in your family Well in this generation yeah, yeah ha ha	*This generation is culturally diverse.* *different from generations before* *nervous laughter?*
I disagree that my child is overweight *Judgment about weight*	**Interviewer: And can you tell me about who in the family has been called overweight?** Yeah, so (childs name) has been called "slightly overweight" by the heath visitor and actually his grandmother from his dads side has called him overweight too! it was just, I swear, its happened a few times casually, maybe she's teasing me, because, erm, I don't really know, I don't really know where it came from, because I was quite shocked, because she is	*She makes quote marks with her hands as she says "slightly overweight" and her tone is one of slight mocking –*

Judgment about weight *Shocking to hear your child be called overweight* *Cultural stereotypes* *Wanting fat kids* *Comparisons around weight* *My mum says…* *Shocking to hear your child be called overweight* *Mothering alone* *Responsibility of being a mother* *Pressures of a mother* *Grandparents opinions matter* *I know my child best*	quite is quite a big lady herself, and people from her family are a bit bigger, so I think she is maybe quite sensitive to it, or maybe aware of it, and errr she was just saying how, yeah we were just at the house the other day and she said "he's getting a bit fat" and I was really surprised, because I don't think of him that way.. at all. Erm. And actually, I have that stereotype that people from both our cultures, Turkish and Chinese want big fat kids. So I'm always feeling like, my mums always saying, MY mums always saying (childs name) is skinnier then my niece was, so.. there are always these comparisons. Yeah, so I'm not really sure why they have said it, it really came out of the blue, and I'm really surprised. But erm, obviously because I'm his primary care taker, and I feel very responsible to like my elders, especially as, the culture I come from, it's a big thing to sort of respect your elders and so, I do somehow feel the pressure, that I have to… make him… I dunno, like I'm taking care of their grandchild I guess, so I'm aware of that. **Interviewer: mmhmmm. So you feel some pressure as a parent.** Yeah! Yeah. **Interviewer: What does it mean to you that (child's name) has been called overweight?** I think that I would be concerned if *I* thought that he was overweight… but, I, dya know to be honest at this age no. Coz I just think like at this age there too small, to worry	*already clear she does not agree with the health visitor* *Indignant about grandmother calling him overweight – she seems more affected by family member saying it then health visitor.* *If you are big you cannot say someone else I big?* *She felt surprised – she does not agree* *"I don't think of him that way"* *pauses and emphasizes "at all"* *Naming cultural stereotype - this is in her awareness. Is this common knowledge in the UK?* *"comparisons"* *'MY' mum – grandparents involvement* *"out of the blue" "really surprised"* *"primary care taker" – she feels responsible to her "elders". Respectful use of language* *"the culture I come from"* *"pressure" "their grandchild" – grandparents opinion seem as important as mothers, trying to prove herself as a mother? Its her responsibility*

Babies need fat for growth	about it. I mean, ok, yeah if he was so rotund he couldn't walk, like, yeah, I would see it was something to be concerned about, I think actually, you know, there so small, they just need to eat…	*"to be honest" – warning me? Parents have their own markers for what they should be concerned about – health care*

Appendix 10: Table of emergent themes for one transcript

Subthemes with emergent themes underneath them

Judgments about - weight especially female weight	*Having control over food is a difficult task*	*Food isn't just Sustenance – it's much more (Subsumption)*	*Importance of culture (Subsumption)*	*Back home vs here*	*Pressures of a mother (Subsumption)*	*Good mother*	*Importance of family*	*Babies need fat*
1. *Judgment about weight* 2. *Cultural stereotypes* 3. *Comparisons around weight* 4. *Female vs male weight* 5. *Outspoken about "fat"*	1. *I have control of my weight* 2. *Control your eating* 3. *Being in control of food* 4. *Regular meals*	1. *Sharing food* 2. *Food as cultural identity* 3. *Pride in cultural food* 4. *Food is care* 5. *Food is pleasure* 6. *Food isn't just sustenance* 7. *Food for survival* 8. *Fat linked with wealth* 9. *"fast food" is bad* 10. *'junk food' is bad* 11. *Food linked with wellness*	1. *Personal Heritage* 2. *Acculturation* 3. *Race and culture* 4. *Culture vs science* 5. *Importance of culture* 6. *Specific cultural language*	1. *Unhealthy lifestyle* 2. *Cultural comparisons* 3. *Cultural differences* 4. *Past vs now* 5. *Food has changed over time* 6. *Back home* 7. *Vs here* 8. *Importance of context*	1. *Mothering alone* 2. *Responsibility of being a mother* 3. *Pressures of a mother* 4. *Comparisons around mothering* 5. *Mothers guilt* 6. *Dilemmas*	1. *'good mother'* 2. *Mother/ child relationship* 3. *I know my child best*	1. *Family "my side"* 2. *My mum says…* 3. *Family involved in feeding* 4. *Importance of family* 5. *Identity shaped by family and food* 6. *Grandparents opinions matter* 7. *Grandparents are important* 8. *Grandmother interfering with feeding*	1. *Babies need fat for growth* 2. *Can't have a fat baby only a fat child* 3. *Babies need fat in case they get ill* 4. *Wanting fat kids* 5. *Babies <u>need</u> fat* 6. *Fat linked with survival*

Appendix 11: Extract from Reflective Journal

Interview 1 – Reflections Before the Interview

This is my first interview, recruitment has been difficult as it has been over the summer months when most children's centres go quiet, and now it is nearing Christmas and parents seem reluctant to engage. It has helped to speak with others on my course who are also having recruitment difficulties. I am wondering what this first interview will include, I am slightly nervous whilst I wait here in room I have booked in this childrens centre. I am wondering if this parent will want to open up, will she have much to say, will talking about her child's weight be a sensitive topic and will this make her guarded or confrontational?

Interview 3 – Reflections after the Interview

This was my first home visit interview. It has made me consider the dynamics and how interviewing a parent at home on "their turf" is different from a more clinical setting in a room in the children's centre. I feel the power differential was altered and it appeared that this parent was much more talkative then the previous two, and this has been my longest interview so far. I wonder if this will be the case for future parents, my next interview is also a home visit.

I generally felt this interview went well, although this mother had a tendency to get side tracked and talk at length about things that didn't necessarily relate back to my original question. Although maybe this is an example of the usefulness of open questions in IPA. Perhaps when I come to analyse her transcript I will find she has offered much interesting insights into her experience.