Parents' journey through treatment for their child's obesity: qualitative study

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What is known about this subject

Treatment of childhood obesity is often unsuccessful, but precise reasons for this are poorly understood at present, and the parent perspective on treatment has not been studied systematically

The development of more successful treatment may be informed by an improved understanding of parental perceptions of existing treatment

What this study adds

Parents often feel that other members of the close and extended family particularly grandparents undermine efforts to change lifestyle

Psychosocial difficulties are what often bring parents to treatment, and improvements in this area may be what motivates them to remain in treatment

ABSTRACT

Background: Treatment for childhood obesity is characterised by patient non-attendance and drop-out, and widespread failure to achieve weight maintenance. Qualitative methods may improve our understanding of patient perceptions and so improve treatment for childhood obesity.

Aim: To provide insight into the perceptions of parents of obese children as they 'journey' from pre-treatment to end of treatment.

Methods: We used purposive sampling and studied 17 parents of children attending 6-month outpatient treatments for obesity (BMI>98th percentile). Parent's perceptions were explored by in-depth interviews, analysed using Framework methods.

Results: Parents were characterised as being unaware of their child's weight, in denial, or actively seeking treatment. Parents were consistently motivated to enter treatment due to perceived benefits to their child's self esteem or quality of life, and weight outcomes appeared typically less important. During treatment parents expressed a lack of support for lifestyle changes outside the clinic, and noted that members of the extended family often undermined or failed to support lifestyle changes. Parents generally felt that treatment should have continued beyond six months, and it had provided benefits to their child's well-being, self esteem, and quality of life, and this is what motivated many to remain engaged with treatment.

Discussion: This study may help inform future treatments for childhood obesity by providing insights into the aspects of treatment of greatest importance to parents. Future treatments may need to consider providing greater support to lifestyle changes within the extended family, and may need to focus more on psycho-social outcomes.

INTRODUCTION

There is a paucity of high quality evidence on how best to treat childhood obesity, and 'office-based' therapy usually has modest success.[1,2] Guidelines suggest treatments should be family based with participation of at least one parent fundamental.[3-6] Yet there is little understanding of the motivation of parents to enter treatment and their continuing role in implementing and supporting recommended lifestyle changes. Qualitative methods can provide valuable information on patient's perceptions of chronic disease management,[7] but few qualitative studies have explored the parent's feelings concerning their child's obesity management. The aim of the present study was to use qualitative methods to gain insight into the journey of parents of obese children to and through treatment. These findings will assist in the development of theories on parental influences on treatment outcomes and help health care professionals in their approaches to family based treatments.

METHODOLOGY

We undertook in-depth interviews with the principal carers of primary school age children who had taken part in six-month dietetic interventions for childhood obesity (BMI > 98th percentile UK 1990 charts) previously described in detail.[8]

Purposive sampling was used [9] namely

- Successful outcome / unsuccessful outcome of treatment
- Age of child (5-8 years and 9-11 years)
- Location (Edinburgh/Glasgow)
- Gender of child
- Family situation e.g. two parents or single parent family, main carer not a parent

Interviews took place 12 months after the start of treatment. Of the 79 families available 17 parents (1 from each family) consented to participate. The study

received ethical approval from the Multi-centre research ethics committee for Scotland.

Taped interviews followed a topic guide with no set questions. Interviews were conducted by two of the authors (LS and JC) who were unknown to the parents, these lasted between 50 - 80 minutes. Recordings were fully transcribed and the 'Framework' method of content matrix data analysis was used.[10] Both interviewers and VP developed the themes independently and then agreed principal themes and sub themes. The themes were coded using Nvivo software (QSR International Pty Ltd).

Peer consultation took place with all authors on coding of transcripts, charting and mapping data, and final interpretations. This was important to help counter any bias that may have emerged during data interpretation. To ensure a transparent audit trail all the audiotapes, paperwork, Nvivo coding, charts and mappings are available for review.

RESULTS

Characteristics of participants

Of the seventeen principal carers interviewed 14 were mothers, two fathers and one a grandmother from diverse backgrounds and family circumstances. The characteristics of participating families in the present study are noted in table 1 and were similar to those referred for obesity management to the two major paediatric centres in Scotland.[11]

Throughout this paper anonymised verbatim quotes from the parents are used. Notations; (1) = child's BMI decreased; (2) = child's BMI increased.

Beginning the journey – why enter treatment?

One parent in each family appeared to have the 'lead' parenting role in the child's weight management; this was generally, although not exclusively, the mother. Prior to seeking help for their child's weight there were varying degrees of awareness among parents regarding their child's weight, ranging

from being highly aware and actively seeking help to being oblivious to any problem. We distinguished between those parents who appeared to be aware of their child's weight problem and those unaware of their child's weight.

Among parents who talked of being aware of their child's weight problem there were two groups - those who sought help after realising the problem we called 'seekers', *' because of the amount of food he was eating constantly and I thought I need to do something before it spirals out of control. Then going out and getting clothes nothing would fit him and I thought you know I need to do something' (2).* There was a second group of aware parents who felt unable/unwilling to discuss their concerns with the child and/or raise the issue with health professionals, we called this group 'avoiders'. *'Not as sitting down and saying you're over* (weight)*, because at the age she was at your frightened you're going to push them the other way' (1).*

Parents who appeared to be unaware that their child was obese generally described their child as a normal weight for their age, *'I didn't realise he was so overweight, I didn't realise he was that, because he doesn't actually look it because he's broad, so he carry it well, but I was quite shocked to find out his actual weight' (1).* Since all these children had BMIs above 2 SD score, we called these parents 'deniers'. These typologies are illustrated in figure 1.

Overwhelmingly General Practitioners (GPs) were the main gatekeepers to dietetic referrals for weight management. 'Seekers' approached their GP asking for help, while 'avoiders' and 'deniers' were typically attending for another reason and the GP raised the child's weight. A number of 'avoiders' and 'deniers' became 'seekers' once the weight concerns had been pointed out to them. When discussed there was a feeling that the health professional who had raised the issue had been insensitive to the feelings of the child and/or the parent.

This pre-treatment phase highlighted the parents' intense and often conflicting feeling and anxieties *'all my childhood bad feelings that I had were coming back. It is cruel to let a child over eat, I know that, but some times and I'm not*

a stupid person I'm quite a bright person, but some times commonsense doesn't come into it, when you love someone you want to make them feel happy' (1).

During treatment – the need for support

Parents strongly and persistently voiced their need for support. Repeatedly the parents talked of looking for *'someone'* outside of the family who could motivate the child and in particular give the child *'a wake up call'*. Support and help was also sought for the child's self esteem, for focus on necessary changes and to reinforce changes already implemented. Less persistently but intensely voiced was the need for support in justifying to other family members (including the other parent) the necessity for an intervention and lifestyle changes *'I just knew I wanted help cause I felt that my husband wasn't listening to me, my friends, my mum was very similar. I need someone then to say so also I could say to my husband I have been to the doctor and there is a problem' (2).* All parents described to varying degrees the support that they needed from significant others can be summarised as

- **not** offering/giving/tempting the child with foods they should be avoiding/cutting down commonly mentioned were sweets, chocolate biscuits, cakes
- **not** undermining the actions and lifestyle changes agreed with/being imposed by the lead parent
- reinforcing to the child, both by action and verbally, the agreed lifestyle changes
- supporting the initial decision to seek and enter treatment

Parents often conveyed a distinction in the level of support given from the nucleus family (those living in the same house); and the extended family (e.g. grandparents, separated parents, aunts, cousins and significant family friends). The nucleus family was generally discussed as being supportive, it was however less typical for the extended family and friends to be seen as supportive (Q1, Q2, Q3, Q4, Q5 table 2). The group most persistently mentioned by the majority of parents as being unsupportive were

grandparents (Q6, Q7, Q8 table 2). Most parents consistently reported that grandparents were not understanding, gave foods the parents had repeatedly asked them not to and sneaked little treats to the child. However in the minority of cases where the extended family including grandparents were supportive this was appreciated**,** *'no even his gran was helping and his aunty was helping, was saying to him try this and your not having this. Try and maybe give him a bit of fruit and he was quite happy with that, because if it was going to help him no one was too bothered' (2).*

In one family where the grandparents were the child's main guardians with the grandmother in the 'lead parent' role the child's natural parents took over the typical unsupportive grandparent role, *'They (*mum and dad*) want to treat them, but you know that is what I was saying to my husband I often end up as the baddie' (1).*

Post treatment – was it all worth it?

Parents commonly felt that the outside support ceased when the treatment finished. They noted that continuing treatment and support '*such as that given by Weight Watchers'* would have benefited the child and that continuous support was needed for treatment to be successful. There was a widespread view that parents and children had not adhered to all of the changes implemented during treatment, but they had continued with relevant positive lifestyle changes. Parents talked of having made lots of changes, a complete change in what was eaten and trying to maintain changes.

The persistent feeling of most parents was that their and their child's overall experience of obesity treatment had been positive and successful. Parents repeatedly talked of the interventions being worthwhile, educational, the best thing they had done and being treated with respect by the dietitian. An exceptional but strongly voiced view was that the experience had been negative, the treatment not as successful as hoped and there was a poor relationship with the dietitian, *'I didn't think it would make a difference where it was I just think he felt that the whole experience was a bit negative for him I don't think he enjoyed any of it. That's why I left and never came back'.* (1)

Parents expressed these positive and negative views regardless of the child's weight outcome.

When discussing their child's weight all parents' comments had varying degrees of ambivalence and ambiguity. The most frequent comment was that even though weight had increased it probably would have been worse if they had not taken part (Q1, Q2, Q3, Q4, table 3). Importantly what most parents did note as a positive and concrete outcome were improvements in the child's self-esteem/confidence. This was generally discussed in terms of style of clothes they could now wear, increased enjoyment in participating in PE and improved peer relationships (Q5, Q6, Q7,Q8 table 4). Indeed by this stage of the journey the majority of parents overwhelmingly saw these positive changes in self esteem as the key outcome, more important than weight change and for them an affirmation of successful treatment.

DISCUSSION

In this study we set out to identify and understand - from the parents' perspective - factors that may have influenced the decision to seek treatment, barriers to parents engaging during treatment and their perceived key outcomes of treatment, summarised in table 4. Resource limitations did not allow us to interview more parents nor to further explore our findings with other groups. However this study contributes by adding to a very limited evidence base on the feelings and influences of the parents of obese children in treatment programmes. For the parents there appeared to be several distinct phases characterised by us as a 'journey'. Parents interviewed cited child's low self-esteem, poor quality of life, awareness of the child being called names and worries about the child's future self esteem as reasons for seeking treatment; health was not commonly mentioned as a motivation for seeking treatment.

We identified parents whom we called deniers and others as avoiders. A number of studies have reported that parents often do not appear to recognise their children as obese or overweight nor the health implications of their child's weight.[12-16] However none have explored parents who are

aware of their child's weight but feel unable/unwillingly to discuss these concerns. Murtagh et al's 2006 [17] qualitative study supports some of these observations**,** but from the child's point of view.

Being a parent who actively sought treatment was not an obvious indicator of family motivation during treatment nor of a successful clinical outcome. 'Avoiders' and 'deniers' often converted to 'seekers' after the issue of weight had been raised. The discussing of weight by GPs was acceptable to these parents. This is an important message for GPs not to avoid the issue of excess weight but to raise the issue in a sensitive manner and offer parents help.

The present study suggests that support mechanisms within the family may be of great importance in achieving and maintaining lifestyle changes. The lead parent may often need help and full cooperation from the nucleus and extended family to make and sustain such changes. We have identified the type of support the parents need from significant others. The strength of feelings voiced by the parents regarding the role of the unsupportive extended family (in undermining lifestyle changes) raises issues for those working with obese children and their parents. Those developing treatment programmes and clinicians delivering treatment should consider engaging the whole nucleus family and possibly the extended family in treatment to improve success. Though this would require a form of care quite different to current 'office based' and low intensity treatments usually directed at the mother and child.[1] The level of support provided by highly intensive treatments may be an important contributor to their success.[3]

An overwhelming theme that emerged from the parents we interviewed was a perceived positive outcome of treatment regarding their child's self esteem and quality of life, indeed this appeared to be more important to parents than a successful weight outcome. Murtagh et al 2006 [17] illustrated the importance of self esteem for clinical samples of obese children, and we have previously shown in this sample that quality of life was significantly impaired.[18] For the children in the study by Murtagh et al (2006) it was the

desire to be ‘socially acceptable’ in the school playground and not long-term health which motivated them to seek treatment for obesity. Health professionals may need to be aware of the importance of this issue for the parents and the child and have more understanding of the need to support self-confidence and self esteem in obese children. For clinicians, outcomes such as weight and BMI SD scores are of fundamental importance in treatment of childhood obesity. However for the parents interviewed weight/BMI was not a priority at the end of treatment. There is perhaps a need for health care professionals to reconsider their outcome measures and perhaps seek greater concordance between the priorities of the family and of the health system.

CONCLUSIONS

Qualitative research is a powerful tool for illuminating peoples’ feelings and capturing participants’ ‘stories’ of experiences and how programmes felt from the inside.[19] The present study may aid in the development of theories and practices on how to empower and support parents through treatment for their child’s obesity. In particular our study highlights potential opportunities for future treatment such as: providing more support for families than can be achieved by short office based consultations; describing to families the types of feelings which other families undergoing treatment have experienced; helping parents make lifestyle changes by addressing the wider family environment; giving outcomes of treatment which are important to parents (psycho-social outcomes) higher priority in management.

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Table 1: Characteristics of participating parents

Characteristics	
Treatment goal met*	7
Treatment goal unmet*	10
Male (child)	8
Female (child)	9
5-8 years old	8
9-11 years old	9
Parent/s obese §	10
Mid-high socio-economic status	9
Low socio-economic status	8

* Goal met = BMI maintained/loss Goal unmet = BMI gain

§ Parental weight is self-reported. Socio-economic status derived from place of residence using the 'Carstairs Score': 1-4 defined as middle-high; 5-7 as low.

Table 2: Quotes from parents on lack of support from the nucleus and extended family

Q1	*'We knew it would be difficult when her cousins came over but because they are boys they were running about all the time, they would have a bag of crisps or something'*	*1*
Q2	*'He sees his brother, he's gonna eat pizza why can't I eat pizza and that's part of our problem'*	*1*
Q3	*'At times I think I was struggling as well because his older brother keeps calling him fatty and things like that'*	*2*
Q4	*'Its sort of friends and visits to friends, classmates and sleepovers and things like that then if he spends company with other children then he will get into a habit of eating sweets that he wouldn't eat at home'*	*2*
Q5	*'I think he cheated when he was with his mum, if mum wasn't watching he took the opportunity because I just changed what was in the house which is different from the way he was with mum'*	*2*
Q6	*'With granny and granddad, if they are hungry they will let them eat anything. Because they couldn't give us these things, they see these foods as a celebration. I don't think they really understand that it can be cruel to just give in all the time'*	*1*
Q7	*'His granddad has never changed the waine wants it the waine will get it. I try not to take him anymore'*	*2*
Q8	*'Granny just likes to buy them sweeties to spoil them'*	*1*

1 – child's BMI decreased; 2 – child's BMI increased

Table 3: Quotes from parents on treatment outcomes

	Weight	
Q1	*'I mean it was the big huge jump in weight had sort of stopped which is what we wanted and as she will grow into it and that is about as much as we could have hoped for'*	*2*
Q2	*'Because she is still gaining weight, I don't know why. She's had tests again for thyroid and diabetes but they've come back negative and she's still gaining weight'*	*2*
Q3	*'Well she kept that weight that she originally had but when she stretched up she slimmed down rather then loosing it all at the same time she kept it the same'*	*1*
Q4	*'Overall I think he has just put on slightly compared to what he started at. Which again wouldn't be too bad over the year, what I mean because if he hadnae been doing it he'd have probably put on a lot more I would say'*	*2*
	Self –esteem	
Q5	*'He used to wear jogging bottoms for comfort but we managed to get him to dress trousers for school. He was saying its really good isn't it, it has been really good for him.'*	*2*
Q6	*'I think it was good for her self-esteem, she was really starting to feel good about her self. Which is more important she has really taken it on'*	*1*
Q7	*'She used to be embarrassed at school cause there were things she couldn't do in PE that she can now do'*	*1*
Q8	'*To actually put the thought in her head of what she wanted to do and achieve and set her own goals. It has been much better than what I expected'*	*1*

1 – child's BMI decreased; 2 – child's BMI increased

Table 4: Summary of main features of the parents' journey

Journey phase	Feature	Sub-feature
Pre treatment	Aware of weight	Seekers Avoiders
	Unaware of weight	Deniers
	Emotional	Fear Angry Guilt Confusion
During treatment	Needing support	From nucleus family From extended family From health professionals
	Unsupportive	Mainly extended family Particularly grandparents
After treatment	Weight outcome	Ambivalence Best it could be Would have been worse
	Self esteem	Important to parents Child more confident Child happier