Parenting an overweight or obese child: A process of ambivalence

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Abstract
Childhood overweight represents a health problem, and research points towards parents as key players. The aim of this study was to deepen the knowledge of how parents of children who are overweight or obese experience their parenthood. Focus group discussions with 17 parents were analysed according to the qualitative method of modified grounded theory. The results expressed the parents’ ambivalence between preventing the child’s overweight and not negatively affecting the child’s self-esteem. The most important issue seemed to be their concern about the child’s construction of self-understanding and experiences in interaction with the environment. The parents had become uncertain of their responsibility, priorities and how to act. In conclusion, parenting a child with weight issues could be a process of loving the child the way he/she is while still wanting changes for improved health, resulting in ambivalence. In addition to traditional advice about lifestyle, many parents seem to need counselling assistance with respect to their parental role.

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Background
The prevalence of obesity in Norwegian children seems to be on the same level as other European countries except Great Britain where it is higher (James, 2004; Julissusson et al., 2007). The World Health Organization (WHO, 2006) regards obesity as an epidemic and one of the most severe threats to public health. Childhood overweight and obesity represents a major health problem, as it is predictive of a lifetime of overweight and obesity (Freedman et al., 2005). It has significant adverse effects on children’s physical and psychological health as well as psychosocial and behavioural difficulties (Reilly et al., 2003). The health-related quality of life of overweight children is observed to be low in clinical populations (Williams et al., 2005). Considerable attention has recently been paid to the identification of obesity and associated co-morbidities (Cole et al., 2000). A variety of weight reduction programmes have also been developed for children during recent years (Grimes-Robison and Evans, 2008). Most conditions are, however, responsive to lifestyle modifications, and interventions should begin early (Nowicka and Flodmark, 2008).

Research points toward parents as being key players in the treatment of childhood overweight (Golan and Crow, 2004; Grimes-Robison and Evans 2008; Howard, 2007). The role of the home environment has long been recognized (Nowicka and Flodmark, 2008). Although the parents cannot control all aspects of the child’s day, they make important choices and decide what is available. Parents are both the responsible actors of the family and the child’s first role models of a healthy lifestyle. Interventions should therefore involve parents rather than children (Golan et al., 2006). It is also important to avoid a child being excessively aware of its body and weight.

Research indicates that many parents of overweight children underestimate their child’s weight (Lampard et al., 2008). They are either unaware of the overweight or do not consider it a threat to their children’s health. Though the parents’ concern is important to be able to start positive actions as early as possible, it is also negative when their concern is too high (Jackson et al., 2005). In this field, there are few publications focusing on the experiences of parents. Jackson et al. (2007) point to the uncertainty among mothers who often feel that they are blamed by other people and who also blame themselves. Interventions should be informed by a better understanding of different aspects of the parents’ lives and knowledge of factors influencing the communication between health professionals and parents (Mikhailovich and Morrison, 2007; Williams et al., 2005).

The aim of this study was to deepen the knowledge of how parents of children who are overweight or obese experience their parenthood.

Method
Setting, participants and procedure
This study is part of a three-year follow-up treatment project at Akershus University Hospital aimed at parents of overweight or obese children (Bechensteen et al., 2009). The parents of children aged four to 11 years whose height–weight scale was above the 90th percentile on a health card used at mother and child care centres in Norway, were invited to information meetings. Another inclusion criterion was being able to converse in the Norwegian language. After these meetings, the parents of 46 children wanted to participate and were divided into six counselling groups. Before the interventions took place, qualitative interviews were carried out in focus group
discussions (FGD) in the first two counselling groups (KvaleRA1, 2007; Lehoux et al., 2006). The parents who decided to participate probably differed from non-participants regarding cultural and motivational aspects. The 17 parents (six of whom were fathers and one of whom was a grandmother) had 11 children (eight were girls, nine had siblings). They had achieved different levels of education and their weight varied from slim to obesity level with differing childhood and contemporary experiences regarding their own weight.

The interviewers (KTSH and BB) were not known to the participants in advance. The focus groups were held in a conversational style and lasted up to 90 minutes. Themes of concern were experiences of being a parent, the child’s story, their daily life and thoughts about the future. The participants had the opportunity to raise questions regarding the study and the interviewers asked relevant follow-up and probing questions. The interviewers were aware of their influence on the data created in the conversation process (Holstein and Gubrium, 2003). The Norwegian Data Inspectorate approved the project.

Grounded theory

According to Corbin and Strauss (2008), grounded theory is especially suitable when studying social processes. Being a parent of an overweight child concerns social processes both in terms of raising the child and in interacting with other parents, teachers and health professionals. In line with this, the qualitative inductive research method of modified grounded theory was chosen. Grounded theory is based on theories of symbolic interactionism, which means that meaning is constructed and changed within interactions between individuals. An individual’s perceptions of the world are changing by new interactions, which are changing experiences (Blumer, 1986). Ontologically, the position in grounded theory has developed from Glaser’s classical assumption of a given reality that can be discovered (Glaser and Strauss, 1967), to modified grounded theory stating that the researcher interprets data (Corbin and Strauss, 2008). Now Charmaz (2006) argues that grounded theories are the researcher’s constructions of reality. The basic principles of grounded theory include constant comparisons, theoretical sampling, saturation and theoretical sensitivity.

Analysis of data

The verbatim-transcribed interviews were analysed in open and selective coding processes (Corbin and Strauss, 2008). Open coding means that the substance of the data was segmented into substantive codes, ending up with clustering substantive codes with similar content and giving them more abstract labels. Questions asked of the data were: ‘What is the process here? What is actually expressed?’ In the selective coding, each category was further developed through finding relationships between categories and a new wholeness. A core category (main results) was identified, describing the processes of the parents’ ambivalence, which could be related to the already defined categories. During the entire process, ideas, preliminary assumptions and theoretical reflections were written down in notes, ‘memos’. The first author created the transcript and did most of the analysis and the last named author reviewed the coding.

Results

Our main finding was that the parents felt ambivalent in their parenthood of their overweight child between taking preventive actions with respect to the child’s weight and, at the same time, which
could be in conflict, also taking care of the child’s self-esteem. The parents’ understanding of their situation differed due to conditions like the child’s reactions and interaction with other people. However, they did experience some common processes. Their ambivalence is described in five categories: being worried about stigmatization of their child; wanting to protect their child; feeling insecure in setting limits for their child; being questioned about their own parenthood; and showing acceptance of their child while still wanting them to change.

**Being worried about stigmatization of their child**

All the parents described their primary worry as stigmatization of their child owing to the child’s overweight. Particularly, they feared their child being teased by other children or having difficulties in finding friends. This subject brought up the parents’ strongest feelings and also caused tears. They thought of friends as an important value for their child’s self-understanding. Being teased could lead to decreased self-esteem, as in ‘not being like you should be’. The parents thought of teasing as wrong. Still they seemed to blame the situation on themselves and did not know how to stand up for their child. ‘What else can you expect, sending a child of that size out in the world?’ one mother asked. The problem was described to be as big at day-care centres as schools. Support from teachers or other grown-ups was essential.

What I am afraid of is that she will be bullied, that’s the biggest fear – Yes, of course, it’s also related to her health, but – it’s the bullying that is the nightmare – and makes me – worry as much as I do – even if we for now have experienced... little of it [cries]. (12a)

**Wanting to protect their child**

Accordingly, the parents wanted to protect their child from stigmatization. They spoke of how they wanted their child to be happy and develop a positive self-understanding. They were worried as they realized their child had problems that they could not just ‘fix’, such as the attitudes of others or the child being concerned about his or her own weight. Some had experienced that others would not take their child’s problem seriously. In contrast, especially parents of younger children had been less concerned about the question of overweight, and at first wanted to protect their child from ‘overreactions’ from others. As they became aware of their child’s struggle to keep up with other children’s activities, they wanted to participate in the project. Parents of older children felt insecure about how to bring up aspects about overweight with their child. They wanted their child to become responsible, but even more so, they wanted to protect their child from being overly aware of their eating routines or body.

She has always been very soft and chubby and – been running around and dancing – she loves it – I haven’t really seen her weight as something that hampered her, but when I was watching her do gymnastics once: she’s so heavy, like – It was like a ‘bomb’ – like, there she stood ... then I saw that she was hampered by her weight – and then, then I think you can say that – then it starts to become a problem. (14b)

**Feeling insecure in setting limits for their child**

In order to protect their child from becoming too aware of the issue, the parents described their ambivalence in setting limits for their child. The parents related that they had already made changes to help their child, especially over what to eat and drink. The children also had more physical activities than before. At the same time, the parents were worried that limits might give the child an experience of not being accepted. They were concerned about their child’s reaction to limits, especially regarding restrictions on their amount of food. Perhaps increased awareness would affect the child’s relation to food, or even
lead to negative self-understanding and an eating disturbance, they thought. The ambivalence affected their reasoning over when and how to set up limits; they felt like bad parents for not giving their child a good time eating all the food he/she wanted. This issue seemed to be extra hard on the parents who were concerned about their own weight: ‘How can I set up limits for my child that I cannot keep up with myself?’ Consequences for slim family members came up as part of the problem, and some slim parents blamed themselves for ‘spoiling’ their child or not supporting the child enough in the issue of weight.

We are obviously anxious to see him not eat a lot of sweets and we have had to restrict his food – plain and simple – with respect to cheese, sweets and not too much food . . . And it often hurts a little – because – I don’t know how many slices of bread he can eat, but it’s incredibly many. You have to stop him, and that’s not very pleasant . . . (11a)

**Being questioned about parenting style**

As a consequence of the described process, the participants asked themselves if they were good enough as parents, particularly those who had been aware of their child’s overweight for a while. The parents’ uncertainty about their responsibility and interaction with their child became worse because of offensive comments from others. They felt judged and blamed, that their child’s weight reflected negatively on them as parents. As they experienced disrespect, they felt others were watching them eating at restaurants or birthday parties. Also, they felt stigmatized as a family. In cooperation with teachers at school some had been met with respect and enthusiasm, but some felt they had not been taken seriously. They were afraid that their child more often was looked upon as ‘the problem’ when together with their peers, for example in fights. Even encounters with professionals in the healthcare system had resulted in experiences of receiving offensive comments. The disrespect seemed especially difficult to the parents who felt as if there were no sense in discussing the issue because of their own big size they were already disqualified as parents.

. . . ‘Well [addressing the mother], you weigh quite a bit [yourself] – and perhaps you should visit the nurse and get some nutrition counselling’; like the woman at the healthcare centre said it in such a way that I sat there feeling that [she thought]: ‘Those people, they go to McDonalds and drink coke five times a week’ – like, it was said in such a negative way that – I was so angry and upset when I walked out of there – and I’m never going back. (14a)

**Showing acceptance of their child while still wanting them to change**

According to the interviews, the parents felt uncertainty regarding whether their child’s overweight really was that serious, as well as their own responsibility for what to do about it. On the one hand, they really wanted their child to be healthy, to fit in with other children and be happy. On the other hand, they wanted to show they accepted their child as he/she was, to make the child feel ‘good enough’ without having to change. The parents’ questions about the child’s weight were close to existential questions about the child’s identity and self-understanding. In general, the younger their child was and the more different experiences the parents had regarding weight, the more ambivalent they were.

He is very conscious himself and so – very eager to ask if there’s sugar in this? And yes, so he is – how much does he think and understand himself? He also weighs himself a lot – and then he holds his breath as he stands on the scales and so – and he’s a 7-year-old boy. That’s what worries me – how much he understands himself and how much – he thinks . . . (11a)

**The core category: Being ambivalent to the child’s overweight as a problem**

According to the interviews, the parents felt ambivalent to the above described aspects affecting the health and self-esteem of their children. The parents asked how they could explain to the child
something they didn’t really understand themselves. They thought they could change the health situation by their lifestyle, and at the same time they feared their actions would make the child less satisfied with him/herself. Whilst they wanted a healthy child with respect to body weight, even more than this they wanted a child with high self-esteem.

Everyone thought of appetite, eating disorders and body image as serious and sensitive issues. They were anxious not to enlarge any problems, and wanted to build up their child’s positive attitude towards their own body, food and meals. They thought they could make changes, but did not know how different actions would influence their child. As the parents were ambivalent it was hard for them to make decisions.

**Discussion**

This study revealed a complex situation for the parents in their efforts to parent a child with weight issues. They experienced their situation as being confusing and full of dilemmas as many aspects were interacting simultaneously with each other: dilemmas of stigmatization, both of the child and parents; the possibility of unwanted harm as a consequence of intervening in order to limit their children’s weight gain; and ambivalence between showing acceptance and making changes. They ended up as ambivalent to the situation of their child’s weight and their parental role in general.

What seemed to be the really important issue for the participants was their concern for the child’s developing identity and quality of life. The importance of the child’s experiences of interacting with the environment, including being accepted, is supported by theories of personal construct (Ginger, 2006; Viney and Winter, 2005). Also the parents’ own attitudes and actions worried them in terms of how they affected their child’s self-understanding. In line with other studies, they were not as concerned about the child’s weight per se, but more about the child’s health in general and their quality of life (Puhl and Latner, 2007). What they feared was how the overweight would affect their child’s self-construction.

Therefore, stigmatization of the child was the parents’ real ‘nightmare’ as they thought of friends as essential to their child’s quality of life and self-construction. They were ambivalent as to whether they should try to make the harassment stop or help their child to lose weight in order to be accepted. The problem of teasing at the day care-centres is in line with knowledge that children are aware of body size at the age of three years (Suzanne et al., 2008). Scientific literature is clear in demonstrating that overweight youth are targets of stigma and that the problem is growing (Jackson et al., 2007). We could not identify specific gender differences either in the parents’ attitude or in the children’s experiences or types of victimization (Griffiths et al., 2006; Wang et al., 2010). This will probably vary in different cultures. In our study the issue of stigmatization brought up strong feelings and tears from all the parents, regardless of their child’s gender, age or the parents’ own weight. Teasing is a prevalent concern related to a variety of health risks (Suzanne et al., 2008). The complex pathways in body weight regulation also include psychological variables (Libbey et al., 2008). Although more work is needed to draw conclusions about stigma, it is demonstrated that psychological outcomes often disappear after controlling for stigmatizing experiences (Suzanne et al., 2008). Puhl and Latner (2007) suggest that the stigmatization can be as unhealthy for the children as the overweight itself.

The parents were ambivalent regarding whether the best protection was to support their child to be happy with their ‘big stomach’ or to become ‘slim’. Parents not being concerned enough about their child’s overweight is well documented, especially among parents who are overweight (Lampard et al., 2008; Myers and Vargas, 2000; Nowicka and Flodmark, 2008). In our study there
were also some slim parents who initially had been little concerned. One aspect that made the parents less concerned was the child’s low age: ‘It’s not an issue at the moment’ (Zehle et al., 2007). In addition, our parents pointed at the child’s high activity, slim siblings/parents, or the experience of overweight children becoming slim naturally. However, the parents need to become aware of the situation to be motivated to make changes (Ginger, 2006). Our parents’ concerns about their child’s well-being rather than the body size are in line with scientific literature suggesting that interventions should promote health practices to parents (Puhl and Latner, 2007). Nowicka et al. (2009) pointed at overweight as a risk factor to low self-esteem. These results might support our participants’ aim to protect their children by acceptance, disturbing the children as little as possible.

On the one hand, the parents loved to see their children happy, enjoying all the food they wanted, on the other hand they struggled with how to find good ways to set up restrictions. The literature states the important role parenting has in children’s development of habits (Ritchie et al., 2005). Common advice to parents is mostly about what to eat and drink along with more physical activity and reducing inactivity by allowing less total ‘screen time’ (Polacsek et al., 2009). Like other parents, our informants had made some restrictions on fatty foods, sweets and soft drinks, while increasing physical activity seemed to be harder (Myers and Vargas, 2000). Hence, Ritchie et al. (2005) report that a high degree of parental control over a child’s dietary intake may disrupt natural systems of self-regulation. The kinds of restrictions are important, but how they are set (parenting style) is probably even more important (Lowry et al., 2007). Interventions should probably aim at the parents’ ability to take control of the child’s access to energy-rich foods in the household without involving the child, and if it becomes necessary, then how to bring up these sensitive issues with their children.

Our informants were most often invited to the information meetings after a routine measurement of their child’s height and weight. From a public health perspective, health professionals focusing on case findings from within the general population represents a ‘high-risk strategy’, different from ‘mass strategies’ which seek to change the public environments. The high-risk strategies in general clearly have their strengths, but also weaknesses, such as the prevention of overweight becoming medicalized and children in some cases being unnecessarily ‘labelled’ with a medical problem (Rose et al., 2008). Another weakness is the poor ability to predict the future for individuals. The weaknesses were illustrated by the parents’ narratives and may point to the need for improving future counselling programmes (Mikhailovich and Morrison, 2007).

The parents constituted a special sample as they were concerned enough to have decided to participate in counselling groups, contrary to the lack of parental concern in other studies. When we added the result from the second focus group interview to the analysis from the first interview, no new issues arose. However, because of the limited group of participants we may have a somewhat limited saturation in our results. Our aim was to document the variety of aspects that might affect these parents in parenting their overweight child. We know little about each parent’s body weight, and their related experiences or attitude to food. These issues as well as cultural differences could be of interest for future studies. Our study was not designed for the comparison of parents of male versus female children, an issue that could also be of interest in future studies. The information supplied by the participants was always influenced by the context of the interview. We think this was for the good of our study as the participants were respectful and encouraged each other’s detailed stories. They wanted their stories to assist the group leaders in order to develop a helpful intervention.
Conclusion

Conclusively, parenting an overweight child could be seen as a process, which includes loving the child just the way he/she is while still wanting the child to change, ultimately resulting in ambivalence between supporting the child’s present self-esteem and trying to avert health problems. We therefore need more knowledge in order to meet parents with respect and assist them in becoming more aware of their own conception of the situation, and able to find their own solutions. Suitable interventions should address parental knowledge, perceptions and practices. In addition to traditional advice about lifestyle, many parents seem to need counselling assistance with respect to their parental role.

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