

Experiences of adolescent weight management:
The perspectives of primary health care professionals,
adolescents, and parents

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Abstract

Introduction

In the last 20 years, compared to other European countries, England has shown the steepest rise in, and now has the highest rates of, obesity in Europe. The rise in childhood obesity has been of particular concern, and it has been suggested that health care professionals (HCPs) like GPs and nurses have a role to play in helping children and families manage obesity. Little is known about HCPs experiences of providing weight management advice to adolescents in the UK, and no studies have explored the experiences of all the parties involved: HCPs, adolescents and parents.

Aim

The overarching aim of the research was to identify barriers and facilitators to general practice based weight management for adolescents

Method

The research presented here comprises 4 studies. Study 1 consisted of a survey investigating the attitudes and practices regarding adolescent weight management of GPs and practice nurses working in general practices in two English counties. This was followed in study 2 by in depth face-to-face interviews with a subsample of HCPs. In study 3, adolescents and parents were interviewed, and study 4 consisted of a survey of young people's perceived barriers and help seeking intentions regarding weight management. All interviews were recorded and transcribed verbatim, and analysed using Interpretative Phenomenological Analysis (IPA).

Results

HCPs discussed the relevance of obesity management to their professional role, with most considering general practice to be a difficult setting for optimum care in this area. They showed ambivalence towards the incorporation of obesity management within their professional role, and talked about their own endeavours in this domain more in terms of personal rather than professional identity. Participants showed a tendency to perceive adolescents as particularly vulnerable with regards to discussions about weight, a perception that acted as a barrier to weight management consultations with this age group. In contrast, both the adolescent interviews and survey suggested that discussions about weight might be acceptable if framed in terms of health and behaviour rather than weight per se. Help-seeking intentions for weight were low among adolescents, particularly for primary health care services. The parents reported concerns about weight in their children to be a balancing act between seeing a need for healthy weight on the one hand, and concerns about stigmatisation on the other.

Conclusion

The stereotypical view HCPs have of adolescents, and their fear of causing them harm, inhibits effective communication between HCPs and young people regarding weight. For such discussions to happen more frequently, HCPs need to feel equipped to manage the consequences, and training in how to manage psychosocial issues with young people could be of benefit. The HCPs described a patient centred perspective on adolescent weight management when speaking in the abstract, but in practice, patient centredness was thwarted by difficulties in communication and a lack of partnership between the adolescent patient and provider.

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The research undertaken here developed out of prior work I had done relating to health service provision for adolescents, and a general passion for young people's health and well-being issues. Passion notwithstanding, however, it would not have been possible without the support of some very good people.

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Chapter 1: Introduction

The escalating incidence of overweight and obesity in children and young people, as well as in the population at large, has been of increasing concern over the past decade. It has been suggested that there is a world-wide obesity epidemic (WHO 2000), and the UK has been seen to fare particularly badly compared to other Western European countries (OECD 2010). Obesity is seen as a problem because of its implications for the health of the population, and because the potential resulting disease burden is perceived to be costly (Comptroller and Auditor General 2001; Department of Health 2011). The high prevalence among children and young people has been of particular concern, both because of its impact in the here and now and for the future (Comptroller & Auditor General 2006). At the same time, it has been suggested that we live in an obesogenic environment that is conducive to weight gain and which makes weight loss difficult (Foresight 2007; Lake & Townshend 2006; Chaput et al. 2011). Because of this, multi-level approaches with action initiated at all levels of society have been recommended as necessary to tackle overweight and obesity in the population (Foresight 2007; Department of Health 2008; Kopelman 2010; Lakerveld et al. 2012; Lang & Rayner 2010), and the need for the NHS to play a key role in this has been indicated (Department of Health 2011). When it comes to children and young people, there is an emphasis on the importance of doctors and nurses helping children and their families to “lead healthy lifestyles” (NICE 2006; Department of Health 2004b), although the specific details of what exactly health care professionals can do to enforce this role is often unclear. Further, it has been suggested that as incidence increases, overweight and obesity is becoming ‘normalised’ meaning that people may be less likely to take action or seek help with weight loss (Foresight 2007).

Also over the last decade or so, there has been an increasing focus from policy and professional groups in the UK on children and young people’s health more generally, and in particular there is now general consensus that adolescents form a distinct group with particular health needs that are

different from those of either adults or younger children (British Medical Association Board of Science and Education 2003; RCPCH et al. 2003; RCGP 2010). Adolescents are at a developmental stage where they will start taking on greater responsibility in many areas of their personal life including health, and some young people may start attending health services consultations without their parents being present. Similarly, whereas obesity interventions aimed at younger children are facilitated mainly through parents, interventions for adolescents will likely involve greater involvement and responsibility on the part of the adolescent themselves (Zwiauwer 2000). This means that conversations and interactions in the health care professional (HCP) encounter need to take their developmental position into account. Taken together, this suggests that there is a need to fully understand health service provision for weight management for overweight and obese adolescents.

This introductory chapter will start by outlining the meaning of adolescence, describing some of the markers of adolescent development that are relevant for young people's utilisation of health services. It will locate adolescents within a larger life course perspective, and describe how and why effective relationships with health care professionals, as part of a larger group of adults important to young people's lives, can be conducive to healthy development. It will then go on to describe some of the issues pertinent to adolescent weight management in health care settings, before presenting evidence to support the idea that, in theory at least, general practice could play a role in weight management for young people who are overweight or obese. The chapter will then state the aims and objectives for the current research, before giving an outline of the dissertation as a whole.

Adolescence

Adolescence has been described as "the period between being a child and being an adult" (World Health Organization 2014a), and Merriam-Webster defines it as "the period of life from puberty to maturity terminating legally at the age of majority" (Merriam-Webster 2014). In terms of specific ages, the WHO considers adolescence to be between 10-19 years of age (World Health Organization

2014a), while others have been reluctant to tie it to set age points (British Medical Association Board of Science and Education 2003) since it is tied with physical and emotional development which occurs at different ages and speeds in different individuals. The terms 'youth', 'young people' and 'teenagers' are frequently used interchangeably with 'adolescents', although the terms do differ in their definition. In their report on children and young people's health, the Royal College of General practice (RCGP 2010) defined the different terms as:

"A young person refers to an individual who has started the process of transition from childhood to adulthood (defined by the onset of puberty) up until their 19th birthday. This overlaps with the terms 'teenager' (defined chronologically) and 'adolescent' (which can be considered as extending until full independence is attained)." (p4)

In this sense, adolescence is defined in terms of function rather than age. This dissertation is focused primarily on individuals aged between 13-18 years, since this covers the time period between entry into the teenage years up to the age of legal majority. Because of this, the terms 'adolescent', 'teenager' and 'young person' are used interchangeably in this dissertation, since they all cover the group in question.

Adolescents form a significant proportion of the population; there are currently around 7.4 million young people aged 10-19 years in the UK (Hagell et al. 2013). It is a time of rapid changes in physical, cognitive, emotional, social and behavioural development (Christie & Viner 2005; Rogol et al. 2002; Hagell et al. 2013) and is characterised by different transitions such as pubertal onset, transitions in school environment, changing relationships with family and peers, and entry into higher education or the workplace (Schulenberg et al. 1997). Because of all these often quite dramatic changes occurring in a relatively short period of time, early work on this age group characterised adolescence as a time of 'storm and stress' (Hall 1904); a definition that has stuck ever since (Hines & Paulson 2006; Graham 2004). Adolescents are typically represented in accordance with this view in the media; they are portrayed as moody, rebellious and difficult, and these perceptions influence how

they are met by adults in society at large (Graham 2004; Department for Education 2011). However, although it may prevail in popular and public images of adolescence, the idea that the teenage years are by necessity difficult or even traumatic have been questioned (Arnett 1999; Laursen et al. 1998). Although individuation from parents necessitates a certain amount of conflict, and communication between parents and adolescent children may decrease as need for privacy increases, many young people go through adolescence with minor difficulty (Schulenberg et al. 1997; Graham 2004; Arnett 1999). It has also been suggested that the fact that adults cannot always understand adolescents is not necessarily a bad thing (RCPCH et al. 2003) and is partly necessary for their individuation from parents to occur (Grotevant & Cooper 1986; Galambos & Ehrenberg 1997).

Life course approach

Although it is important to recognise that adolescents form a distinct group with their own priorities and needs, this time period is best understood viewed from a life course perspective. Young people are shaped both by the children they were, and the adults they are striving to become. Although their reliance on parents lessen during this stage and ideally results in complete individuation (Kroger 2004), most adolescents in the UK still live with their parents or other caregivers for the majority of their teenage years. The importance of seeing adolescent development as occurring in the context of their wider environment has been stressed in ecological models of human development (Bronfenbrenner 1977). Further, the theory of developmental contextualism posits that individuals are affected by their environment, but also have their own unique impact on their social contexts (Lerner et al. 1997; Lerner 1995; Lerner et al. 2011; Lerner & Castellino 2002; Gestsdóttir & Lerner 2007). Developmental contextualism views human development throughout the lifecourse as a reciprocal relationship between individual and environment, and stresses the importance of all aspects of a young person's life for their individual developmental trajectory. From this perspective, health services and the people who provide them can be seen to have a major role

to play in the development of concepts of health, and effective use of health services, for the adolescent (Maggs et al. 1997).

It has also been suggested that precisely because of their increasing need for independence and autonomy, adolescents may be more receptive to health promotion messages than other age groups (RCPCH et al. 2003). From a policy perspective, the importance of addressing young people within a life course approach has been reiterated by the 2010 White Paper on health (Department of Health 2010). This means understanding the increasing need for autonomy and independence that occurs during this time period, but also recognising that there is often a certain sense of loss associated with transitions as well; a loss of childhood (Schulenberg et al. 1997). Therefore, getting a sense of how ready individual adolescents are for taking on responsibility and independence is paramount for working effectively with them and ensuring that they feel both heard and understood. Although looking towards adult roles is an important feature of adolescence (Jeffrey Jensen Arnett, 2000; Church, 1994; Thomson et al., 2004) young people's health needs to be considered for its importance in the here and now and not just because of the impact it may have on the adults they will become (Wills et al. 2008).

Supporting adolescents' developmental needs

In line with the developmental contextualism perspective, it has been suggested that services for young people need to focus not just on tangible outcomes like educational attainment or absence of risk behaviours, but also on working with young people to support the development of their social and emotional needs (McNeil et al. 2012). Such skills will have a positive impact in the young person's life immediately, but are also known to be associated with positive life outcomes further down the line (McNeil et al. 2012). However, negative views presented of young people in general may incur negative feelings and mistrust among adults towards young people (Graham 2004). Because of their developmental stage, adolescents may lack the voice or confidence to successfully

negotiate services; it is therefore the responsibility of adults to make sure that this can be achieved (RCPCH et al. 2003). Developing strong supportive relationships with trusted adults is paramount for healthy development and transition into independence and autonomy (Lerner et al. 1997; Resnick et al. 1993; Mcneely et al. 2002); in the health care arena this translates into HCPs enabling young people to establish trusted relationships with the health care profession which in turn will aid effective use of services both in the here and now and in the future (RCPCH et al. 2003; Department for Education 2011). Further, it has to be recognised that in order for services to best meet the needs of young people means listening to what they have to say – even if that means also accepting that sometimes they give difficult answers that may be hard to implement (RCPCH et al. 2003).

Focus on adolescent health

Adolescence is generally considered a healthy age, but it was the only age group that did not see significant improvements in mortality during the course of the second half of the twentieth century (RCPCH et al. 2003). It has been suggested that the health and well-being of children and young people should be a top priority for the NHS (NHS Future Forum 2012), and the Children Act 2004 tasked providers with the responsibility to ensure children and young people receive the support they need to be healthy (Great Britain 2004). Health needs are greater during adolescence than the time periods immediately before or after (RCPCH et al. 2003), something that has been increasingly recognised by both policy and professional bodies over the last decade. From a policy perspective, adolescent health has gained greater attention through the release of documents like the National Service Framework for Children, Young People and the Maternity Services (Department of Health 2004b). The need for adolescent specific services and recommendations for how to achieve them were reiterated in a report by the British Medical Association (BMA) (British Medical Association Board of Science and Education 2003), and a joint report on adolescent health was published by the UK Medical Colleges (RCPCH et al. 2003).

Health and weight in adolescence

When asked about the things that are important to them, health has been rated as one of the top priorities by young people (McNeil et al. 2012). Within health, weight is one of the things young people are most concerned about (RCPCH et al. 2003). However, even in a context that views high levels of adolescent overweight and obesity as a public health concern, providing recommendations for helping young people to reduce weight is not straightforward. While there is the concern for young people becoming too overweight on the one hand there is also a worry that unrealistic images of celebrities with perfect bodies can create poor body image, lack of self-esteem and consequent health issues (Department for Education 2011). Overweight and obesity is known to be associated with high levels of stigma in young people (O’Dea 2005), therefore discussions around weight with this age group needs to be handled with care and sensitivity. The responsibility for tackling the ‘obesity epidemic’ has been said to lie with all levels of society (Foresight 2007), with the health services being viewed as key partners (Department of Health 2011). General practice forms perhaps the most generally accessible health service for the population at large, and a significant proportion of young people visit their GP on a regular basis (Brooks et al. 2015; Hagell et al. 2013). It is therefore reasonable to surmise that effective communication between general practice based HCPs and adolescent patients would be beneficial for weight management as well as for health promotion more broadly.

Adolescents and GP services

Despite the increasing recognition of the health needs of adolescents by the medical professional bodies described above, it has been suggested that adolescent health is a neglected subject at practitioner level in England, with no sub-specialty in adolescent health and most paediatricians viewing younger children as their ‘core business’ (Payne et al. 2005). It has been suggested that adolescent health is marginalised within general practice in particular; according to the RCGP (RCGP

2010) “less than 3% of Quality Outcome Framework (QOF) indicators relate to children and young people” (p7). Further, no QOF indicators relate to adolescent overweight and obesity (The National Obesity Observatory 2010), potentially resulting in this becoming a low priority area for general practitioners. Further, many HCPs feel uncomfortable and unsure of their skills when dealing with adolescent patients (Jacobson et al. 2001; Jacobson et al. 2002; Payne et al. 2005). General practice has been criticised for not being ‘teen-friendly’, and the need for services that are accessible to young people has been stressed as paramount (Viner & Barker 2005; RCGP 2010; Department for Education 2011; RCPCH et al. 2003). According to Positive for Youth (Department for Education 2011):

“It means helping young people to view seeking advice and help from general practitioners and other professionals as normal and not an act of last resort, and ensuring that judgmental attitudes and stigma no longer deter young people from seeking early advice.”

(p45)

Although the importance of HCPs recognising the need to work with young people and ensuring the best outcomes for them have been set out in policy (Department for Children Schools and Families 2008), there is a need for training in adolescent health issues (Department for Children Schools and Families & Department of Health 2009). Staff working with young people need to be empowered to make sure that they can best support and meet the needs of those young people (McNeil et al. 2012; Viner & Barker 2005). According to the National Service Framework (NSF) for children, young people and maternity services, all professionals working with adolescents should receive training in adolescent health (Department of Health 2004b).

The majority of children and teenagers who see a doctor do so accompanied by their parents (Rutishauser et al. 2007). As they enter adolescence, young people may want to attend on their own, or it will at some point be appropriate to give them greater control and responsibility over their

health; because of this, it has been argued that adolescents should be considered as 'new service users' who need to learn how the service works and need to be supported to make best use of it (RCPCH et al. 2003). Adolescent health promotion should take a holistic view and focus on emotional as well as physical health, and on giving early support to young people who need it (Department for Education 2011). It has been suggested that general practice represents an important setting for health promotion with children and young people (RCGP 2010), and that the opportunity for health promotion should be seized within consultations whenever possible (NHS Future Forum 2012).

However, having the opportunity to bring up health promotion issues is usually not enough. Firstly, HCPs need to feel comfortable and confident in managing such consultations. Secondly, for such consultations to be effective, communication between patient and provider is of vital importance (Street & Epstein 2008). Effective communication has been described as characterised by trust and respect, and by engaging patients as partners (Stewart 1995). This is congruent with the idea of patient centred care, which states the importance of being able to take the individual circumstances of each patient into consideration as paramount for consultations to be effective and valued positively by patients (Little et al. 2001; Mead & Bower 2000). In this way, adolescents need to be able to trust HCPs to engage with them and, by extension, start taking responsibility for their own health. This is important for the health of the adolescent, both for their current life but also for their future; if such relationships are not developed during adolescence (when they can be more easily negotiated in a balance between parents and young person), they will have to be built in adulthood, but they are more likely to be positive and effective if they have already been started during adolescence (RCPCH et al. 2003). GPs have a unique role in this because of built up relationships with families and continuity of care, and because of their well-established networks with other supporting services (RCGP 2010).

Aims and objectives

Aim

The aim of the research was to identify barriers and facilitators to general practice based weight management for adolescents

Objectives

- To elicit attitudes and current practice of general practice based HCPs with regards to adolescent weight management
- To gain an in-depth understanding of HCPs' experiences of providing weight management advice for adolescent patients
- To explore how the experiences of adolescents and parents contribute towards an understanding of general practice based weight management
- To assess help seeking intentions and attitudes towards general practice for weight management among adolescents

Structure of dissertation

This introductory chapter has set out why an investigation of adolescent obesity management is needed to fully understand the potential of general practice in contributing towards tackling obesity in young people.

Chapter two provides an overview of background literature and key theoretical ideas that have guided the development of the study. Previous research of HCPs was found to have been undertaken primarily outside of the UK, most notably in Australia and the US, and to ask the experiences of HCPs regarding all children and young people without considering adolescents as a

distinct group. This omission goes against the recommendations from government and professional bodies outlined above which state the importance of understanding adolescents as distinct from younger children, with particular needs relating to their developmental position. The few studies that have asked specifically about adolescents have tended to be descriptive and fail to provide in depth understanding of the HCP experiences of weight management consultations with this age group. Since the research presented in this dissertation was first initiated, the interest in adolescent perspectives has increased, which is reflected in the research that looks at the experiences of young people themselves. These perspectives, as well as that by parents, are outlined in this chapter as well.

Chapter three provides a rationale for using mixed methods and provides an overview of the philosophical underpinnings of the framework used for the qualitative component; interpretative phenomenological analysis (IPA). The literature reviewed in chapter two revealed a dearth of evidence relating to the experiences of general practice based HCPs with regards to adolescent weight management in the UK. This chapter therefore starts by justifying the use of firstly a survey to gain a broad understanding of the attitudes and practices of general practice based HCPs in England today. Subsequently, it explains the need for in-depth qualitative interviews with a sub-sample of HCPs to understand the meaning of such experiences and to get a better understanding of the 'doctor-as-person' in weight related consultations with adolescents. Interviews with adolescents and parents were undertaken to illustrate how their experiences relate to that of HCPs, followed by a survey of young people's help seeking intentions regarding weight management, barriers to using GP services, and beliefs around weight as a medical issue.

Chapters four, five and six outline the findings from HCPs (ch 4), a qualitative study of adolescents and parents (ch 5), and a survey of help seeking intentions for weight and related issues among adolescents (ch 6) respectively.

Chapter seven brings together the findings from the preceding three chapters to discuss the implications for adolescent weight management in general practice. The findings are compared against what is known about such consultations in younger children and in adults and place the encounters between providers and adolescent patients in a developmental, life course perspective. The findings are further discussed in relation to theories of patient-provider communication, and how such communication can aid adolescent autonomy and personal responsibility for health within a larger framework of developmental contextualism.

Finally, **chapter 8** sets out the conclusions of the study overall, stating the contribution to knowledge, suggesting implications for policy and practice, limitations of the current study and suggestions for further investigation and research.

Chapter 2. Literature review

Introduction

As described in the introductory chapter, the increased focus on obesity as an issue for public health in the UK results from concern about its steep increase among both adults and children since the early 1990's. In this time, compared to other European countries, England has shown the steepest rise in, and now has the highest rates of, obesity in Europe (OECD 2010). The rise in childhood obesity has been of particular concern (Department of Health 2004a; Comptroller and Auditor General 2006).

According to the World Health Organization, "Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health." (World Health Organization 2014b). Obesity is most commonly assessed by calculating a person's Body Mass Index (BMI), which is achieved by dividing weight in kilograms by height in meters squared (kg/m^2); in adults, a person is said to be overweight if their BMI exceeds 25, and obese if it exceeds 30 (WHO 1995). For children who are still growing, BMI charts adjusted for age and gender have been produced (Cole et al. 1995). In England in 2012, 34% of boys and 37% of girls aged 11-15 year olds were overweight or obese (Ryley 2013). Obesity prevalence among 11-15 year olds increased at a steady rate from 1995-2004, but has decreased (among girls) or levelled out (among boys) since 2005 (Hagell et al. 2013). The trend for an increase is a globally observed phenomenon, which has led some to concede that we are now suffering from an obesity epidemic (WHO 2000; Caballero 2007). The rise in obesity in children in particular has generated much debate, with a suggestion that this constitutes a ticking time bomb for ill health in the future population (Department of Health 2002).

Consequences of overweight and obesity

In adults, the health consequences of obesity are well documented. Diabetes, heart disease and cancer have all been linked to excessive weight (Kopelman 2007). In young people, the health consequences have traditionally been less obvious, and the idea of fat being bad in children and young people is relatively recent; to the contrary it was long seen as a sign of good health (Stearns 2002). Historically (and in many parts of the world still) underfeeding and malnourishment have been of much greater concern (Patton et al. 2009; Blum & Nelson-Mmari 2004). As the status of children shifted due to decreased infant mortality and a reduced need for putting children into work early, it has been argued that happy, healthy children as a sign of parental competence and devotion became increasingly important (Stearns 2002). In late 19th to early 20th century, malnutrition in children living in modern western societies came to be seen as reflecting badly on the image of affluence and abundance of such societies. Overweight was therefore preferred as a sign of a well-fed (and by implication well cared for and loved) child. It has also been suggested that as the responsibility for child care over the early part of the 20th century came to rest more solely with just the parents (or more typically, primarily with the mother), the visibility of the responsibility of a child's well-being also became more apparent. Placating and keeping children happy by using food (and in particular sweet and snack-foods) became more common. Further, it has been suggested that as children learned that being fussy eaters or refusing certain foods would not result in starvation, their power in terms of 'choosing' their diet increased (Stearns 2002).

However, while the popular image of a happy healthy child tended to verge towards a heavier child, the medical establishment started to sound warnings over the risks of overfeeding. From the 1960s onwards, the medical literature increasingly referred to evidence of ill health consequences of obesity in childhood (Caballero 2007; Stearns 2002). Since then, the issue of obesity in young people can be said to have become increasingly medicalised.

The meaning of weight in adolescence

The interpretation of weight as a problem among young people can be said to fall into 3 broad categories: (1) because of the impact on emotional well-being; (2) tracking of weight from adolescence to adulthood; and (3) physical health outcomes experienced in the here and now.

Emotional well-being and quality of life

While the evidence of physical co-morbidities are not always obvious in overweight and obese young people, the immediate impact on emotional health through the stigma attached to overweight may be more immediate. There is often an assumption that being overweight in adolescence in particular can have a negative impact on emotional well-being because of the importance put on physical appearance during this age (Puhl & Latner 2007). Similarly, adolescence is a time when fitting in with social norms is more important than possibly at any other time (Ruble et al. 1980), and the current norms idealise bodies that are lean with very little visible body fat. It may therefore be assumed that young people who do not conform to these idealised norms, or who at least deviate from the peer group norm, may be at risk of being ostracised. Although not all overweight and obese young people will suffer poor emotional consequences because of their weight, being classed as overweight has been found to be associated with being both a victim, and also a perpetrator, of bullying among school-aged children (Janssen et al. 2004), and to lower reported quality of life (Tyler et al. 2007). Obese adolescents have also been found to score higher on a 'shame-index' measuring degrading or shaming treatment by others (Sjöberg et al. 2005). Further, Whetstone, Morrissey & Cummings (2007) found overweight adolescents to be significantly more likely than non-overweight young people to have thought about, planned or attempted suicide.

Tracking of overweight and obesity

Until relatively recently, there has been far more emphasis on overweight as a problem in childhood and adolescence because of its meaning for future, rather than immediate, weight and health of the individual. Research shows that obesity tends to track from childhood through adolescence (Angbratt et al. 2011) and into adulthood (Guo & Chumlea 1999; Freedman et al. 2005; Singh et al. 2008), and that being an obese adolescent therefore increases the risk of becoming an obese adult, which in turn increases the risk of health problems in adulthood. There is evidence that childhood BMI is associated with risk of coronary heart disease (CHD) and other comorbidities in adulthood (Baker et al. 2007; Reilly & Kelly 2011; Inge et al. 2013), and that high BMI in adolescence poses a greater risk to future health than high BMI in younger children (Baker et al. 2007).

Physical well-being

However, there is also increasing evidence that being obese or very overweight does impact on the health of the individual even at a younger age (Powell et al. 2005; Schwimmer et al. 2006; Weill 2004). Skinner et al. (2008) found overweight children to have a substantially higher prevalence of 3 specific weight-related chronic conditions (dyslipidemia, hypertension and dysglycemia) and poorer health status, while others have reported greater incidence of musculoskeletal pain, and particularly back pain, among obese compared to normal-weight young people (de Sá Pinto et al. 2006).

Diagnosis of type 2 diabetes, which is linked to weight, has also increased in line with increased prevalence of overweight and obesity among young people (Aylin et al. 2005).

Research shows that those young people who are most persistently overweight in adolescence are at most risk of overweight or obesity in young adulthood, suggesting that intervention at this age may have beneficial and long-term effects (Patton et al. 2011). It has been suggested that the

optimal policy in terms of impact on adult morbidity should focus intervention on older adolescents rather than children (Wein et al. 2012).

Adolescent development and autonomy

Based on the above, it appears that there is now a general consensus that obesity in children and young people is an issue that has implications for both current and future health. What is less clear is where to place responsibility and control for obesity when it comes to adolescents; they are in a special position in that they fall between the specific roles of children and adults. From the body of research that concerns transition from paediatric to adult care services, it is known that adolescents say that they do not feel that they 'fit' in either with adult or children's services (Burr 1993), although this research tends to focus on children with long term conditions that have been in the health care system throughout their lives, and is often concerned with secondary care (McDonagh 2005). Much less research has focused on the transition in healthy adolescents. Work on the rights and responsibilities of adolescents has often looked at implications for juvenile delinquency (Caffman & Steinberg 2000), or in the case of health care, has often taken the form of looking at issues where there may be tricky moral or legal implications for the adolescent being given decision making over their own health care, e.g. in relation to sexual health (Cook & Dickens 2000).

Risk and responsibility in adolescence

When dealing with adolescents, this issue of personal responsibility becomes complex not simply because of the question around who is responsible for health, but because the very nature of autonomy and personal control are integral to psychological development at this age and to what it means to be an adolescent, as opposed to a child or an adult (Zimmer-Gembeck & Collins 2003).

It is undisputed that for any individual, adolescents included, to lose weight, behaviour change is necessary. From a psychological development perspective, adolescence is a time for establishing personal identity (Kroger 2004), and a time when more responsibility is taken on in different contexts such as within the home, in school, and in wider society (Schulenberg et al. 1997). They have greater control over the foods they eat and whether or not to participate in physical activity. However many adolescents still live at home with their parents and may have little influence over, for example, what food is kept and cooked in the home. On the other hand, it is known that many adolescents (and girls in particular) reduce their participation in physical activity as they get older (Brooks et al. 2011; Currie et al. 2012), and many also have increased control over purchasing of foods outside of the home through less regulated leisure time and increased spending power from pocket money or paid work (Story et al. 2002; Alhabeeb 1996).

Research on the psychological development of adolescents shows that adolescents are as aware of risks associated with certain behaviours (e.g. anti-social behaviours) as adults are, and that they process information related to those behaviours in much the same way (Cauuffman & Steinberg 2000). However it has been suggested that the difference in risk-taking behaviours between adults and adolescents may lie in aspects of psychosocial development (Cauuffman & Steinberg 2000). Three aspects of psychosocial development were investigated by these authors: (1) responsibility (self-reliance, clarity of identity, independence); (2) perspective (considering situations from different viewpoints and placing them in broader social and temporal contexts); and (3) temperance (tendencies to limit impulsivity and to evaluate situations before acting). Values on these measures combined to form a measure of 'psychosocial maturity'. It was found that psychosocial maturity increased as a function of age, but was independently related to decision-making in that more 'psychosocially mature' individuals tended to make less risky decisions regardless of age. This indicates that as individuals go through adolescence, they develop in a way that leads them to take greater responsibility for themselves and their actions, and are more able to see the long-term consequences of their actions. In this way, they are different to younger children, but not yet as

competent as adults (although this will vary between individuals). This emergence of psychosocial maturity relates to taking responsibility for obesity in that adolescents have greater capacity for evaluating and understanding the consequences of behaviours that increase their risk for obesity, while not yet having the capability to take full responsibility as might be expected of adults. However, it has also been suggested that while for some individuals adolescence appears to be a time of development of greater risk taking, it can also be a time for developing health enhancing and protective behaviours (Thiede Call et al. 2002).

Obesity does not fit easily into any of the traditional adolescent health areas, which are much focused on risk behaviours. First, it is not a problem specific to young people, as obesity occurs across all age groups, and independent of socioeconomic sphere. Although it is increasingly being discussed in medical terms and seen as a public health problem, it is more the potential consequences of obesity than obesity per se that are of concern. Nor is obesity a behaviour. The most prominent causes of obesity – unhealthy diets and lack of physical activity – are sometimes grouped together with other adolescent health risk behaviours such as smoking, alcohol use and risky sexual behaviour, however again this is problematic. Unlike the other behaviours mentioned, eating and physical activity are not behaviours that are initiated during adolescence, and while there is evidence that young women in particular may reduce their participation in physical activity during adolescence as a sign of maturity (Brunton et al. 2003), lack of physical activity does not imply adult status or individuation in the same way as smoking and drinking alcohol.

A 'paradox of control' has been pointed out in relation to personal control in adolescence: at the exact point when individuals may start experiencing greater freedom and choice in the type of behaviours they engage in, they are also placed under expectations to make the 'right' and 'healthy' choices. Thus, the freedom and control they envisaged may not be perceived as such at all (Spruijt-Metz 1999). Further, as obesity is increasingly considered as a public health problem that places considerable pressure on health services and the economy, the choice to engage in behaviours

related to obesity (or failing to 'do something about it') may be seen as a failure of the individual to act responsibly towards the community in which they live (social justice) (Spruijt-Metz 1999). As adolescence is also a time when the development of morality and appreciation of social justice solidifies (Kroger 2004), the responsibility of the obese individual towards their own community may be another issue for obese adolescents during this time period.

Diet and physical activity in adolescence

The recent increases in levels of obesity in children and young people are most commonly blamed on the ready availability of junk and snack-foods (including soft drinks), and a shift away from traditional (often outdoors) active play towards activities such as videogames and computer use – the so-called obesogenic environment (Lake & Townshend 2006; Egger & Swinburn 1997; Chaput et al. 2011; Kirk et al. 2010). In this sense, children are alternatively presented as victims (e.g. of food advertising, inadequate school policies and of unsafe environments unsuitable for outdoor play), and alternatively as lazy and unconcerned about their future health. Adolescents usually have more opportunity to buy food outside the control of their parents than do younger children, partly because they tend to have more money to spend (either through pocket-money or through paid work) and partly because they spend more time unsupervised by parents or other adults. Research from the US shows that adolescents aged 12-16 spend around a fifth of their own weekly income on food, drinks and snacks (Alhabeeb 1996). Further, teenagers who had jobs spent more on food, possibly because of the need for them to spend extra time outside of the home (Alhabeeb 1996). Further, adolescents use the autonomy they do have to make decisions about what kinds of foods they will eat. Research shows that when the provision of school meals occurs in contexts that are not acceptable to the adolescent, they may opt to eat away from the school premises, purchasing foods in other local outlets, often including fast food outlets or places that are unlikely to provide 'healthy' choices (Wills et al. 2005). There also appears to be a change in dietary behaviour from childhood

and through adolescence that continues into adulthood. From childhood to adolescence, a decrease in consumption of fruits, vegetables, milk and fruit juice, and an increase in consumption of soft drinks, has been noted (Story et al. 2002). This decline appears to continue throughout the adolescent years; as a decrease in consumption of fruit and vegetables, and increased consumption of soft drinks has been found to occur between the ages of 14 and 21 (Lien et al. 2001). Further, increases in the frequent consumption of fast foods from adolescence to early adulthood has been reported among males (Larson et al. 2008).

Adolescence often marks a drop-off in participation in physical activity, with girls in particular moving away from active leisure activities (Brooks & Magnusson 2007; Brooks et al. 2011; Currie et al. 2012). The increasing aversion of young women towards physical activity has sometimes been blamed on a reluctance to display their bodies in revealing exercise clothing (Brooks & Magnusson 2006), and on a perception that sports are 'babyish' and do not fit with the grown-up image young women want to portray (Brunton et al. 2003). Thus developmental aspects of adolescence may clash with physical activity participation for young women. Increased focus on academic activity has also been blamed by adolescents for reducing levels of physical activity participation (Berry et al. 2005), and transitions to employment or higher forms of education may reduce time and energy for physical activity further (Coleman et al. 2008). Research shows that the increased choice in whether to participate in physical activity is one of the most significant stated reasons for choosing not to participate among young women (Coleman et al. 2008). However, it is also known that when compulsory physical activity programmes such as school PE lessons are adapted to provide more autonomy and control for adolescents, this benefits participation (Brooks & Magnusson 2006).

The socialising aspect of sports and physical activity participation is also important; adolescence is a time when peers and friendship groups are becoming increasingly important to the individual (Brown et al. 1997), and whether or not friends participate in activities has a major impact on the likelihood of the adolescent themselves participating (Coleman et al. 2008). For many physically

active adolescents, sports clubs and participation in activity is as much about socialising with friends as about the activity per se (Brooks & Magnusson 2007). At the same time, coming from a home where sport and physical activity participation is the norm makes continued participation more likely, both because of the emotional support for participation, and because parents that are themselves active encourage participation through paying for clubs or providing transport (Coleman et al. 2008). This is however a very fine balancing act as 'pushy' encouragement once the adolescent has established a disinterest in sport may disengage them further (Coleman et al. 2008).

The findings that the physical activity behaviours of family and, in particular, friends, are influential on adolescents' participation in sports and activities may also reflect the process of establishing identity during adolescence. Adolescents who do not see themselves as athletic may reject physical activity as a pastime at odds with the groups they identify with and the persons they aspire to be (Coleman et al. 2008). This may be particularly the case if 'sports' is associated with elitism and a level of performance most adolescents feel they cannot achieve (Brooks & Magnusson 2006).

Implications

As children enter adolescence, their behaviours in relation to both food and exercise are increasingly under their own control. Consequently, addressing weight with young people means giving them some form of responsibility over their own actions. At the same time, the idea of the obesogenic environment has come to mean that many see weight to be beyond the control of the individual. This means there is a balancing act to be achieved, between victim blaming on the one hand and removal of control (and consequent victimisation) on the other. A rigid focus on personal control can lead to victim blaming whereby individuals are held responsible for their own health (or lack of) and seen as having an obligation (moral, social) to do something about the problem, lest they are seen to be 'letting down' their families, their society and themselves (Adler & Stewart 2009; Puhl & Heuer 2010; Savani et al. 2011). Personal irresponsibility has even been described as possibly being seen as

'anti-social' (Spruijt-Metz 1999). However, if adolescents are socialised to believe that their obesity is a by-product of themselves being victims of a larger societal problem, the solution to which lies in legislation and policy change, they may be at risk of losing a sense of control over their own bodies. This may be especially true if they have attempted to lose weight but failed. A belief that personal outcomes lies in the hands of others may lead not only to a lack of trying to change behaviours, but also to a sense to helplessness that can foster poor emotional well-being (Wallston 1992; Wallston & Wallston 1982; Walker 2001; Lau 1982).

Policy and the medicalization of obesity

Although they suffer less physical health problems as a consequence of weight than do adults, overweight and obesity in young people tend to be problematized primarily in terms of the risk of poorer physical health, particularly from a policy perspective. This has led to overweight and obesity having become increasingly medicalised. Parallels have been drawn between obesity and smoking, in that obesity is now going the same political way as tobacco use by persuading policy makers that some familiar, private activity poses a public problem and requires government action. As with smoking, this problem is posed to be in relation to the health and, consequently, economic burden that obesity will place on a nation (Kersh & Morone 2005).

It has been suggested that medicalisation occurs on three levels: the conceptual, the institutional, and the interactional (Conrad 1992). Evidence for medicalisation of childhood obesity on a conceptual level can be seen in the use of terms such as 'epidemic' for describing the extent of the condition (Foresight 2007), and it popularly being referred to as a 'health time bomb' (Department of Health 2002). Also, the clinical guidelines developed by the National Institute for Health and Clinical Excellence (NICE; 2006) refer to people 'with obesity' (as opposed to people who 'are obese'); language that implies identification of obesity as a medical 'condition'. Medicalisation at an institutional level is suggested by the publication of policy and other government documents that

propose a role for the health services in treating the problem. A number of policy and guidance documents over the last ten years (Comptroller and Auditor General 2001; Department of Health 2004a; Department of Health 2008; NICE 2006; Department of Health 2010) have stressed the importance of reducing obesity in the population, proposing strategies to help manage and prevent the condition. Most of these documents stress the importance of a collaborative approach that relies on intervention and support at different levels. In the UK, the National Service Framework for Children and Young People (Department of Health 2004b), the Choosing Health White Paper (Department of Health 2004a), and the NICE guidance (2006) all state that primary care in particular has a responsibility for helping young people and their families to lead healthy lives that minimise the risk of obesity and other health threats. The NICE guidelines recommend treatment with anti-obesity medication and bariatric surgery for those young people who are most severely obese (NICE 2006). When it comes to children and young people, there is an emphasis on the importance of doctors and nurses helping children and their families to “live healthy lifestyles”(Department of Health 2004b; NICE 2006), although the specific details of what exactly health care professionals can do to enforce this role is unclear.

Evidence for medicalisation on an interactional level is however less obvious. At this level, it is suggested that medicalisation occurs through the doctor-patient interaction, where the doctor would give a medical diagnosis and offer a medical form of treatment (Conrad 1992). For adults at least, there is evidence that some GPs regard obesity to be a disease (Bocquiere et al. 2005), but while some doctors will offer advice and treatment for obese children and young people, it is uncertain whether they would consider offering obesity as a ‘diagnosis’ in the traditional sense of the word. Further, it is an area often not well covered in traditional medical training (Baur 2006). And while both drugs and surgery are sometimes (though rarely for children) offered as treatments, a more common approach would be life-style advice (Webb & Viner 2006; Shield et al. 2008; Flodmark et al. 2004). This is where the issue of responsibility and control becomes relevant. The medical (in a traditional sense of the word) treatments for obesity, medication and surgery, put

control for treatment very much in the hands of the health professional. Life-style changes on the other hand can feasibly vary in the amount of control divided between patients and health care providers. In relation to adults, it has been found that GPs generally believe obesity to be a problem which has both been caused by and should be managed by the individual themselves (Epstein & Ogden 2005). They felt that obesity was the patient's responsibility, but at the same time also stated that patients on the other hand felt that the responsibility rested with the doctor. This suggests that, according to the perception of GPs at least, adult patients opt for a medical model of obesity that may be at odds with placing of responsibility from the point of view of GPs. In the US, Story et al. (2002) found that a majority of health care providers felt that childhood and adolescent overweight was a chronic condition that needs treatment and affects chronic disease risk and quality of life. This indicates a view of childhood obesity as a medical problem. Little evidence of health professional views in relation to obesity in children and young people is currently available from the UK, but one study suggested that GPs saw it as their role to flag up the problem of obesity to parents, but that they consider the management of the obesity from there on the responsibility of the parents (Walker et al. 2007). However, the research that has been done so far has tended to group adolescents with younger children (Walker et al. 2007; Story et al. 2002), which may not be helpful as it is likely that the level of attribution of personal vs. parental control and responsibility will differ between these two groups.

Obesity in the health services

The extent to which obesity is addressed in the doctor-patient encounter is dependent on a larger framework of health promotion and the role of the health services.

Over the last few decades, health promotion and illness prevention (rather than just treatment and cure) have been increasingly recognised as essential parts of the National Health Service (NHS) and this is reflected in the focus of public health policy (Department of Health 2004a; Department of

Health 2010). While in the US obesity is now classified as an 'illness' for medical insurance purposes, in the UK, obesity treatment still falls largely under the remit of health promotion in that advocating weight loss is assumed to help individuals stay healthy and less likely to suffer illness such as heart disease and certain types of cancer. This increased focus on a health service concerned as much with health promotion as with treatment and cure has coincided with a shift in focus away from hospital based services towards a primary care-led health service (de Leeuw et al. 2006). However, it has been suggested that the policy-driven enthusiasm for health promotion and a model of care that is based in a biopsychosocial approach has not been shared by the health care professionals that provide the services (Wall & Owen 1999). However, it may be less that HCPs are hostile towards engaging in health promotion than that they lack belief in its effectiveness. For example, a cross-European study found that even when GPs agree that health promotion efforts should be part of their duties, this belief did not necessarily translate into practice (Brotons et al. 2005). Other research suggests that GPs may approve of providing health promotion services, but have little faith that their patients will do their part by changing actual behaviour (Jacobsen et al. 2005; McAvoy et al. 1999).

It has been argued that most GPs are by training and culture based in a traditional biomedical approach to care (Wall & Owen 1999). In relation to obesity this is perhaps supported by the fact that, despite it being a major concern for health care policy for quite some time, the only points available under the current UK GP contract are for screening for obesity in adults, with no points at all available for addressing obesity in patients under the age of 16 (The National Obesity Observatory 2010; Booth et al. 2013). Health care that is policy driven rather than driven by the views and opinions of HCPs run the risk of prioritising certain groups or conditions that may not necessarily resonate with HCPs as being most deserving or most in need of treatment. This may be especially the case where policy dictates treatment (such as prevention/ treatment of child & adolescent obesity) that is not recognised under the GP contract. Consequently there is a need to explore how encounters within this context are experienced by HCPs.

Help seeking

The decisions that lead an individual to seek advice from their HCP regarding a health issue can be explained through models of help-seeking. The action of seeking help is an intentional response to a perceived problem, and can be thought of as problem solving (Cornally & McCarthy 2011), and has been described as a form of coping mechanism (Gourash 1978). With regards to adolescents, it has been suggested that the ability to seek appropriate help when needed is a key predictor of positive adjustment during the adolescent years (Schonert-Reichl & Muller 1995).

According to Cornally & McCarthy (2011), there are three essential precedents to help seeking initiation: recognition and definition of the problem; decision to act; and selecting a source of help. Recognition and definition of the problem is achieved based on perceived symptoms, as well as the meaning those symptoms hold to the individual (e.g. perceptions of severity and threat). Making the decision to act meanwhile is influenced by factors such as self-efficacy (Garland & Zigler 1994), help-seeking experience (Vogel et al. 2005; Demyan & Anderson 2012), gender norms (Garland & Zigler 1994) and experience with self-management (Cornally & McCarthy 2011), and has been framed in terms of cost-benefit analysis (Liang et al. 2005). Benefits of help seeking would be finding a solution to the problem or health concern, while the costs may include feelings of vulnerability and stigma (Liang et al. 2005), and potential backfiring (Murray 2005). Greater perceived benefit compared to perceived cost has been found to be associated with help-seeking also in children (Newman 1990). The step of selecting a source of help will depend on individuals' beliefs about available sources and services, as well as prior experience (Murray 2005; Vogel et al. 2005; Gulliver et al. 2010; Cornally et al. 2011). It has been suggested that positive past experiences may make future help seeking more likely by increasing health literacy (Gulliver et al. 2010).

Both individual and external factors impact decisions to seek help. Research has shown that help-seeking may be initiated when distress relating to the problem is high (high perceived severity and consequences of the issue) (Cramer 1999; Raviv et al. 2000) and attitudes towards services are

positive (Cramer 1999; Gulliver et al. 2010). Others however have found that high distress levels are predictive of lower actual help-seeking in individuals that had received prior treatment (Demyan & Andersson 2012), indicating that different barriers impact on each other as well as on actual help-seeking. Meanwhile, distress is likely to be high when social support is low, and among individuals who are reluctant to discuss their problems with others (Cramer 1999). Fear of self-disclosure is also associated with lower levels of help-seeking (Vogel et al. 2005).

It has been found that interventions that address factors associated with beliefs, attitudes and intentions regarding help-seeking can result in more positive attitudes towards help-seeking post-intervention, although intentions to seek help may be mediated by prior experience with help-seeking (Demyan & Andersson, 2012). This demonstrates the salience of prior experiences in people's decisions as to whether to seek help or not (Vogel et al., 2005; Demyan & Andersson, 2012). Further, research shows that having utilised one type of help source increases the likelihood of using others in the future (Schonert-Reichl & Muller 1996).

With regards to individual factors, women are generally found to be more likely to seek help, and have positive attitudes towards help seeking, than men (Garland & Zigler 1994), a pattern that is also found among adolescents (Schonert-Reichl & Muller 1996; Raviv et al. 2000). This has been explained in terms of social acceptance and expectations of gender norms, which suggest that men should be able to manage their own problems and may see help seeking as a weakness (Garland & Zigler 1994). Locus of control (the extent to which individuals believe they can control events affecting them, (Rotter 1966)) has been found to be associated with help seeking in that individuals that have a chance locus of control (i.e. a perception that neither self nor others can control the outcome of events) are less likely to seek help (Tijhuis et al. 1990). Locus of control may also impact the source of help that is accessed: it has been found that adolescents with an internal locus of control prefer seeking help from adults whereas those with external locus of control seek help from friends (Schonert-Reichl & Muller 1996). Locus of control may also be linked to how individuals view

themselves more generally, in that those with higher internal locus of control feel more sure of themselves relative to those with high external locus of control. Individuals with low self-worth have been found more likely to seek professional help than those with high self-worth, possibly indicating that help-seeking might be considered a threat to self-worth (Schonert-Reichl & Muller 1996). However, others have found that students that are unsure of themselves experience a greater threat when asking for help and consequently were less likely to seek help (Ryan & Pintrich 1997).

Adolescents have generally been found to prefer informal over formal sources of help (Grinstein-Weiss et al. 2005; Murray 2005; Cakar & Savi 2014). It has been suggested that informal sources are preferred because they are perceived as more socially acceptable, and may be perceived as less threatening than formal sources such as health professionals (Raviv et al. 2000). Further, adolescents who are more satisfied with school have been found to be more likely to seek formal help, suggesting that school may play an important role in the development of young people's attitudes to formal sources of help (Grinstein-Weiss et al. 2005).

In a systematic review of barriers and facilitators to mental health help-seeking among adolescents, Gulliver et al. (2010) found stigmatising attitudes, lack of confidentiality and trust, characters of service providers, and knowledge of services to be barriers to help seeking. Facilitators included positive past experiences, along with social support for help-seeking, positive relationships with service staff, and perceived problem seriousness. Another important factor influencing young people's decisions to seek help is problem legitimacy, as help-seeking may be less likely for problems that young people either do not consider legitimate, or which they perceive potential help sources as not believing to be legitimate (Murray 2005). Thus, an understanding of how young people view a particular problem, and how they believe others view it in terms of legitimacy is important for understanding their intentions to seek help for that problem.

The health care consultation

The preceding section outlined some of the processes that influence individuals' decisions to seek, or not seek, help for a particular concern. It also characterised help seeking as a problem solving mechanism, where help is sought when one's own personal resources are deemed inadequate for solving the problem. This means seeking out someone that is perceived to have greater knowledge, experience or power than oneself, and therefore is in a better position to solve the presenting problem. When health care is sought for medical problems, those individuals are the HCPs working in practice.

The traditional biomedical model of care viewed HCPs as objective experts, whose response and decision making during clinical consultations is shaped by their training and experience. Outcomes in this model are seen to be primarily influenced by the accuracy of diagnosis, and the extent to which patients follow the recommended course of action prescribed by the HCP (adherence). According to this position, HCPs should vary in the way they treat patients only to the extent of the content of the training they have received, and their relative clinical experience. In reality however, what happens within a consultation with regards to diagnosis, treatment decisions and outcomes is a complex interplay between HCP personal characteristics (which include but are not confined to knowledge and experience), conditions of the consultation (e.g. time constraints), and characteristics of the patient. The modern consultation has thus moved away from the top-down, doctor-led experience towards one that focuses on this interplay and is said to be more patient-centred.

Patient centred care

In the area of doctor-patient encounters, patient-centred medicine (Balint 1969) has emerged as a key concept in effective consultations (Thistlethwaite & Morris 2006). This is seen to contrast with the traditional biomedical model of health care, or 'illness centred medicine' (Balint 1969) and relies

on an interaction that is focused on the needs of the patient, which in turn requires an understanding of what those needs actually are. Despite the importance that has been placed on care that is patient-centred, it has been argued that patient centredness is an unclear concept where a general definition is assumed rather than explicit (Bensing & Verhaak 2004). Mead & Bower (2000) conducted a review of the meaning of 'patient-centredness' and identified five key dimensions which differentiate patient centred medicine from the biomedical model of care: (1) the biopsychosocial perspective, (2) the 'patient-as-person', (3) sharing power and responsibility, (4) the therapeutic alliance, and (5) the 'doctor-as-person'. They argued that the dimensions differ regarding which can be applied to consultations in general (e.g. dimensions 1 and 4) and which will be particular to individual consultations (e.g. 2 and 5). The third dimension (sharing power and responsibility) may be particularly interesting to adolescent health care in that it has to take into account not just the extent to which this is shared between the HCP and the patient, but also with parents.

Emphasis on patient centred care has often been born out of the assumption that consultations that are patient centred will lead to improved outcomes. Support for this comes from studies that show patient centred consultations to result in decreased health care costs (Bertakis & Azari 2011), although some sound caution due in part to inconsistent findings (Mead & Bower 2002). However, it has also been argued that patient centred care is morally just, as an end in itself (Duggan et al. 2006), and many of the aspects related to patient centredness such as building trust and sharing responsibility and control are issues highly pertinent to adolescent development (Resnick et al. 1993; Mcneely et al. 2002; Maggs et al. 1997).

GPs and patients have been found to largely agree on the importance of several aspects of patient centred care (Ogden et al. 2002), although patients have also been found to perceive higher levels of patient centredness than that measured through observation (Clayton et al. 2011). Mead & Bower (2000) acknowledged the influence of consultation-level factors, such as demographic and

psychological characteristics of the HCP and the patient, on the extent of patient-centredness achieved by HCPs. The literature shows that psychological factors such as personal beliefs do have an impact on how HCPs relate to their patients and the type of care they provide (Marteau & Johnston 1990). Research in the area of primary care provision of health promotion shows that perceived behavioural control and self-efficacy relating to offering health promotion advice influences intentions (Puffer & Rashidian 2004) and actual provision of advice (Laws et al. 2008). Self-efficacy and confidence may also be mediated by other factors, such as identification with professional role: Laws et al. (2008) showed that HCPs who were high implementers of health promotion activity tended to go ahead and offer advice in a particular area even if they had doubts about the efficacy of doing so, because they felt it was part of their responsibility (professional role) to do so. There is evidence that HCPs' expectations regarding consultation outcomes may become transmitted to the patient and affect their own outcome expectancies (Bensing & Verhaak 2004), and since evidence suggests that HCPs have little faith in the efficacy of weight management interventions (Hoppe & Ogden 1997) this may affect patients' own beliefs regarding treatment efficacy. Patient expectancies in turn have been found to be important predictors of medical outcomes (Crow et al. 1999).

The interaction between practitioners and patients within the consultation affects the extent to which patient-centredness is achieved; there is evidence to suggest that HCPs are more patient-centred in consultations with patients that are assertive and involved during the interaction (Cegala & Post 2009). Further, others have found perceptions of patient centredness to be related to role-negotiation between patient and practitioner (Clayton et al. 2011).

While the debate over what actually constitutes patient centred care continues, several models and versions of the concept have been proposed. However, certain core elements are consistent across various models and definitions and include communication, partnerships, and a biopsychosocial perspective (Bauman et al. 2003).

Clinical decision making

Just like the process of help seeking, clinical decision making has been discussed in terms of problem solving. The most frequently cited model regarding how HCPs make decisions in practice is the hypothetico-deductive (or information processing) model (Elstein et al. 1978; Tanner et al. 1987).

According to this model, there are four aspects to decision making in practice: (1) cue acquisition, (2) hypothesis generation, (3) cue interpretation, and (4) hypotheses evaluation (Tanner et al. 1987).

Cue acquisition is based on the initial symptoms and explanations brought by the patient, which then leads the practitioner to develop an initial hypothesis of what the problem might be. This hypothesis is then tested by further interrogation of the patient (and physical examination) to establish evidence to either support or refute the hypothesis. Hypothesis evaluation follows as a result of this further interrogation and testing, until the practitioner is satisfied that the retained hypothesis is sound and plausible in light of the evidence gathered (Thompson 1999; Pearson 2013).

This model presents decision making as a process which is in line with the recommendations of evidence-based practice; that clinical decisions should be based on robust scientific evidence (Department of Health 2000). As long as the HCP is up to date with the latest evidence, this can be incorporated within the model and would be hypothesised to result in sound and accurate decisions being made. However, as well as expertise and evidence, there are a number of factors that influence HCPs during the stages of hypothesis generation, cue interpretation and hypothesis evaluation. Personal experience will influence this process in that practitioners are likely to form hypotheses that are in line with their prior encounters with a particular problem (Charlin et al. 2000). HCPs may be more likely to generate a hypothesis that supports the diagnosis of a condition that is seen as common (whether through experience or as accepted fact) than one that is more rare, due to saliency of such conditions and perceived probability of its occurrence (Elstein & Schwarz 2002). Although probability of occurrence would be a valid factor to be included in hypothesis testing if all other evidence is equal, when affecting the line of interrogation and

interpretation at the exclusion of consideration of contradictory evidence it risks leading to misdiagnosis. Further, HCPs are known to ask more questions that would support their initial hypothesis than ones that would refute it, and to search for information that confirms their existing practice (Thompson et al. 2004), leading to bias. Length of experience in clinical practice may influence these processes in both directions; HCPs may be more effective in evaluating supporting evidence when they draw on lengthy experience in practice, however they may also be less likely to consider evidence that goes against what they would expect based on past practice, and may use strict hypothesis testing only for cases that are novel or difficult (Elstein & Schwarz 2002). Further, it has been argued that what many HCPs consider 'knowledge' is, in fact, beliefs (Bradley 1995). Decisions that are made based on beliefs cannot be said to be evidence based, and so go against best practice.

Decision making is also influenced by the personal characteristics and behaviours of the HCP. Some behaviours engaged in by the practitioner themselves, such as having cholesterol and blood pressure monitored regularly or undertaking physical activity, have been found to correlate with an increased likelihood of such courses of action being prescribed or recommended to patients (Brotons et al. 2005). On the other hand, certain practitioner characteristics may lead to a reduced treatment implementations in practice. HCPs who smoke have for example been found to be less likely to engage in smoking cessation discussions with their patients (Brotons et al. 2005; Tong et al. 2010). Prejudice, stigma and stereotyping further influences decision making. There is evidence that HCPs hold prejudiced views similar to those of the general public of people in respect of conditions that are known to be stigmatised, like obesity or mental health problems (Caldwell & Jorm 2008; Harvey & Hill 2001; Nordt et al. 2006; Teachman & Brownell 2001; Schwarz et al. 2003). More negative views of obesity are known to be associated with reduced likelihood of initiation of weight management interventions with overweight and obese patients (Engström et al. 2013), and HCPs may also avoid discussing weight with overweight and obese patients out of fear of embarrassing or offending them (Keyworth et al. 2013). Further, obese individuals themselves report avoiding

situations where they might encounter stigma and embarrassment (Lewis et al. 2011) meaning that they may avoid seeking help from HCPs in the first place (Budd et al. 2011). HCPs may also avoid discussing topics with patients which they fear could be psychologically distressing or damaging (Maguire et al. 1996; Parle et al. 1997), which may result in important information not being disclosed (Maguire et al. 1996).

Attitudes towards weight management consultations

Given the importance of attitudes and beliefs with regards to all aspects of the consultation, from help seeking to treatment outcomes, it is essential to understand the beliefs and experiences of all the parties involved in weight management consultations for young people . The following section reviews what is currently known about attitudes towards weight management in health care settings from the perspectives of providers, adolescents, and parents.

The views of health care professionals

A number of studies have investigated the views of health care professionals regarding obesity management. The studies vary in the types of professionals questioned, and what patient populations they address. Those summarised here all relate to primary care practitioners in a number of countries, and include GPs and nurses working in general practice, community and school settings. Some do not specify the age range of the patient population and tend to focus on the management of obesity in adults, while others ask for professional views on management in children and young people. While one study (Turner et al. 2009) focused only on younger children, most tend to group children and adolescents together and none targets views relating specifically to adolescents.

Studies in this area have generally found HCPs to consider primary care an appropriate setting for weight management in children and young people and that they themselves have an important role to play in addressing the problem (King et al. 2007; Turner et al. 2009; McFarlane et al. 2009).

However, while some have found a general tendency to disagree that the best role for primary care practitioners is to refer obese children and young people to other services (Buffart et al. 2008), others found that although GPs saw themselves as having a role in managing child and adolescent obesity, most would refer the young person to a dietitian or paediatrician (Mcfarlane et al. 2009). Many GPs may not consider obesity to be a medical problem and therefore not see it as falling within their professional domain (Epstein & Ogden 2005).

Australian GPs have been found to see themselves as less professionally prepared to deal with overweight and obesity in children and adolescents than in adults, but those who feel more confident in their ability to manage obesity are also more likely to address this with their patients (Buffart et al. 2008). In contrast, GPs may feel more confident in their abilities to deal with the health consequences of overweight and obesity (King et al. 2007), and more comfortable bringing up the issue of weight if they can relate it to a presenting health problem (King et al. 2007) or if the obesity is severe (Mcfarlane et al. 2009).

While the research to date gives insight into how HCPs view the provision of help for children and young people who are obese, it does not differentiate between children and adolescents and thus it is unclear whether HCPs perceive there to be different issues relating to obesity care in different age groups. HCPs have expressed lack of confidence as a barrier to working with adolescents in general and may not see themselves as having adequate communication skills for interacting with young people effectively (Jacobson et al. 2001; Kang et al. 2003). There has also been a reported tension around how best to involve parents in adolescent health care without compromising the young person's emerging autonomy (Jacobson et al. 2001; Kang et al. 2003). Neither of these factors has currently been investigated in depth in relation to obesity management.

The views of young people

Research shows that although adolescents believe professionals would have the most accurate knowledge and information about health, most would choose to discuss health problems in general with parents or friends rather than seeking professional help (Booth et al. 2004). Similar findings are reported relating to discussing obesity (Cohen et al. 2005), although Owen et al. (2009) found that adolescents attending an obesity clinic programme for weight loss said they rather discussed weight with a professional than with parents. This may indicate that acceptance for HCP interaction increases as the adolescent gets used to a particular setting or programme and establishes a relationship with the HCP providing care.

Overweight adolescents have been found more likely than non-overweight adolescents to say that they wished their HCP had brought up weight-related issues with them at last appointment, but many overweight young people report not wanting their HCP to discuss weight with them (Cohen et al. 2005). Research has also found that when young adults reflected on their adolescent overweight/obesity, most did not recall having seen it as a problem, and certainly not as a health problem, at the time (Smith et al. 2013). However, there is also evidence to show that heavier adolescents are more likely to worry about their weight (Sweeting et al. 2008). HCPs tend to report that they would bring up weight problems even if not specifically mentioned by adolescents, but at the moment, it is not well understood whether a discussion of weight might be acceptable to adolescents under certain circumstances and if so, what those circumstances might be. It is likely that the relationship between the HCP and the adolescent patient is particularly important in this respect as young people rate HCP characteristics higher than content of a consultation when it comes to patient satisfaction (Freed et al. 1998). Further, Cohen et al. (2005) found adolescent BMI scores to be negatively correlated with satisfaction of the affective component of the patient-provider relationship, indicating that the heavier adolescents got, the less likely they were to perceive the relationship as characterised by trust, confidence and positive regard for the patient. They also found that length of time having seen

a particular provider was associated with consultation satisfaction, indicating the importance of established relationships between HCPs and adolescent patients (Cohen et al. 2005).

While young people recognise that social and emotional factors have an impact on health, they tend to define 'health' itself in rather medical terms with an emphasis on physical wellness (Booth et al. 2004). Similarly, they have identified health professionals as appropriate for consultation only regarding physical health, although they also express uncertainty over the types of services that health care providers can offer and may see uncertainty over when and for what it would be appropriate to consult as a barrier to accessing services and many would rely on their parents to decide when it would be appropriate to seek help from health care services (Booth et al. 2004). However, while they may still depend on their parents in this respect, the importance of the HCP showing respect and treating adolescent patients "as an adult" or talking to them in a manner that is appropriate to their age has been rated as crucial to a positive HCP-patient relationship by adolescents themselves (Ginsburg et al. 1997). Owen et al. (2009) found that some parents attribute the successful weight loss of their adolescent children to the communicative style of clinicians.

The views of parents

While research shows that for children aged under 12 years, targeting parents (mainly or exclusively) as the agents for change to achieve weight loss in their children gives the best outcomes, the role of parents in adolescent obesity treatment is much less clear (Spear et al. 2007). Parents acknowledge the importance of taking age in to account when deciding who (parent or adolescent) to direct information and assessment outcomes to, although most parents may want to be involved to some extent (Shrewsbury et al. 2010).

Edmunds (2005) interviewed parents of children aged 4-15 years, and found both positive and negative views of HCPs expressed by the parents. Some had experienced being made to feel to

blame for the weight of their children, as the adult responsible for diet and feeding within the family. There was a view that HCPs tended to see parents as overly worried and causing a fuss over the weight of their children, and some expressed a sense of helplessness after being left unsupported by the health services they had approached.

Research with the parents of younger children (aged 5-11) has found a view of GPs as gatekeepers for referral to other weight management services, and that parents were looking for someone outside of the family to affect a change in their overweight children (Stewart et al. 2008). They further found parents saw positive psychological outcomes of obesity treatment programmes, such as increased self-esteem, to be more important than any actual weight loss. They argued that as clinicians view weight loss primarily in terms of the positive impact on physical health, there may be a need for HCPs to understand this aspect of definition of 'successful treatment' on the part of parents (Stewart et al. 2008). Overwhelmingly, parents state that they would attempt weight loss for their children within the family before seeking professional help (Shrewsbury et al. 2010; Edmunds 2005).

Shrewsbury et al. (2010) talked specifically to adolescents and their parents, although their participants were not selected by weight. They found parents to recommend an approach to adolescent weight management that involved discussion and empowerment rather than 'telling them what to do', and highlighted the importance of HCPs being sensitive when discussing weight with adolescents. They were generally in favour of routine weighing of adolescents by HCPs, but showed some concern about the risk of instigating eating disorders if HCPs brought up weight as an issue. These are factors that need to be explored in greater depth with the parents of adolescents who are obese and who have had the experience of trying to manage their children's weight.

Chapter summary

This chapter has outlined how adolescent obesity, as a part of obesity in the population at large, has increasingly come to be seen as a major public health problem over the last two decades. It has demonstrated that while not as prevalent as among adults, overweight and obesity in young people has recognised consequences for health which are both psychosocial and physical, as well as being a critical time for tracking of weight into adulthood. This increasing burden of obesity has resulted in an increasing focus from government in the form of health policies, which has paralleled a general shift in the health services away from a traditionally biomedical focus towards one that is incorporating a biopsychosocial perspective and greater emphasis on health promotion. In light of this, obesity in general has been described as becoming increasingly medicalised.

The evidence base around help seeking behaviour and decision making in clinical encounters shows that aspects throughout the whole process of initiating weight management, from identification of a problem that needs action, to achieving successful outcomes, are influenced by the beliefs, behaviours and prior experiences of both patients and providers. This demonstrates that to understand the role that primary care can play in helping young people manage their weight means to understanding those perspectives and experiences. At the same time as policy is placing increasing pressure on the health services for the management of weight in the population, health care providers display ambivalence and uncertainty regarding their role in helping patients manage their weight, and their views on obesity as a medical problem are unclear. Most do, however, see themselves as playing some part in helping overweight and obese patients, and claim that they will intervene when such cases present. In line with patient centred care as a key framework for effective consultations, it is essential that individual patient characteristics are taken into account in the patient-provider encounter. In this sense, it needs to be recognised that adolescents are a distinct group from either adults and younger children and that interactions with adolescent patients will differ from those with other groups. The literature presented here shows how adolescents have

distinct needs both in relation to health care in general, and obesity management in particular. At the same time, their dependence, to varying extents, on parents is recognised and the implications for working with families have also been addressed. Adolescents' development is dependent on the context in which they live, and their development in respect of managing their own health in relation to weight will be affected by how their health care encounters are managed.

Although previous research, as discussed above, has investigated views of HCPs, adolescents and parents regarding health care and weight management, there is still limited evidence relating specifically to adolescents (as opposed to children and adolescents being grouped together). This is particularly true for research focusing on HCPs and based in general, as opposed to specialist, services. This dissertation will contribute towards a greater understanding of the issues in this area.

Chapter 3. Rationale for mixed methods

Introduction

The literature review revealed that there is currently a limited amount of research evidence regarding adolescent weight management in general practice in the UK. In particular, there are few studies investigating the experiences of health care professionals (HCPs) in depth, and no studies looking at such provision from the perspective of all relevant individuals (HCPs, young people and parents). There is a need for an understanding of what is currently going on in general practice with regards to adolescent weight management, and what the beliefs and attitudes are of GPs and practice nurses regarding the issue. This information needs to be set against the experiences of adolescents themselves, to triangulate the experiences of all involved parties in order to fully understand the barriers and facilitators for adolescent weight management in the general practice setting. Because of the different kinds of information needed – an overview of current practice together with in-depth personal experiences – different methods were deemed appropriate for different aspects of the study. The attitudes of both HCPs and young people towards general practice as a setting for weight management would be best assessed using surveys that could capture the views of a large number of people. In contrast, to fully understand what those experiences were like, in-depth interviews with a subsample of both HCPs and young people were conducted.

In order to ascertain what was currently happening in general practice regarding adolescent weight management, and to set this against the current policy context, the first stage of the research employed a survey of HCPs in order to explore attitudes, awareness, and current practice. However, such a survey can only ever provide a surface view of what is currently happening; it does not

necessarily explain why or how. Plenty of research has investigated the doctor-patient experience from the perspective of the patient, and this is a valid focus in light of the shift towards patient-centred, as opposed to provider-centred, medicine. However, this may leave an assumption that the provider experience is universal rather than individual, and precludes understandings of the personal factors the HCP brings to the patient-provider encounter. Mead and Bower (2000) include 'doctor-as-person' as one of the five dimensions of patient-centred care, and thus, according to this view of the patient-provider encounter, the personal experiences of HCPs matter. In order to get a deeper understanding of this, it was decided to interview general practice based HCPs on their experiences. Further interviews were undertaken with adolescents and parents to get a full account of the weight management experience of all involved parties. Hence, the study utilised mixed methods.

Mixed methods research

Mixed methods as a methodology has gained increasing attention over the last couple of decades. The 'mixing' refers to the utilisation of both quantitative and qualitative methods within the same study, and varies with regards to the relative importance of one method over another within a specific study, as well as the level of integration of data obtained through each method (Creswell 2009). According to Johnson et al. (2007);

"Mixed methods research is, generally speaking, an approach to knowledge (theory and practice) that attempts to consider multiple viewpoints, perspectives, positions, and stand-points (always including the standpoints of qualitative and quantitative research)" (Johnson et al. 2007) (pp 113).

Mixed methods may be particularly relevant to research in health care and health promotion, where requirements are rapidly changing in response to new evidence and policy (Andrew & Halcomb 2009).

Origins of mixed methods

The employment of mixed methods as a research method distinct from the traditional 'pure' approaches of quantitative or qualitative approaches, has gained popularity and standing over the last couple of decades (Creswell 2009). It has developed alongside the debate regarding the relative merits of the quantitative positivist paradigm versus the qualitative constructivist paradigm, and has been described as the response to the call for a synthesis between the different paradigms (Johnson et al. 2007; Muncey 2009). Rather than criticising either of the other methods as flawed (which has tended to be the main focus in the debate between the traditional paradigms; the so-called "paradigm wars"), mixed methods research has been suggested to be based in a pragmatic view of the world which posits that researchers should be led by their research questions, rather than strict adherence to a particular paradigm, when selecting their methods (Muncey 2009). This focus on pragmatism as a natural paradigm for mixed methods is supported by others (Johnson et al. 2007; Sale et al. 2002).

Nonetheless, the mixed methods approach has been criticised as a valid method precisely because it aims to integrate methods associated with two traditionally opposing paradigms. Sale et al. (2002) for example sees the theories of truth and what can be known associated with the 'pure' methods as so fundamentally in opposition that, in their view, combining them undermines the credibility of the research. This view however precludes the idea of pragmatism as incompatible with either of the other paradigms, rather than complementing them – not a view most pragmatists would take. It has been suggested that rather than being dichotomous, the quantitative and qualitative paradigms are dimensionally different (Crossley 2000).

Further, mixed methods is not simply the collection of both quantitative and qualitative data within the same research study – in order for methods to be truly mixed, the quantitative and qualitative perspectives should address the same research question (Yin 2006), and data needs to be integrated at some stage in the research process (Creswell et al. 2004).

Strategies in mixed methods research

Just like the traditional methods, mixed methods encompass a wide variety of different strategies. Different aspects that affect the design of a mixed methods study include timing of data collection (whether data are collected concurrently or sequentially, and if the latter, whether the qualitative or quantitative component is completed first); the weight or priority given to each of the methods (i.e., is the quantitative or the qualitative component the main focus, or do they occupy equal importance within the study); when (at what stage) and how the data is mixed (e.g. at one end, the two data sets may be completely merged (e.g. by quantifying qualitative data into counts) while at the other, the two data sets are kept completely separate and only mixed at the stage of overall interpretation); and the presence of theorizing or transforming perspectives (whether a larger theoretical perspective guides the entire design) (Creswell 2009). Collins et al. (2007) proposed four rationales for conducting mixed research: (1) participant enrichment (engaging different populations through different methods), (2) instrument fidelity, (3) treatment integrity (i.e. assessing fidelity of interventions), and (4) significance enhancement (facilitating thickness and richness of data, augmenting interpretation and usefulness of findings). Meanwhile, it has been proposed that there are six major strategies in mixed methods research (Creswell et al. 2003): (1) sequential explanatory strategy, (2) sequential exploratory strategy, (3) sequential transformative strategy, (4) concurrent triangulation strategy, (5) concurrent embedded strategy, and (6) concurrent transformative strategy. As implied by the names, the first three strategies relies on data collected sequentially, while the latter three employ concurrently collected data. The sequential explanatory strategy consists of a first phase of quantitative data collection, followed by qualitative data. The kind of data collected in the qualitative phase is typically informed by that obtained in the quantitative phase, and may be seen to complement it. The sequential exploratory strategy sees the phases reversed, with qualitative data collected first and the quantitative phase building on that. This strategy is useful for testing emerging theory, to determine distribution of a phenomenon within a chosen population, or for instrument development. The sequential transformative strategy also collects data

in phases, with either the qualitative or quantitative phase occurring first. The difference compared to the other sequential strategies is the presence of an overarching theoretical lens to guide the study. According to Creswell (Creswell 2009) *“By using two phases, a sequential transformative researcher may be able to give voice to diverse perspectives, to better advocate for participants, or to better understand a phenomenon or process that is changing as a result of being studied”* (p213).

The concurrent triangulation strategy relies on data collected concurrently, which is then compared for convergence or differences. The method may be used to compensate for methodological weakness within each method to improve validity of data collected. The concurrent embedded strategy is similar to the concurrent triangulation strategy, but whereas in the latter equal (or near-equal) weight is given to both methods, in the former one method dominates. Finally, the concurrent transformative strategy is again guided by an overarching theoretical framework guiding the entire study (Creswell 2009).

Mixed methods in the current study

The particular type of mixed method employed within the current study was what has been described as sequential explanatory strategy (Creswell 2009). In this approach, quantitative data is collected first, followed by a second phase of qualitative data collection where the qualitative data is used to explore and expand on the findings from the quantitative phase. In the current study this was followed by a final phase of quantitative data collection to broaden the understanding of young people’s experiences. This strategy, using mixed methods to increase the breadth of the research findings, has been described as one of the main justifications for using mixed methods research (Johnson et al. 2007).

Qualitative research: Analytical framework

The development and descriptions of the surveys used with HCPs and young people are described in their respective chapters, as is the development of interview schedules. However, all interviews (HCPs, parents and young people) were analysed using the same analytical framework, Interpretative Phenomenological Analysis (IPA), and the background and rationale for this particular method is provided here.

Choosing qualitative methods

The early origins of IPA can be said to be based in the school of experiential psychology that has been associated with William James, and the idea that to understand people's experiences it is necessary to also understand the individual, as experience is shaped by the interaction between people and the world they live in (Fancher 1996; Smith et al. 2009).

This experiential psychology took a backseat to the much more dominant experimental model of psychology for much of the 20th century, but over the last few decades a movement has emerged within psychology that criticises the rigidity of the experimental model. This critical psychology has argued that the attempt to study human beings as objects in a traditionally scientific manner and to classify experience and behaviour in the same way that the natural sciences tended to classify physical reactions and observations is misguided (Crossley 2000). The central tenet in this argument is that human beings are not objects but subjects that not only live in and react to the world, but who integrate with it, who reflect on their own experiences, and whose perceptions are shaped by their situations and circumstances. It emphasises that people attempt to make their experiences meaningful; they take on roles and ideas that fit with their own perceptions of a meaningful and worthwhile life (Crossley 2000).

Cooper et al. (1996) have also critiqued how the biopsychosocial model of health and illness is understood within mainstream health psychology. They argue that mainstream health psychology still tends to see the different components of the model as fragmented and very separate from each other. A critical health psychology, in contrast, would endeavour to explain the inter-relationship between the different components, and to see health and illness in the context of this interaction (Crossley 2000).

Because of this, the critical movement refers to a need for the experiences of health and illness to be understood more fully in terms of what they mean to people, and not just how to predict, manage and control health-related factors and behaviours. In order to understand more about the psychology of health and illness, it is necessary to understand more about the contexts in which people make decisions about their health, and what health actually means to them. This relates also to understanding the experiences of health care professionals and how this will impact on the care they provide for their patients.

Interpretative phenomenological analysis - IPA

Following on from this argument, IPA was developed based on the need in psychology for an approach that is able to capture the experiential and qualitative, and which could still dialogue with mainstream (quantitative) psychology (Smith 1996). For this reason, it may be seen to be particularly suited to mixed methods research. The philosophical underpinnings of IPA are found in phenomenology, hermeneutics and idiography (Smith et al. 2009). Drawing on the phenomenological approach associated originally with Edmund Husserl, IPA is concerned with thinking about everyday lived experience; people's subjective interpretations and the meanings they attach to events (Langdridge 2007; Smith et al. 2009). In this way, phenomenological psychology becomes based on what occurs between a person and the world they live in, including relationships between people. Husserl also argued that something which is experienced is always experienced in a

certain way, and that this is dependent on the individual. This means both that the experience will be unique to the individual because of the personal attributes they bring, and also that by studying the meaning of experience to individuals it is possible to understand something about their selves through how they experience events (Langdridge 2007). IPA also recognises the importance of bracketing (*epoche* in Husserl's terms); the duty of the researcher to identify privately held preconceived ideas and notions about the phenomena under investigation, and their ability to as far as possible put those ideas to one side and not let them overly influence the process of data generation and analysis. However, since IPA also draws on the philosophy of hermeneutics, it argues that presuppositions can never fully be bracketed, and hence the final product of an IPA analysis is by necessity an *interpretation* of the experiences of another (Smith et al. 2009). This school of thought suggests that an unbiased, true account of phenomena is never possible, and that people do in fact also interpret and make sense of their own experiences, leading to a *double hermeneutic*.

Finally, IPA is rooted in idiography, referring to the fact that it is concerned with the particular – both in the sense that analysis should endeavour great depth and detail, as well as how IPA concerns itself with the particular experiences of particular people (Smith et al. 2009). Individual accounts are viewed as important in their own right for what they can tell us about a particular phenomenon, without necessarily enabling generalisations to populations at large. IPA may be used to make more generalised claims, but the starting point is always the particular, such as individual cases. In this way IPA like other qualitative methods is interested in existence of phenomena rather than incidence.

Analysing the interviews

Following the framework of IPA, the interviews in this study were thus analysed according to the principles as laid out by Smith et al. (2009). Honouring both the phenomenological and idiographic roots of IPA, each transcript was analysed in its entirety and written up as a separate case before

moving on to the next one. The analysis began with a close reading of the text to get a feel for how the interviewee had been relating their experiences, and general thoughts about the interview were noted down. Often at this stage a feeling of what the interview 'was about', exemplified by key words or repeated phrases, would appear and this was noted as something to be aware of for bracketing and for checking the analysis against upon completion. The initial read-through and note taking was followed by close line-by-line analysis of the text. Paragraphs and sentences were broken down into components that conveyed specific meaning or had something to say about the experience being described. These fragments were annotated with analytic thoughts regarding their meaning, broadly corresponding to the types of comments suggested by Smith et al. (2009): descriptive, linguistic and conceptual, although these were not differentiated as such in the annotation. After the text had been broken down into smaller components and annotated, each annotation (and its corresponding piece of text) were assigned to a node within the qualitative software package NVivo. These free nodes were then investigated for commonalities and sorted into categories, which were eventually grouped under themes. The same procedure was followed for each participant.

Once all interviews had been analysed in this way, they were compared for common themes. Where such appeared, they were compared to see how the themes differed and/ or converged between different participants. This procedure of treating each case separately, meant that certain themes that were similar across participants were coded and named slightly differently between participants. This was down to how the meaning of a particular theme for a particular interviewee was influenced by their story as a whole, meaning that each experience was unique to each participant. This initially caused some concern as to how similar themes could be grouped together under 'common themes' without losing the nuances of each participant's story, however by including a synopsis of each participant's story as well as looking at how certain aspects of their stories coincided with others', a balance was felt to be found.

Chapter summary

This chapter has outlined the rationale for using mixed methods research, highlighting how the different aspects of quantitative and qualitative inquiry can be combined to attain an overview of a problem that is more inclusive than what might be achieved by using one of the methods alone. It has traced the increasing utilisation of qualitative methods in health psychology research through the lens of critical health psychology, and described the philosophical underpinnings of one of the most frequently used qualitative methodologies in health psychology; interpretative phenomenological analysis (IPA). It has further provided an explanation of how all the qualitative interviews in the studies that followed were analysed and how this reflects the assumptions of IPA. This chapter sets the scene for the following three chapters which will describe the separate studies undertaken for this dissertation.

Chapter 4. Health care professionals' survey and interviews

Introduction

One of the objectives of the study was to get an understanding of the current attitudes and beliefs of GPs and practice nurses regarding adolescent overweight and obesity, and how it can be managed. Since no previous surveys exploring these issues specifically regarding adolescents in the UK had been identified, the first stage of this study consisted of a survey of HCPs working in general practices in two counties in England. At a time when considerable media and policy focus was directed towards how obesity in young people could be managed, the dearth of studies providing evidence for how this was experienced by the professionals frequently expected to provide this type of service seriously undermined the understanding of service provision. The survey was necessary to get an understanding of what general practice staff in general were experiencing, but in order to get a more comprehensive understanding of how those experiences impacted on practice, interviews were also undertaken.

Qualitative research on practitioner views on obesity management (although not relating specifically to adolescents) does exist, however it frequently is medically focussed and rather descriptive. This part of the study aimed to provide a truly qualitative account of HCPs' experiences, with a view to situating these within a framework of patient-centred care.

Choosing the participants

The aim was to recruit HCPs that as far as possible represented 'regular' GPs and nurses working in general practice in England, i.e. not professionals with particular experience of providing weight management advice to young people. The rationale for this was: 1) General practice is regarded as the first port of call for individuals seeking medical help; 2) GPs and practice nurses have general

training that will include issues relating to weight but are not generally specialists in this area; and 3) although it is reasonable to expect that these HCPs come into regular contact with adolescents through their practice, they are not usually specifically trained to care for this age group. Since most obesity management guidelines recommend that obesity should be dealt with across the spectrum of primary care, it was considered essential to understand the experience of those professionals that have no particular expertise in either the management of obesity, nor in dealing specifically with young people. Such professionals are likely to occupy the largest proportion of HCPs grouped under the umbrella of primary care, and it is reasonable to surmise that they might be the ones who find the implementation of guidance most challenging, precisely because of their lack of expertise.

Both GPs and practice nurses were included in the study, since both groups have been identified as potential agents for intervention with obese young people (NICE, 2006), and because they vary as to the role they occupy within general practice.

Philosophical underpinnings

The philosophical stance in undertaking this research was based in the phenomenological view of psychology originating with Husserl in the 19th century (Langdrige, 2007; Spinelli, 2005; see chapter 3). As such, the focus for this stage was to understand HCPs' personal experiences of providing weight management advice for overweight and obese young people, rather than providing a structural account of the processes involved in such provision.

According to Spinelli (2005), phenomenological inquiry can serve the role of clarifying and explaining the variables and variants uncovered through traditional (quantitative) methods. Thus, findings from the survey that identify the incidence of a particular viewpoint may be illuminated by a deeper understanding of the meaning of such viewpoints to HCPs, arrived at via qualitative interviews. Further, Mead & Bower (2000) state that "*qualitative research may generate valuable explanatory*

insight into mechanisms underlying observed relationships” and “may be the only way of fully examining some dimensions of patient-centredness” (p1102).

In order to understand more about the psychology of health and illness, it is necessary to understand more about the contexts in which people make decisions about their health, and what health actually means to them. This relates also to understanding the experiences of health care professionals and how this will impact on the care they provide for their patients. Typically, research investigating both patient centredness, and patient-provider communication in general, tend to focus on patient perspectives, and how aspects of care are experienced by them. While many studies have been undertaken to explore provider perspectives from a process perspective, fewer have investigated the personal experience of care provision, the ‘doctor-as-person’ dimension of patient-centred care as described by Mead & Bower (2000), using qualitative methods. This understanding is important, as it is generally recognised that personal factors do impact on both diagnosis and subsequent care in health care settings – aspects such as prior experience, expectations, patient stereotyping, gender and mood all impact here (Street & Epstein 2008).

Aims

1. To investigate attitudes and beliefs towards adolescent weight management among GPs and practice nurses
2. To elicit a greater understanding of the experiences of health care professionals of providing weight management care for overweight and obese adolescents

Ethical approval

The Local Research Ethics Committee gave approval for the study (appendix 6), and Research Management & Governance (RM&G) approval was obtained from the relevant Primary Care Trust (appendix 7).

Study 1. Survey of health care professionals

Methods

Materials

The questionnaire (Appendix 5) was developed based on a survey of health care professional views of child and adolescent obesity conducted in the US (Trowbridge et al. 2002). The original questionnaire made no distinction between children and adolescents, but for the current study questions were reworded to pertain to adolescents only. This was because of the likelihood that several questions might generate different responses considering whether the respondent was answering in relation to adolescents as opposed to younger children, e.g. questions around patient and parent involvement and motivation. In addition to questions from this existing questionnaire, questions were also asked about awareness of UK specific guidelines for the management of child and adolescent obesity, and access to age standardised charts for assessment.

As well as questions relating to age, gender, ethnicity and position in the practice, respondents were therefore asked about their attitudes and experiences of adolescent weight management in 7 areas:

- 1.** *Beliefs about adolescent obesity:* 'adolescent obesity needs treatment', 'obese adolescents will outgrow their weight', 'adolescent obesity is more amenable to treatment than adult obesity', 'obesity in adolescence affects current quality of life', 'obesity in adolescence

affects future quality of life'. For all these statements respondents were asked to tick a box on a 5-point continuum from 'always' to 'never'.

- 2. *Treatment of adolescent obesity:*** 'GPs and nurses' time would be best spent in this area by preventing obesity in children and young people in the first place', 'counselling adolescent patients who are obese, or at risk of becoming obese, is professionally rewarding', 'the best role for a GP is to refer obese adolescents patients to other professionals rather than attempt to treat them', 'I would only offer advice regarding weight control when an adolescent patient requests it', 'I would only offer advice to an obese adolescent patient if their parent requested it', 'I would offer advice to an obese adolescent patient even if neither they nor their parent had specifically asked for it', 'I am professionally well prepared to treat adolescent patients who are obese', and 'I would be interested in further training in treatment of child and adolescent obesity'. These questions were answered on a 5-point continuum from 'strongly disagree' to 'strongly agree'.
- 3. *Barriers to treatment:*** Respondents were asked to rate the following as barriers, on a 5-point continuum from 'always' to 'never': lack of patient motivation, lack of patient involvement, lack of parental involvement, lack of clinician time, lack of reimbursement, lack of clinician knowledge, lack of treatment skills, lack of support services, treatment futility, eating disorder concerns.
- 4. *Guidelines for adolescent weight management:*** participants were asked about their awareness of government, professional or other forms of guidelines relevant for adolescent weight management, whether they had ever used guidelines in their practice and, if so, whether they had found them useful.
- 5. *Treatment options:*** Respondents were asked for their views regarding the appropriateness of a range of treatment options for adolescent obesity (responses on a 5-point continuum from 'always' to 'never'): behavioural management strategies, modification of eating

practices, modification of physical activity, modification of sedentary behaviour, medication, and surgery.

6. *Assessment*: participants were asked whether they had access to age-standardised charts for BMI and waist circumference in their practice, and whether they felt confident using such aids.
7. *Adolescents seen in practice*: respondents were asked to estimate how many obese adolescents they had seen (for any reason) in their practice in the last 6 months, and how many they had treated for obesity or a related condition.

Procedure

The questionnaire was mailed to GPs and practice nurses (PNs) working in general practices across one Local Health Authority (comprising two counties) in England. GPs (n=1176) were identified from official records of general practitioners, and so questionnaires were mailed directly to them via the general practice at which they were employed. At the time of data collection, no similar record existed for practice nurses so instead a number of questionnaires were mailed to each general practice 'care of' the practice manager together with a letter explaining the study and a request that the questionnaires be handed out to all practice nurses working at the practice. Requests for further questionnaires were welcomed if necessary. All mailed questionnaires were accompanied by an information letter (appendix 1) and a pre-paid self-addressed envelope for ease of return. Confidentiality was assured.

Data analysis

Returned questionnaires were entered into SPSS (v12) and analysed using frequencies, cross-tabs and chi-squares as appropriate.

Results

Response rate and demographic details

In total, 300 completed questionnaires were returned. Of a total of 1176 questionnaires sent to GPs, 210 (18%) were completed and returned. Seventy seven completed questionnaires were returned from the practice nurses. Eleven respondents stated their position at the practice as 'other'. Two participants did not give their professional position. Two thirds of total respondents were female (100% of practice nurses; 54% of GPs).

Attitudes towards adolescent obesity

More than half the respondents said that adolescent obesity needs treatment always or often, and just under 90% thought that obesity in adolescence affects both current and future quality of life (QOL) (Table 4.1).

Table 4.1. Practitioners' attitudes towards adolescent obesity (%)

	Always	Often	Sometimes	Rarely	Never
Adolescent obesity needs treatment	72 (24.2)	113 (37.9)	101 (33.9)	12 (4)	-
Obese adolescents will outgrow their weight	-	5 (1.7)	144 (48.2)	145 (48.5)	5 (1.7)
Adolescent obesity is more amenable to treatment than adult obesity	6 (2.1)	99 (34)	139 (47.8)	46 (15.8)	1 (0.3)
Obesity in adolescence affects current QOL	83 (27.7)	186 (62)	30 (10)	1 (0.3)	-
Obesity in adolescence affects future QOL	74 (24.7)	191 (63.7)	33 (11)	2 (0.7)	-

There was a significant difference between male and female GPs in the proportions that said that adolescent obesity is always or often more amenable to treatment than adult obesity (27.2% male v 42.9% female GPs; $p=0.041$).

Attitudes towards treatment

Overall, between a quarter and a fifth of GPs (21%) and PNs (23.4%) agreed that they would only offer weight management advice to an obese adolescent if the patient themselves requested it. However, GPs were more likely than PNs to agree that they would offer weight management advice even if neither the obese adolescent nor their parent requested it (72.4% v. 55.8%; $p<0.05$). Twenty percent of both GPs and PNs agreed they were professionally well prepared to deal with adolescent obesity. PNs were twice as likely as GPs to say that counselling obese adolescents was professionally

rewarding (48.1% of PNs v. 23.9% of GPs; $p < 0.01$), and more likely to agree that the best role for GPs would be to refer obese adolescents to other services (45.3% v. 25%; $p < 0.01$).

Gender differences in attitudes towards treatment were also found among the GPs. A significantly larger proportion of male than female GPs disagreed that GPs' and practice nurses' time is better spent on prevention of adolescent obesity in the first instance (31.2% v 13.6%; $p = 0.01$). Female GPs were more likely to disagree that the best role for the GP is to refer obese adolescent patients (57.3% female v 41.5% male GPs; $p = 0.022$), and male GPs were more likely to say that they would offer weight advice to an obese adolescent patient only if such advice was specifically asked for (30.5% male v 12.6% female GPs; $p = 0.001$). Females were more likely to report being interested in further training (64.9% female v 43.2% male GPs agree; $p = 0.007$).

Barriers to treatment of adolescent obesity

GPs and PNs also differed on several items related to perceived barriers to treatment (table 4.2). GPs were more likely to see a lack of support services, while PNs were more likely to state a lack of clinician knowledge and skills as a barrier to treatment. Male GPs were more likely to see treatment futility as a barrier to treatment than were female GPs (47.9% male v 29.6% female GPs responded 'always' or 'often'; $p = 0.010$)

Table 4.2. Differences between GPs and PNs in perceived barriers to treatment of adolescent obesity (those responding ‘always’ or ‘often’)

	GP	Practice Nurse
Lack of patient motivation	173/ 208 (83.2)	60/ 76 (78.9)
Lack of patient involvement	150/ 207 (72.5)	52/ 77 (67.5)
Lack of parental involvement	129/ 207 (62.3)	42/ 77 (54.5)
Lack of clinician time	161/ 209 (77)	49/ 77 (63.6)
Lack of reimbursement	79/ 205 (38.5)	28/ 73 (38.4)
Lack of clinician knowledge	56/ 209 (26.8)**	32/ 77 (41.6)**
Lack of treatment skills	65/ 208 (31.3)*	34/ 76 (44.7)*
Lack of support services	161/ 208 (77.4)**	42/ 76 (55.3)**
Treatment futility	78/ 206 (37.9)	19/ 76 (25)
Eating disorder concerns	37/ 209 (17.7)**	26/ 77 (33.8)**

* $p < 0.05$; ** $p < 0.01$

Treatment options

The majority of respondents endorsed behavioural management strategies and modification of eating, physical activity and sedentary behaviours as suitable treatment strategies, while they were much less likely to see surgery or medication to be appropriate treatments for obesity in adolescents (table 4.3). There was no difference between professional groups or between males and females in perceived suitability of various treatment strategies.

Table 4.3. Perceived suitability of treatment options for adolescent obesity

	Always	Often	Sometimes	Rarely	Never
Behavioural management strategies	56 (18.9)	161 (54.2)	77 (25.9)	2 (0.7)	1 (0.3)
Modification of eating practices	118 (39.5)	153 (51.2)	28 (9.4)	-	-
Modification of physical activity	145 (48.5)	140 (46.8)	12 (4)	1 (0.3)	1 (0.3)
Modification of sedentary behaviour	143 (47.8)	141 (47.2)	14 (4.7)	1 (0.3)	-
Medication	2 (0.7)	2 (0.2)	94 (31.6)	158 (53.2)	41 (13.8)
Surgery	1 (0.3)	2 (0.7)	15 (5.1)	164 (55.4)	114 (38.5)

Guidelines & assessment

Fewer than half of all health care professionals (117/ 299; 39%) claimed to have a good understanding of the NICE guidelines in relation to adolescent obesity, and awareness of any other government (10/ 297; 3%) and professional (29/ 296; 10%) guidelines was low. Thirty four HCPs (12%) reported ever having used any guidelines for adolescent obesity management, but of those 85% (28/ 33) said that they had found them useful.

Just under half (139/ 299; 47%) reported having access to age-standardised BMI charts at their practice, and around a fifth (63/ 296; 21%) to age-standardised waist circumference charts. Among those that had access to such age-standardised charts, confidence in using them was high both for BMI (133/ 139; 96%) and waist circumference (49/ 62; 79%).

Perceived skills and further training

Overall, 20% (56/ 287) of the HCPs said that they were professionally well prepared for treating obese adolescents. Those who reported being professionally well prepared were more likely to agree that treating obese adolescent patients is professionally rewarding (55% v 19.4%; $p<0.001$), and more likely to disagree that the best role for the GP is to refer obese adolescent patients (61.7% of those who (strongly) agree v 38.5% of those who (strongly) disagree; $p<0.001$). They were also less likely to see lack of clinician knowledge (10% of those who (strongly) agree v 47.9% of those who (strongly) disagree; $p<0.001$) and lack of treatment skills (10.2% of those who (strongly) agree v 52.8% of those who (strongly) disagree); $p<0.001$) as barriers to treatment, and more likely to report having a good understanding of NICE guidelines in relation to adolescent obesity (71.2% of those who (strongly) agree v 23.4% of those who (strongly) disagree; $p<0.001$). Finally, they were more likely to agree that they would offer weight advice to obese adolescents even if neither they nor their parents requested it (80% v 56.6%; $p=0.001$).

Those who agreed they were interested in further training were more likely to disagree that the best role for the GP is to refer obese adolescent patients (53.1% of those who (strongly) agree v 35.4% of those who (strongly) disagree; $p=0.011$). Further, they were more likely to see lack of clinician knowledge (35.6% of those who (strongly) agree v 18.8% of those who (strongly) disagree; $p=0.001$) and lack of treatment skills (41% of those who (strongly) agree v 22.9% of those who (strongly) disagree; $p=0.013$), and less likely to see treatment futility (26.4% v 57.4%; $p=0.001$), as a barrier to treatment. They were more likely to report finding treatment of obese adolescent patients to be professionally rewarding (36.7% of those who (strongly) agree v 20.8% of those who (strongly) disagree; $p=0.005$).

Those who found treating obese adolescent patients to be professionally rewarding were less likely to see treatment futility as a barrier to treatment (23.9% v 52%; $p<0.001$).

Summary

HCPs see adolescent obesity as a health problem that requires treatment, but many feel professionally unprepared to deal with it and would like further training. GPs and practice nurses may be more likely to bring up obesity in a consultation with an adolescent than with a younger child, but perceive a lack of motivation and involvement on part of the adolescent patient as barriers to effective treatment in this age group. Training that includes skills in how to engage with young people in the consultation may therefore be useful in overcoming these barriers. Support for HCPs in dealing with adolescent obesity should also take into account that practice nurses may perceive personal factors such as skills and knowledge to be areas for greatest improvement while GPs may be most interested in increasing collaboration with other agents.

Although most GPs and practice nurses surveyed in this study said they had not used any form of official guidance regarding adolescent obesity management, use of such resources may reinforce personally held beliefs about appropriate treatment strategies. This in turn may lead to a strengthened belief in the efficacy of treatment, which could have a positive impact on treatment outcomes. Promotion of simplified and user friendly guidance resources may therefore be beneficial to this group of HCPs.

Study 2: Interviews with health care professionals

Methods

Participants

All interviewees were recruited by contacting HCPs who had completed a section within the questionnaire saying that they would be interested in taking part in an interview, and providing contact details. Communication to arrange interviews was done via email and telephone. Interviews were arranged with four GPs and four practice nurses; all interviewees except one GP were female. Seven interviews were conducted at the participant's place of work, the remaining one took place at the University. They ranged from 33 to 58 minutes in length, and were recorded using a digital recorder. All participants signed a consent form prior to the interview (appendix 4). Participant characteristics are summarised in table 4.4.

Table 4.4: HCP Interviews participant characteristics

Professional role	Gender	Age bracket	Practice location	Interview location
GP	Female	40-49	Urban	Work place
GP	Female	30-39	Urban	Work place
GP	Male	30-39	Suburban	Work place
GP	Female	30-39	Urban	University
Nurse	Female	40-49	Suburban	Work place
Nurse	Female	50-59	Suburban	Work place
Nurse	Female	40-49	Suburban	Work place
Nurse	Female	40-49	Rural	Work place

Interview schedule

The interviews were all semi-structured, based around an interview schedule (appendix 8) designed to probe participants' experiences of providing weight management advice to overweight and obese adolescents. In line with the framework of patient centred care, questions explored issues relating to views on obesity as a medical issue; experience of adolescents as a patient group; issues relating to control and responsibility; reflections on sense of self and professional identity in weight management; and the doctor-patient relationship as relating specifically to young people. In line with the recommendations for carrying out interviews to gain rich accounts of participants' personal experiences (Willig 2013), the schedule was used flexibly within each interview, and the interviews were guided by the stories the participants were telling. Using this approach the themes of the

interview schedule were explored with all participants, but to varying extent depending on their own personal experiences.

Throughout all interviews it became clear that none of the HCPs interviewed had extensive experience of providing weight management care specifically for adolescents, therefore discussions by necessity focused largely on weight management for patients in general, and on the adolescent-as-patient. However, based on these experiences HCPs were also able to theorize what providing this service specifically to young people would be like, and how they felt about that. Since the aim was to get a greater understanding of the experiences of general practice based HCPs in general, this lack of direct experience was not considered problematic but rather something that might help the understanding of HCP reactions and responses to meeting the expectations of policy and guidance.

Analysis

The analysis of the interviews was done using the qualitative data management software QSR NVivo (v. 7). Upon completion, all interviews were transcribed verbatim, and the transcripts were then imported into NVivo files for analysis. In line with the philosophical underpinnings described in chapter 3, interpretative phenomenological analysis (IPA) was used as the analytical framework.

Themes

The survey provided an overview of the views and attitudes of general practice based HCPs regarding adolescent obesity management, and suggested potential barriers to providing weight management help for this patient group. The interviews were used to gain a fuller understanding of HCP experiences, and to explore both barriers and facilitators to adolescent weight management consultations in depth. Three overarching themes were identified: (1) Professional role and identity;

(2) Managing patients; and (3) Managing adolescents. Each of these themes had their own sub-themes (Table 4.5), and these are presented here.

Table 4.5 Themes identified in the HCP interviews

Major theme	Subthemes
Theme 1: Professional role and personal identity	Obesity in general practice
	What you do
	Being a health care professional
Theme 2: Managing patients	The elephant in the room
	Patients protecting the self
	Patients as partners
Theme 3: Managing adolescents	The nature of adolescence
	Adolescents as victims of their social environments
	Adolescents in the consultation
	Managing independence and responsibility

Theme 1: Professional role and personal identity

One of the recurring themes throughout the interviews was that of professional role and personal identity. The two concepts of 'role' and 'identity' are recognized as being clearly separate; 'role' suggests something more action oriented that is tied in with expectations (from self and others) of what being a HCP is actually about and that which you do, while 'identity' refers to how the HCP views themselves as a person, what being themselves is about and that which you are. However, despite referring to distinct concepts, the two were often found to be impacting on each other.

Obesity in general practice

Under this theme falls the fundamental question of what place obesity management should have within the general practice setting. While all of the participants saw a professional duty to provide on demand at least some response, even if on very basic terms through information or referral to another service, the extent to which they saw themselves having a responsibility in weight management varied between participants.

At the one end, two of the PNs saw themselves as not having enough training or knowledge to provide adequate weight management services, and therefore feeling very unsure of what they could realistically provide for patients that would be effective. One of them, PN04, was the most emphatic out of all the HCPs interviewed in declaring her opinion that doing weight management was not something she saw as part of her professional role – it was something she perceived others considered to be part of her role, but which did not fit in with her own view of herself as a general practice nurse.

“I think it’s expertise, cause I can’t begin to pretend that I’m a dietician. You know? I’m not. ... You know, we can do our best, but you know, I can’t see how people after only a couple of training sessions could come and do my job for example, and I don’t begin to believe that I could do a dieticians job. Ehm...I think they’re just asking us to do everything, and we can’t. You know, we don’t have the expertise.” (PN04)

“I didn’t, I suppose, come in to nursing to become a dietician. I mean, I agree that it is fundamentally important because of all the other illnesses that come from being overweight. But I don’t necessarily see that nursing is, can actually...cure that.” (PN04)

The other PN at this end of the spectrum, PN01, felt that from her own experience bringing up weight was part of her role as a family planning nurse, since weight would impact on the efficacy of certain contraceptives, but not in her general practice role. While she perceived weight as relevant in this context, it was not relevant in most general practice consultations where medical consequences were not obvious. In this sense, she had not just one professional identity but two,

depending on the context in which she was practicing. In her family planning nurse role, measuring weight caused no concern since it was part of the protocol, it could be easily explained and justified to the patients and was routine. None of the HCPs that talked about weight monitoring in a family planning context expected this to be met with hostility by the patients, since it was justified and expected. However, it may also be the case that because it is so routine, bringing up weight in this context does not instigate a feeling of having to take action on part of the HCP, but only a role of flagging up the problem and leaving responsibility for management with the patient. This is supported by the same nurse who despite describing having no problem bringing up weight as an issue in family planning settings nonetheless described feeling ill equipped in actually offering help:

“As nurses we support the odd patient who wants some support. Uhhh...but on the whole we can’t talk about a great deal with them, a lot of people wants like a calorie counter, they want a specific diet to follow that will guarantee that they will lose weight but we can’t do that. We provide them with healthy eating, and what their ideal weight should be, and more exercise, and you know...less on their plate. But we don’t actually offer like Slimmers World or Weight Watchers...I mean we can weigh them but we don’t have all the other things that go with it. What they should have for breakfast or lunch or tea...so in that way I suppose we could be educated more” (PN01)

The majority of the HCPs fell somewhere in the middle of this spectrum, feeling that there was an expectation on themselves and the profession that they needed to provide some kind of service to overweight and obese patients, but frequently expressing ambivalence as to how they saw it as fitting their professional role. It was often talked about as something that required something extra on the part of the HCP, some inherent personal characteristic that was more to do with the individual than with their training as medical professionals. One GP described this taking on of obesity within the role as being ‘enthusiastic’ about weight management; she described enthusiasm in general as something needing to be present for a HCP to internalise a particular issue within their professional identity, and that without this enthusiasm, things would not be addressed:

“Ehm...the other thing is that, there’s lots of different attitudes about weight-loss, so if you talk to, we’ve got 10 doctors here, they will all have completely different attitudes to weight-loss. Some of them will just think “what a pointless waste of time, I’ve been trying for 15 years to get this person to lose weight and they’ve lost nothing”, some may be a bit more enthusiastic about it. I know more about it because I’ve tried to lose weight myself, so I know more about the practicalities of the diets, and I feel more enthusiastic about it than some people.”(GP02)

Other HCPs also referred to having a personal interest in obesity, something that they identified with on a personal level and therefore had incorporated within their view of themselves as a HCP, without necessarily seeing that as being part of the general expectation of what your role in relation to weight management is as a HCP. So for example, one of the GPs identified other health concerns that fell within his remit and which had led to an interest, or enthusiasm as it might be described by GP02, in obesity management:

“Ok, well I’ve got a bit of an interest in obesity at the moment, partly because I’m the cancer lead for the locality, and we’re beginning to have a shift in focus in towards prevention aspects. Uhhh...and the next big thing in terms of prevention in terms of cancer risk is obesity, diet and exercise combined together. So that’s one of, one of my interests. I’m also the diabetic lead in this practice, and am interested in obesity and I’m aware of the difficulty patients have in managing obesity.”(GP03)

The personal interest could also result from having personal experience of being overweight. Several of the HCPs talked about battling overweight now or in the past, and therefore ‘knowing what it was like’. This knowing what it was like translated into being more open to provide weight management advice for others both because of a sense of wanting to help others to feel better about themselves and be healthier, and also feeling better able to relate to such patients because of personal experience. Some HCPs saw overweight to be harder to deal with for adolescents than adults because of stigma and potential for bullying, and one nurse described her empathy for overweight adolescents as relating back to having experienced that herself:

“Yeah. It is why I have the empathy... Ehm, and...the whole point is that you don’t want them to have health issues. I’m now diabetic with a thyroid problem. I have a terrible weight issue, it goes up and down weekly. Ehm, and I really believe it started way back when I was very young, when I was not being encouraged to have the fresh fruit, vegetables, things like that. And...really and truly, my interest in adolescents is that I understand how crippling and embarrassing it is, ehm, and how much stigma is attached, and how much teasing you get and all of that, and I’m looking at having a nice healthy balanced lifestyle with a happy child.” (PN02)

This particular nurse can be said to be at the other end of the spectrum with regards to fitting weight management into her professional role. Her interview stood out from the others in the sense that a large part of it described her experience of actually working with an adolescent patient for weight management. Although this was something she has undertaken together with a dietician, she described this experience as having been very involved with the patient in question. Possibly because of the relative success she had achieved with this patient, this PN had no problem assimilating adolescent weight management within her professional role. She saw it as something she was enthusiastic about implementing, and something that could work given the right circumstances:

“And I was feeling quite pleased that we’d managed to reach one. (laughing) Gotcha! (laughing) And...I was thinking you know, how do I expand that, how can I get that across without making it feel I’m ordering them in to some kind of...”(PN02)

More generally, while most of the HCPs interviewed saw weight management as an at least small part of their professional role, it was generally on an individual level rather than in the sense of curing a population crisis. In this way, working with individual patients coming into the practice having difficulties because of their weight fitted into how they saw themselves as HCPs, while the expectations on a greater level were perceived as unfair or unrealistic:

“And what we’re doing is we’re getting government pressure for us to intervene for state reasons, as opposed to individuals coming in and requesting help for personal reasons. That’s not really what general practice has traditionally been about.” (GP04)

What you do

One interesting aspect relating to how HCPs saw themselves in providing weight management advice for overweight and obese adolescents was in how they talked about the meaning of 'doing something'. From this, it appeared that in general those nurses who had positioned themselves as reluctant to accept obesity management within their professional role defined it as something they would have to carry out themselves (without involving external support) with their patients. In light of this, their perceived lack of training and expertise perhaps explain why this role did not appear to fit with them. In contrast, the nurse who described herself as having successfully worked with an adolescent patient, had done so by largely referring him to a dietician (while still maintaining regular contact to check progress). Thus, she described the work done by the dietician almost as her own achievements – not because she did not recognize the strength of that resource but because she saw her role in putting the patient in contact with the dietician as instrumental. Several of the other HCPs also talked about 'what they could do' in terms that included both direct communication with patients and referral to other services, and most described the need to refer to specialist children's services in cases where obesity was severe. However, one GP in particular described a way of working with obese adolescents that was both through direct contact (not referral) and very much something she saw as part of her sense of self. She talked about the need for using a 'coaching' strategy, for working with a patient in an almost therapeutic manner which include plenty of reflecting back to the patient and enabling them to make the necessary changes in themselves. She described this way of working as something she associated with 'what I am about':

"It's something that I do...probably originally intuitively. But I've done some sort of CBT training, depression and anxiety management things. And that sort of coaching, coaching view is something I think intuitively my consultations start like that anyway, so it wasn't a difficult style to adopt." (GP04)

Regardless of how well the HCPs saw obesity as fitting within their professional role, they all implied that to provide this type of service effectively you had to go above and beyond what would strictly

be expected of you as a HCP. You would 'get away with' doing the bare minimum, like acknowledging the overweight and suggest changes to be made, and still be seen to fulfill your professional duty. On the other hand, if you wanted to provide weight management support that might result in actual change you would have to step out of 'care as usual' and into a more personal model of care. In this, there was a distinction between 'expected/ acceptable' on the one hand and 'effective' on the other. This stance of just doing the minimum in terms of weight management was seen as associated with the traditional medical model of care:

"I think it will be acceptable to say 'I've seen you, I've told you you're fat and I've given you the advice you need. Go away'. But I don't think, I just don't think that's effective. And I suppose it depends on whether you want to be an effective practitioner, or if you want to be a practitioner that can't be criticized". (GP04)

"I mean I think that, health care professionals if they, if they challenge them, they will say you know, "eat less and exercise more". Which is all very well but it's kind of a little bit restrictive in terms of, you know, how valuable that information is." (GP03)

One obvious example of how practitioners wanting to provide effective care had to invest themselves in the process and do more than what would be expected was reflected in a sense of having to play detective in order to find the necessary resources. This related in particular to weight management care for children and young people, as the necessary resources were not always available to them in the practice. This involved things like ringing around or searching the internet for appropriate services that young people could be referred to, but also more basic tools like age standardized BMI charts.

“So it’s not something that is available in the practice?”

No. it’s not, no. Cause that’s where I struggled as well, when the mum rang me and said you know, “can you tell me what her BMI is”. I said “oh yeah, no problem”, thinking that I got these charts and then I said “Oh, actually no it doesn’t go that young”. But I found one on the internet. (PN01)”

“There’s a knowledge issue there I suppose. But I’m not sure how many GPs know about the new weight charts either.

No.

I suspect a lot of them don’t. I think I only found out about it through my interest, ringing around a bit.” (GP03)

This sense of having to put a lot in yourself, relying on personal interest, in providing effective obesity services was reflected in a frustration over not knowing exactly what was available outside of the general practice setting. Just like the nurse described above, rating her importance in getting her patient connected to the dietician, *what you do* would definitely include linking patients with other services that had the necessary resources. This was particularly pertinent to adolescent patients, since most of the HCPs were aware of at least some services (e.g. weight watchers) that they could link adult patients to, but knew of no equivalent for young people. Further, there was a sense that leaving adolescent patients unsupported after the initial weight assessment would be worse than doing the same for adults, as adolescents would be more vulnerable and likely to suffer emotional consequences. Because of this, not having knowledge of what services are available severely restricted the HCPs’ ability to do anything at all, since they were reluctant to bring up weight in the first place unless they felt that they had a clear structure for what they could do next.

“I don’t feel that we’ve got anything particularly for children. I mean I know there are various exercise things, ehm...we’ve got something on the board out there for children, but it’s not, doesn’t seem to be as well known or at least I don’t know it.” (PN04)

“So it is more difficult, sometimes you do feel a bit...lost, knowing what you can do, what you can do next once you’ve give as much as you have got to offer yourself in terms of dietary advice and emotional support, it’s then knowing where can they go next?” (GP01)

Being a health care professional

Throughout all the interviews, it was obvious that the HCPs saw obesity as being much easier to incorporate within their professional role if it could somehow be tied to a physical health issue. In this way, general practice was seen to be very firmly about physical health, and obesity on its own did not appear to qualify as a medical issue to most. There was ambivalence over this however, as all recognized the health consequences of obesity and overweight – and thus, by extension, obesity became a health issue. However, it was not until the health consequences became obvious that weight would legitimately become a general practice issue – and at that stage, the presenting health complaints would be the reason for intervening. In relation to adolescents, the majority appeared to consider it because of its impact on emotional rather than physical health, and the frequent absence of physical health consequences in this age group was problematic. Most had a view of adolescents that suggested that for an adolescent to be overweight would cause significant emotional difficulties in terms of self-esteem, self-worth and peer relationships, but these emotional health aspects were not experienced as legitimate causes for intervention in general practice in the same way that physical health complaints were. The potential emotional aspects were even actively considered a hindrance to weight management, because they indicated need for extra help and support that HCPs may not feel equipped to manage.

“Occasionally you get a patient come in just purely for their weight problem on its own, but more often than not you have the angle with the medical problem as well. Yeah...it’s not often that you see a child purely just for weight loss on its own, ehm...it’s usually because there’s a problem either with chest infections or some other problem that started, you know, as a result of their overweight.” (PN03)

One of the PNs who had difficulty seeing obesity management as being part of her professional role in general practice, was very comfortable addressing it as part of her role as a family planning nurse. In this setting, she encountered a large number of adolescent girls, many of whom she described as overweight. As part of contraceptive consultations she felt that weighing, and having a discussion about weight, was relevant because of its impact on the efficacy of certain contraceptives. This view was echoed by many HCPs, and the potential for emotional upset did not appear to be so much of a concern in those settings. Thus, when weight could be easily medicalised and tied to the markers of traditional medicine (the prescribing of pills), it became unproblematic.

“I think because, well certainly in family planning we have to do their sort of BMI because it’s...being on the proviso anyway, it’s not difficult to bring it up because you can say “well, you should be on this level or this level, you perhaps need to lose a stone”. It’s not difficult to bring it up there.” (PN01)

Similarly, a nurse specializing in asthma management felt that discussing weight in relation to asthma was both appropriate and easy, and something she would rightly be expected to do as part of that role:

“So I’m picking up on those that are asthmatic, mainly, cause they’re the ones that come to see me, ehm...mainly. And obviously if they are obese that is something that I’ve got to tackle, ehm, and that’s having implications on their asthma as well.” (PN03)

However, while having a medical issue to attach obesity to might make it more legitimate to address in the general practice setting, the definition of general practice as an ‘illness service’ was seen by some to be a reason why general practice in general was not considered the most appropriate setting for obesity management in young people. The HCPs felt, firstly, that adolescents tended not to be ill, and therefore attended general practice less frequently than both adults or children.

Therefore, the opportunity to engage adolescents in weight management as and when they attended was seen to be more restricted. Secondly, and probably related to the first point, HCPs also perceived young people themselves to not see themselves as ill – another reason for their less frequent visits. Therefore, to discuss weight management with adolescents would be inappropriate because it would be beyond the bounds of what adolescents themselves would expect from general practice.

“I think in general practice we don’t see as many young people because they’re not ill usually and so they only come in when they’re ill. So I feel that maybe the obese young child will be better looked after by a school nurse, but... you know I can see there’s a role in general practice for it but I think on the whole because they’re in school during the day they’d get a lot more from the school nurse” (PN01)

Summary of theme 1

Because of the nature of obesity management as something that would not be classed as a medical issue in the way general practice would traditionally define such matters, it both impacted on and was impacted by HCPs’ sense of professional identity. The professional role of being someone that provides health related care to those who require or request it, and its implications for duty of care, meant that all HCPs interviewed here saw it as their role to at least respond to requests for help in this area, even if such responses consisted of referring to other services. If weight impacted on other, more legitimate, health problems it could more easily be incorporated within the professional identity. Those HCPs who saw weight management for its own sake as being appropriate for their professional role nevertheless would also indicate that you would still have to go beyond what would normally be expected of a HCP in order to provide effective care. Being able to relate obesity management to aspects of one’s personal identity, such as own weight problems or as fitting with a personally favoured consultation style, also made it easier to assimilate into the professional role.

Theme 2: Managing patients

Many of the varied themes that were prominent in individual interviews could be brought together under the wider main theme of 'managing patients'. Relevant here were issues related to the practical and structural (organizational) aspects of providing obesity care in general practice, but also (and more importantly) the relational aspects of the interactions between HCPs and patients. This was where HCP experiences of talking to overweight and obese patients about weight management became apparent, including the reactions of patients to such conversations. Although the discussions were focused on adolescents where appropriate, much of these narratives also included the experiences of weight management overall, including with adult patients, since an understanding of all such experiences is essential for understanding the context of dealing with a particular patient group, such as young people.

Through the theme of the meaning of weight consultations to HCPs' professional identity and sense of self, it was evident that most felt that weight issues they would have to address on some level with patients. However, the ambivalence of many regarding the exact importance and responsibility of the HCP on this issue made clear that it is not something that can always be unproblematic and straightforwardly discussed.

The elephant in the room

One strong subtheme that was evident in all the interviews was that of how to go about addressing weight with overweight and obese patients; how to bring it up. All of the HCPs stated that among patients in general, and adolescents in particular, weight was rarely the presenting problem for patients attending for consultations. This meant that if the HCP considered the weight of a patient to

be a problem that needed discussing, it would be necessary to find a way in to bring it up that would both be relevant and non-offensive.

“But it’s very difficult addressing it if they haven’t brought it up for a start.” (GP02)

“I think it’s more difficult in the surgery, because often we’re just doing you know, a pre-pill check or whatever and...I don’t know, it’s not necessarily so relevant there as it is in family planning. You’re talking more about their body, you’re not just talking about their weight, you’re talking about sexual health and things so it’s all encompassed whereas in the surgery it’s really just a case of ‘is everything ok, you’re alright with the pill?’”. (PN01)

“And sometimes they get upset if you sort of mention it, so what I tend to say in those times is like ‘if you ever want to talk about it, how we can work through it, how we can look at what you like and make it less...’. All of those things I was just saying. Ehm...then I’m here for that. ‘I can certainly help you, just pop in’”. (PN02)

“And health promotion is a really...a really tricky one to...it depends on how well you know them. It depends on what sort of rapport you form when dealing with the presenting complaint, it depends on how rushed you are, it depends on how busy you are, it depends if you can get a tie-in.” (GP04)

“...but certainly you get people in their teens and early twenties coming in, and they are, they’ve got BMIs of 40. And...it sort of sits there like the elephant in the room, you know it’s not something they bring up as their presenting complaint, their reason...their reason for attendance” (GP04)

This subtheme was further divided into several components that all impacted on the ability of HCPs to address weight with overweight and obese patients.

Making it relevant

The first concern of HCPs when deciding whether to address weight with an overweight or obese patient is of whether bringing it up on a particular day, with a particular person, is relevant to the reason for their attendance in the first place. Several stated that to bring up weight when patients were attending for something for which their weight was of no importance would be inappropriate;

it went against their view of what general practice is about and would be potentially awkward for patients in that it would be incongruent with their patient identification at that particular time. In this way, there is a sense that general practice consultations need to make sense, they have a theme (the presenting complaint) and in order to honour this, such themes should in most cases not be deviated from. This of course ties in with a practitioner's professional identity and what they see themselves as being about, but there was a practical aspect to this as well since most consultations would not allow too many issues to be discussed during what is mostly a very limited time slot. It was also felt to be important to the relationship with the patient, a sense perhaps that trust might be broken if unrelated issues, such as weight, were discussed during the consultation.

"I mean, we have to see them for a wide variety of things, and they have to feel that they would be happy to come back and see us for other reasons. You know, anything really. And I think if you...however nicely you put it, if you start accusing people of not feeding their children properly, then you're going to break all sorts of trust with that family that you might never get back for all the other things that you need to look after them for. You know, for the rest of their lives really." (PN04)

"But again, the trouble is that when they have come in about one thing, they're not necessarily receptive to something else, because obviously they've come in with that particular agenda. Unless of course, I mean sometimes people come in with one reason but that's not the reason they've come in and they want to then move on and talk about something else. But it doesn't tend to be their weight." (PN04)

In this sense the HCPs interviewed here viewed consultations from a rather patient-focused perspective; that what the patient had brought up and prioritised is what would be important. At the same time, many felt that to be an effective HCP also meant having to be somewhat hypervigilant and being able to read people in terms of what they might want, or be receptive to, discuss. Several of the HCPs alluded to what one GP described as dealing with 'the elephant in the room'. There was a sense that often, even if weight was not the presenting complaint, there would still be an awareness of it that may be felt as an unspoken tension between the patient and the HCP. This

referred to situations where the patient was aware of their overweight and the potential health consequences but neither they nor the HCP brought it up for fear of a difficult discussion. It was the perception of the HCPs that the patient (or sometimes the parent for children and young people) were almost expecting a telling off, which resulted in HCP and patient tip-toeing around the issue but never addressing it straight on. For the HCPs in those situations, it was a questions of gauging whether weight was something the patient was aware of but did not want to discuss, or something they might want to address but felt embarrassed to mention (or sometimes possibly question the relevance of themselves). This was a feeling that the patient perceived their weight to perhaps be something their HCP would pick up on and feel a need to mention, while the HCP themselves might be trying to gauge the appropriateness of bringing up the issue and judging the response of the patient to any such discussion.

“..it’s a subject really, especially adolescents and children, you never know really whether you should mention that you think someone looks rather, you know, someone’s child looks rather overweight when they come in for something else or not.” (PN04)

Thus, weight could be brought up if the practitioner felt that the patient might expect or welcome such a discussion even if it was not their main reason for attending. In such situations a contrasting dilemma might present if the HCP felt physically unable to have that conversation on that particular day, if contextual factors such as running over time or not being prepared to deal with the fall-out of a discussion of weight on a particular day meant that they felt unable to meet such an unspoken expectation or wish.

“Ehm...that’s a difficult one, sometimes, it really depends on what they’ve come with. If they’ve come with something that you can loosely connect the weight to then it’s much, much easier to bring it into the conversation. ... But if they’ve come with something completely unrelated and you’re running 20 minutes late, then...you probably know that you should, but...you maybe don’t always do that, you know.” (GP01)

As well as judging whether bringing up weight would be acceptable or welcomed was a sense that if you did not have anything to point them towards in terms of helping or follow-up, bringing weight up would be unprofessional:

“...and then there’s the issue of what do you do about it once you’ve told them? Just telling someone that they’re fat is not a terribly helpful thing, unless you say ‘you’re overweight; these are some of the things you may want to do about it, and these are the things I can direct you towards’”. (GP03)

Regardless of whether the patient was perceived as wanting a discussion about weight or not, all practitioners interviewed here agreed that to bring up weight unsolicited in the consultation would be much easier if there was something medical to hang the issue on. This was firstly because it would remove some of the uncertainty over relevance (both from the patient’s and the practitioner’s point of view), but also because the HCPs appeared to feel more on solid ground when this was the case; they were more sure how to have such conversations and how to follow them through with advice. When discussing medical concerns, HCPs felt that they were acting inline with their professional role and what was expected of them by their patients and in general. Because of this, adolescents were seen as more problematic than adults because their overweight or obesity had not usually yet manifested in physical health complaints.

“And certainly, it’s always difficult because you can’t guarantee, you can just about say to people who smoke, you know “You will, you know, end up with...if you don’t get lung cancer you will get COPD”, there’s a huge incidence... I think it’s much harder, cause where is the science that says if you’re an obese teenager your risk of diabetes age 50 is double?” (GP04)

Medical consequences such as hypertension and heart problems provided an opening and a way in to bring the issue up, as did general aches and pains (back aches, knee pain) which again were not

thought to present as frequently among the adolescent patient population. The way that co-morbidities were discussed by these HCPs suggested that the presence of such complaints provided the key to open the door to weight management consultations, a straight forward way in. When discussing weight because of its implications for physical health the HCPs felt on safe ground, knowing what to do and being comfortable in the relevance for their own professional role. This sense of comfort appeared to be related to their perception of patient expectations of their role as much as their own expectations of themselves.

As described under the theme of professional role and identity, one area that was discussed particularly by the nurses as being relevant for discussions regarding weight in young people was that of family planning. It was described as a type of consultation where talking about weight was unproblematic because of the relevance of weight to the management of contraception. Thus, in their roles as family planning nurses there was a more straightforward way into discussions of weight:

“It tends to be the girls that come in for the contraception, so that’s an opportunity to discuss weight and weight management, because obviously we’re having to weight them and do their blood pressure and general things like that as part of the ongoing contraceptive care.”
(PN04)

This suggests that weighing patients in family planning consultations was part of routine care, not something that needed to be deliberated over whether to do or not. Further, it was the perception among the HCPs that young people in such situations would also expect weighing to take place, and so it was normalised. In line with this, one approach that was described as effective for consultations in general, and particularly with younger patients, was to make weight a normal part of the consultation. If having height and weight measurements taken as part of what it means to go to the doctor’s, this could be done without risking it being seen as an attack on the self.

The meaning of weight

While the way to best approach weight management with a patient was one of the main concerns for professionals, another one was that once the issue had been brought up it would result in a strong emotional reaction on the part of the patient. The need to be gentle and non-judgmental was described as relevant for patients in general, and adolescents in particular. Again, this potential emotional fall-out meant that HCPs had to be able to read their patients carefully, using intuition and gauging cues like body language and tone of voice.

“And very often I’m very soft about bringing it up and I’ll then pushing it further depending on what they say. I feel that, with someone that is obviously huge I’ll say “Would you like me to weigh you, while you’re here?”, and they can say yes or no. Or they can say yes in a way that they don’t care, or yes in a way that they value a conversation about it. Or they can say no in a way that says I don’t care, or they can say no in a way that says “this is a huge issue for me, and if you approach it carefully we may be able to have a conversation”. So it’s very much a sort of edge, and edge towards...” (GP04)

There was a strong sense that to ‘create’ weight as a problem in the patient-HCP interaction was something that could be seen by patients as an attack on the self; a criticism of appearance and lifestyle as much as a professional concern for physical health.

What was also evident under this theme was how frequently HCPs associated weight issues with emotional health. This manifested in two ways: firstly as emotional issues such as depression and low self-esteem resulting from being overweight or obese and unhappy about it, but also in suggestions that emotional issues may underlie the weight problem in the first place. In relation to the first concern, the risk of uncovering mental health problems (which were largely seen as inevitable in overweight and obese patients) were one reason for HCPs being reluctant to bring up weight with patients as a cause for concern. If such issues did present they needed to be dealt with there and then, and that might be another barrier to bringing them up.

“and it is taking the lid off a can of worms, sometimes. And if you do, if there’s someone where obviously, having brought it up it obviously is an issue, you have to deal with it there and then. You can’t say “oh, would you like me to weigh you?”. “No because I know I’m horrendously overweight and it’s a huge issue for me”, and burst into tears. To say “well, why don’t you make an appointment with the nurse for some dietary advice”, then leave the room. Yeah, you can’t do that.” (GPO4)

There was often a sense that ‘I am not equipped’ to deal with those kind of issues, that their medically focused training had left them unprepared. Further, with patients in general and adolescents in particular, many described a worry that bringing up weight with a patient would somehow legitimise any psychological concerns the patient may already have had about their weight and appearance, so that those would manifest more strongly. This again relates to the way weight was described as ‘the elephant in the room’; once it had been mentioned it was made unconditionally real, which was seen as being potentially very (emotionally) damaging.

“I wouldn’t feel that I was skilled to be able to do that in such a way it might not harm their body image and how...you know, so I think I would have to refer them on to somebody else that would understand that sort of thing much better than I do. Because I think they’d need a lot more support and other sorts of specific interventions that I don’t think that I would be able to give in this sort of set-up. I mean I’m assuming...I’m probably talking about someone who was very overweight. Ehm...but sort of psychological issues, and sort of reasons why they were so overweight might need to be addressed and that might open up a whole bag of worms that I wasn’t reckoning on.” (PN04)

This reinforced the necessity of finding a way to bring up weight that would be non-offensive and as focused away from appearance (and towards health) as possible, which is why medical associations and something done as routine were seen to be helpful.

As well as the potential outcomes for emotional health from being overweight, many HCPs also alluded to the fact that underlying psychological problems might be the antecedents to the weight

problem in the first place. This was something that was perhaps seen as even more problematic, since getting to the bottom of, and successfully addressing, the weight problem would then be something that required intervention on a deeper and more psychological level. Several of the HCPs mentioned the need for understanding 'where the patient is coming from' and what is going on in their life in order to be able to manage the weight effectively, however most questioned their own ability to do this if emotional difficulties were underlying the weight problem. Again, the HCPs identified their skills and capacities almost exclusively in terms of managing physical health complaints; addressing psychological problems was seen as risky and outside their remit for the most part.

In contrast to the situations where weight was considered to be an issue that would bring almost inevitable emotional consequences for the patient, HCPs also somewhat paradoxically described a sense that overweight has been normalised to the extent where people neither recognise nor are concerned about their weight as problematic. This normalisation was seen as something that had gradually occurred over the years as overweight became more common. In this way, the increased visibility of overweight individuals in terms of incidence paradoxically was seen to lead to a decrease in visibility in terms of something that stands out.

"Whereas I don't think it was acceptable...if you go back 10, 15 years, longer, you didn't get fashionable clothes in big sizes, if you were above a size 18 it was tents and tracksuit bottoms and things, whereas it has become more socially acceptable, you're allowed to look pretty and have nice things and wear nice clothes, and it's not...people don't...tut at you in the street I don't think for being big anymore, whereas some time ago there was a lot more societal condemnation." (GP04)

This was problematic to the HCPs for two reasons. Firstly, it meant that people's motivation for losing weight was not high enough, and secondly, there was a concern about problematising something that patients themselves (and relating to young people in particular) had not been overly

concerned about. This normalising was exclusively seen as something negative in that it prevented patients from taking action on something that could have potentially negative consequences for their health, and because it made the job of the HCP harder by resulting in less motivated and engaged patients. With regards to adolescents, there was also the worry that they would not be learning the habits to look after themselves for the future if they did not see weight as a problem in the here and now. To some of the HCPs' this trend in society at large had led to them seeing themselves as needing to take on a role of guardian against the problematisation of weight; for making clear that being overweight or obese is not acceptable from a medical perspective even if it does not lead to emotional problems because of appearance. Fitting in this role in a context where discussing weight with overweight and obese patients was so difficult, and where most questioned the relevance to their professional role, was however problematic.

As well as a normalisation of larger sizes being seen as being a result of a larger population in general, HCPs also described a certain amount of normalisation within certain families where the tendency was for a large number of the members to be overweight or obese. Thus, patients would justify their own weight as resulting from coming from a large family, and therefore their weight was normal to them and within that context.

“For lots of them it doesn’t seem to be a huge problem for them, and certainly there are some people who come from very huge families. “But my mum is big”. Yeah, well that’s because you’ve both got the same social factors driving your obesity, but they don’t see it. It’s natural. It’s natural and acceptable, it’s ok.” (GP04)

This was considered a particular problem when dealing with children and young people, as getting parents on board to recognise weight as problematic might be difficult if parent expectations of children would be that they would be larger than average.

Patients protecting the self

As well as preventing some people from seeing themselves (and/ or their children) as larger than would be considered healthy, the way HCPs talked about patients using the 'large family' argument as a way to justify their own weight suggested it may also be used as a way to protect the self. It was evident that a large part of the reason HCPs were reluctant to bring up weight with patients, whether adolescents or adults, was because they perceived that their patients would see it as an attack on the self.

"if you do try and bring it up as a health promotion thing people are often very, very defensive. You know; 'I want to be like this, this is my choice. Who are you to tell me that I can't be how I am and who I want to be?'" (GP04)

This would particularly be the case when there was no clear medical reason for addressing weight, in which case talking about weight might be seen as something that was done purely because of the way a patient looked. It might also be considered a criticism of a particular lifestyle, so that both what the patient are and what they do might be perceived to be under attack. In relation to children and young people this was made more complex in that the attack was often seen to be not just towards the overweight/ obese patient themselves, but also their parents who might feel (or be perceived to be) at blame. In this way, the bringing up of weight by a HCP was seen by some to be a criticism of their skills as a parent, and consequently an attack on their parent self. Using the argument of coming from a large (in terms of weight) family was one way the HCPs saw patients defending themselves against such attacks; by removing personal responsibility patients might feel protected, but it also impacted on the relationship between the HCP and patient, making collaboration over weight loss harder.

At other times, the protection of self manifested in denial from patients with regards to what their weight-related behaviours were like. Several of the HCPs recounted instances where patients claimed to be living on salads, or eating next to nothing, when this was obviously not the case.

“Often the parents will say this, you know “oh well, my parents were big so my child was big because of me, that’s just the way it is”, you know... and then you also get others who try to tell you that they live on lettuce leaves. They eat nothing. You know, “we don’t eat much”, you know...”we hardly eat anything...we live on salads at home”. Yeah. You get this quite a lot.” (PN03)

HCPs also described similar instances where parents when prodded further about the exact content of diets would relent and acknowledge that what they had claimed to be feeding their children was not an entirely accurate representation. In this way, the HCPs felt that the ignorance over own (or child’s) diet was not about knowledge, which was often sound once explored further, but in a tendency of patients to exaggerate or underestimate in order to fool both themselves and the HCP.

“Oh he only eats chicken. He only eats chicken and vegetables. I don’t know why he is so fat, he only eats chicken and vegetable”, which on the face of it you think, ‘Oh yeah’. But no he eats chicken nuggets and potato smilies. ‘He only eats chicken and fish’, no he eats breadcrumbs. Vast amounts of batter and breadcrumbs. That’s not what chicken and fish mean. Chicken and fish don’t...’Oh no, I know that really’...” (GP04)

As an extreme case of protecting the self, one GP referred to what she saw as an inability of parents to have their children dislike them. Thus she described the feeding habits in families where children’s personal tastes would go unquestioned and be catered for rather than risking alienation and upset from the child should the parents insist on different dietary habits. Similar themes were picked up by another GP who talked about the difficulty as a parent of balancing ‘getting children to eat *something*’ versus insisting on healthy foods. Thus these practitioners saw a certain uncertainty among parents regarding their own worth being tied up with children’s responses to their actions. If

an unhappy child is seen by the parent as reflecting badly on them, placating would be easier than maintaining standards.

“She’s [mother] doing alright, she sort of took her lead from him. But it did take a bit of talking, you know, to mum saying “look, it’s not he thinks you’re bad, or what you are providing isn’t right, it’s just he needs to have less of the good stuff”.” (PN02)

Patients as partners

Because of the nature of weight as being something for which the necessary change needs to come from the patients, there was a certain sense of lack of control in relation to weight management consultations among all the HCPs. Even in instances where a more typical medical model might be assumed, such as where weight reduction medication was utilised, a substantial proportion of the control regarding successful outcomes still lies with the patient. This makes weight management a type of consultation where the outcome is very much dependent on a collaborative effort between the HCP and the patient, in which they both have a part to play.

“I see more of sort of saying to people, you know, “have you thought about doing something about your weight?”. You know...if they have come in for something else, and if I get a sort of positive response, and if, you know, you can then get into a dialogue about it, then having some options that you can then put to them and see which one they like the sound of.” (PN04)

It appeared from the way HCPs were talking about this however, that this sense of collaboration was something they saw themselves as advocates of to a much greater extent than their patients did. In a way, the way they described patients was often much more reminiscent of a traditional medical model, whereby they saw patients as often expecting consultations to follow along the traditional

diagnosis – treatment structure. This was particularly evident when talking about more medically focused treatments such as medication or surgery.

In contrast, one practice nurse described her work with an obese adolescent patient as very much a collaborative effort, where she had worked (together with the dietician) with him to make sure both he and his mother had got as engaged in the process as she was. The way she described how this partnership had been achieved, through negotiation and in-depth discussions (particularly with the mother), was echoed by the other HCPs as well when they talked about the need for ‘getting patients on board’. This suggests patients that need coaxing and convincing, and a process that is mostly orchestrated by the HCP.

Distribution of control

With the shared responsibility implied in the partnership process, a certain loss of control on the part of the HCP is inevitable. This was most evident when practitioners perceived patients as not playing their part or doing their bit in the partnership, for example by avoiding personal responsibility as a form of self-protection. Those situations were often talked about in terms of ‘you can only do so much’ or ‘it has to come from them’.

“You can offer them what there is, you can support them, what is it that you need to get back on track or to change or to whatever. And...but you can’t sort of make it happen. It comes down to them in the finish. But you can do your best.” (PN02)

This relates back to how HCPs saw themselves and their role in weight management consultations; how they often perceived their responsibility to be as a *facilitator of change* rather than the expert with a solution to the problem.

“And I think that what I do, certainly what I do is, what I do with weight loss, although I’ve got aids and I do give advice, I don’t see the effective role is being information giver, I see it as being someone encouraging behavioural change.” (GP04)

In terms of partnership, consultations with adolescents were seen to differ from those with adults because of the need for creating not just a two-way partnership, but often one that involved a third party as well, namely parents. In fact, adolescents themselves were perceived by the HCPs as having little personal agency when it came to discussing weight in general practice - they were repeatedly described as being ‘brought’ to the consultation by their parents, who had been the ones concerned about the weight in the first place. The problem here was then more about how to redistribute power and involve the adolescent as a partner in the consultation to the same extent as their parent(s). This has implications for the distribution of control within the partnership as well, with some HCPs seeing a role for themselves in facilitating the shifting of control and responsibility for health from the parent to the young person, as part of the developmental process:

“It’s like with the asthma, cause that’s obviously another big thing, I like to move over from the mother having the control to the child having the control. It’s just the same. You know, making sure that the child has the inhaler, and has the responsibility of when to take it, and knowing when...having all that information. Taking control. It’s exactly the same thing. ... Probably from the age of about 9 or 10. You know? And probably it’s the same sort of age for diet as well. That they should be taking responsibility for what they’re eating at that sort of age.” (PN03)

However, the concern was not necessarily always regarding parents standing in the way of adolescents being equal partners in the consultation process, but also a recognition on the part of the HCP that they may have to play the role of impartial third party. HCPs described situations where parents felt their adolescent children would not listen to them, and refused to follow their advice

simply because it had come from them as parents and the individuation processes taking place meant a natural resistance towards following parental advice.

“and sometimes they’re quite glad that you’ve... brought something up, because it may be that they’ve been battling and trying to persuade their teenager that...their diet isn’t...they’ve had a few, you know, mum is in complete despair and not really knowing what to do.”(GP01)

As a HCP, in order to facilitate the partnership and enable a sense of control in the patient, it may be necessary to frame consultations in such a way that patients can take ownership over the bringing up of weight. This also absolves the HCP of a certain amount of responsibility, perhaps lessening the fear of causing offense if weight is brought up against someone’s wishes.

Summary of theme 2

This second theme illustrates the perceived difficulties of HCPs in bringing up the issue of weight with overweight and obese patients. The HCP accounts showed a reluctance to bring up issues that were not the presenting concern within a consultation, for fear that it might be seen as meddling by the patient and because to discuss something outside of what the patient had attended for was not seen as good practice. This demonstrates the HCP views that consultations need to make sense, to both the patient and the HCP. In this way, the HCPs interviewed here saw consultations from a patient-centred perspective; that what they wanted from the encounter mattered. At the same time, HCPs also described how the desires of patients were frequently not obvious, and so in order to be an effective practitioner the HCPs had to try and gauge the mood of the patient, almost being able to read their mind from minimal clues and body language. If this reading failed and practitioners brought up weight when such discussions were not wanted, patients may perceive criticism and an attack on the self. Further, the normalisation of weight was also seen to cause problems for HCPs in

that it rendered some patients oblivious or defensive regarding their weight. Such justifications made engaging patients as effective partners in the consultation difficult. Partnerships were seen as essential because of the large amount of control held by the patients in weight management consultations, which meant that any change for the better had to be actioned by themselves, rendering the HCP almost powerless to effect change.

Theme 3: Managing adolescents

Although many of the issues that were described by health care professionals in relation to managing patients overall also applied to adolescents, or in some cases had particular implications for the care of adolescent patients, there were also a whole array of issues that related specifically to adolescents as an age group. This applied both to matters that directly impacted on how well HCPs felt they could care for adolescent patients in weight management consultations, but also contextual factors they felt were important to this age group and which shaped their ideas of what adolescence is about, and how weight concerns might be experienced by them.

The nature of adolescence

This first theme represented the ideas of HCPs in general of what adolescents are like. While always talking about the need to recognize each patient as an individual, it was also clear that all of the HCPs had similar ideas about the nature of adolescence based on both personal experience and to some extent on the common stereotypes of this age group. These ideas influenced several aspects of the care they felt they could provide for overweight and obese adolescents, from how young people would relate to their weight in the first place, to how the issue of weight might be approached in the consultation, to considerations for sharing of control and responsibility.

Living in the here and now

One aspect of adolescence that most of the HCPs brought up was that of the tendency for young people to be living very much in the present, and unable to take a long-term view on health and other issues. This was manifested in how they talked about adolescents as having the knowledge regarding the impact of obesity on health, but not being able to connect that future possibility of ill health to their life right now. Their experiences of adolescents were as being unconcerned about what would or might happen tomorrow, and not being able to plan their actions with that long-term view. Consequently, the HCPs did not believe health-related outcomes to be particularly pertinent for young people when considering weight.

“I think for young people health issues in the future is a very nebulous concept. I think it’s very difficult for young people whatever they’ve got going on to see that they will still be the same person when they get older.” (GP04)

Because those health outcomes were located so far off into the future, and not something young people would see very often among their peers, HCPs also saw adolescents as adhering to the ‘it will not happen to me’ attitude. Young people were seen to be biased in their assessment of risk to themselves from any potentially risky behaviours they were engaging in, so that they could not connect the possibility of ill health to themselves. The HCPs discussed this as something universally inherent in adolescents, whom they saw as unrealistically optimistic regarding their chances of ‘getting away with it’. They drew parallels with other risky (and stereotypically teenage) behaviours such as unprotected sex (‘even if I am overweight I will not get health problems’) and smoking (‘I can quit/ lose weight whenever I want’).

“I think that’s you know the same as a lot of things with young people, “it doesn’t happen to me”, it’s a bit like getting pregnant. You know “I’m not gonna get pregnant if I have unprotected sex, cause you know, I’m only 13, 14 so it won’t happen to me”. It only happens to other people. A lot of them do see it that way, that “ok I’m fat but I probably lose it when

I'm 20" or something. "It's not going to affect my health". It's, you know their way of thinking, they're not mature enough to realise it can happen to them as well." (PN01)

Although this perception of young people might appear negative in the sense that they often felt that this inability to look and plan ahead got in the way of taking action for reducing weight, most of the HCPs talked about this as something inherent to adolescent development, something they saw as normal and therefore not necessarily negative even if it might cause certain problems. There was no expectation or demand that young people 'should' be different in this respect. However, because negative health consequences were believed to be seen by adolescents as remote and unlikely, the HCPs felt that using health as an incentive would not be very effective with young people.

The one exception to where the living in the here and now was seen as something beyond normal development was in a certain sense that young people today had greater expectations of personal satisfaction, and inability to delay gratification. This was seen as something that has developed as part of the changing modern life, where things like video games, advertising and accommodating parents were all seen as having a part to play in making young people want things 'now'.

"I don't know if people have shorter attention span than people used to have, or whether as I've gotten older my attention span's grown so young people's seem shorter. I don't know which way round it is, but certainly you look at young people and it's now quick, immediate, go, go, go, and I think it is different to when I was young. I think there is a societal change about speed of gratification, must have, must do..." (GP04)

This inability to delay gratification was seen to impact on weight management in two ways. First, it was the view of HCPs that adolescents would be less likely to delay the gratification of being slim by foregoing less healthy foods in the here and now. The immediate lure of palatable, but calorie-dense, foods would take precedence over the prospect of being a lower weight tomorrow. Secondly, the HCPs felt that this inability to delay gratification would cause difficulties for young people in that

weight loss is a slow process. They considered young people to be after a quick fix, and believed that they would get impatient if they did not see big changes in a short space of time and would therefore grow despondent and give up.

The emotional time bomb

Across all the interviews, HCPs related a view of adolescents that presented them as inherently emotionally volatile and vulnerable. Young people were seen to be moody and easily upset in the sense that any little thing might be perceived as criticism that would trigger an emotional outburst. In the minds of the HCPs this positioned adolescent patients as particularly vulnerable, and needing to be treated with particular care and sensitivity. This emotional volatility was framed in terms of normal adolescent development and therefore seen as inevitable and unavoidable, and part of a larger view of adolescence as being a 'difficult time'. In practice, this meant a general experience of adolescent patients as uncommunicative on the one hand, but prone to emotional reactions if things were discussed that they felt sensitive about.

"A lot of them I haven't known cause they've been well so they don't come to the doctor. And then when they do, they are very difficult to talk to. Or they just get upset, you know, they just start crying about it, or..." (GP02)

As described above, none of the HCPs perceived adolescents as worrying about weight because of its potential impact on health. Rather, they all felt that young people worried about their weight because of the meaning it had for their looks. The HCPs talked about body conscious adolescents whose self-esteem was severely impacted by how favourably they rated their own attractiveness compared to others, and being overweight or obese was thought to be perceived very negatively in this context. Because of this, bringing up weight as a concern with an adolescent patient was a frightening prospect for the HCPs. In the absence of a related medical concern, to talk about weight

was to acknowledge that the weight had been seen, and therefore to imply that it mattered. The HCPs felt that by doing this, they would cause damage to the young person's self-esteem and body image, and therefore inflict actual harm. To some, this fear extended to worrying about pushing young people into eating disorders, but mostly the fear was related to the purely emotional consequence in the here and now.

"You know, certainly for some teenagers it could, it's a really big issue and problem, the, the emotional side of it, and you know, it affects all other aspects of their life, really. Certainly some teenagers with self-harm and that kind of thing certainly weight can be a factor in that." (GP01)

There was a sense that the adolescent emotional volatility needed to be kept under guard to make sure that something was not said or done in the consultation that might set off a reaction in the adolescent that might be difficult to manage. There was great uncertainty among the HCPs as to how much damage control they could actually do once the reaction had been triggered in the first place. As well as causing immediate harm, impacting on adolescents' self-esteem was thought to have potentially long-term consequences. Because of the importance weight was seen to have for young people's social standing in terms of attractiveness, HCPs were concerned that saying something in a consultation that could set off an emotional reaction might extend to that individual losing confidence in social interactions, leading to difficulties with relationships and other problems for the foreseeable future. In this way, the HCPs were concerned about setting off a reaction that they would not be able to manage, and which would run away out of their control very quickly. They felt a great amount of responsibility for how their interactions may shape the adolescents' life along the way and for the future.

“I think it’s about going away, you know, you walk out and think “the doctor’s said I’m really fat. Does that mean they think I’m unattractive, does that mean they think I’m sexually unattractive? Does that mean I’m never going to have a boyfriend, does that mean something bad’s going to happen to me now? Does it mean they think I’m lazy? Does it mean they think I eat too much, do they think I’m greedy, do they think I’m weak willed?”. I think that introspectiveness, much more a function of adolescence than adulthood. Adults will be “the doctor’s said I’m fat, well I know I’m fat. Fine.”, and walk away with it. But I think adolescents...every, I suppose they’ve had less experience, every significant emotional experience hits them bigger and harder” (GP04)

An age of rebellion

The stereotype of the rebellious adolescent was also a theme visible in these HCP interviews. They talked about their roles as adults in this relationship, and how they might serve the purpose (for the adolescent) of providing something, an authority figure, to test their developing autonomy against. In relation to weight, this was discussed in terms of young people going against that which would be asked or expected of them (like eating healthily and doing regular exercise) and establishing their independence by doing what they desired instead. Like living in the here-and-now, rebellion was seen as a normal part of adolescent development, and at least some of the HCPs talked about it in positive terms, something necessary for young people to break free from their dependence on adults and forming their own individuality.

“It’s an age of rebellion is it not? And they’re finding their feet, they’re pushing the boundaries, they see how far they can push you as a parent and whatever. Ehm...they are setting their own little boundaries and learning from their mistakes, and you can only learn from getting up and doing stuff.” (PN02)

In general, the rebelliousness of adolescents was seen to form a barrier to effective consultations. Although the HCPs recognized that rebellion would be more likely turned against parents than

against themselves, they nonetheless felt that as adults, they represented at least part of that which adolescents would be rebelling against. Because of this, they felt that to engage adolescents as partners in a weight management project would be more difficult than working with adults, as there would be more resistance and stubbornness. One GP however saw potential in adolescents' propensity for being rebellious. That was considered a possibility at least if the patient was from a home where less healthy eating and exercise practices were learnt from parents in the first place, and adolescent rebellion thus could be an opportunity for getting them to change their eating habits in the right direction:

“So you have to then pick up on what adolescents like to do, be different, and probably there, you’ve got to get them then and motivate them to eat differently to the parents.” (GP02)

Because adolescents tended to mostly attend consultations together with their parents, many of the HCPs described witnessing such power struggles occurring during the consultation. This was reflected also in how HCPs described adolescents as frequently being ‘brought’ to the surgery, more or less against their wishes. This was talked about for consultations in general, but particularly where weight was concerned. It was the HCPs experience that the adolescent patient and their parent(s) frequently had very different views of what was actually going on, or where the blame for particular behaviours lay. Adolescents were often described as being embarrassed by having been brought in to speak to the doctor, and as being less communicative because of it. Several of the HCPs described arguments or battles playing out in front of them during some consultations with adolescents.

“When they do come to primary care they tend to come with their parents and they’re often embarrassed or cross with their parents about if weight is discussed. Or in fact, bring up pretty much any health issue.” (GP03)

“Yeah, sometimes you can even end up having a bit of a ding-dong battle going on here, I’ve known that happen with the parents saying one thing and the child saying another. I’ve known that happen. You know, ehm...yeah, it can often get quite, quite difficult but you can

have a child that just doesn't want to speak at all and mother's brought them in so...that's slightly harder to handle with, you know, the mother's decided and the child is really not interested at all." (PN03)

Because such fraught relationships were frequently observed between adolescent patients and their parents, some HCPs saw it necessary to try and mediate in such circumstances, or to find a way to talk to the adolescent on their own, without at the same time alienating the parent. This kind of balancing act was described by one nurse:

"I mean, you can always ask and say you know, "would you like to talk to me on your own?" or, you know...you can offer it, but I think you've got to be careful cause you don't want to get the mother off side either, so I think you got to try initially to try and talk together. But see if you can get the child to open up a bit initially and have them there together, because you don't want to upset the mother." (PN03)

Adolescents as victims of their social environment

This theme related to how HCPs often saw the problem of obesity having manifested in the young person's life. This wider social context was important because of its implications for the obesity epidemic in general, and also on how the weight management consultation was managed; the things that needed taking into consideration, and which outcomes could realistically be expected.

Firstly, there appeared to be a feeling that 'modern life' and the way things had changed over the last couple of decades put young people now at much greater risk of obesity than had been the case before. This was facilitated through things like greater availability of unhealthy foods, fewer opportunities for physical activity (both through the removal of outdoor spaces that young people had traditionally used for recreation, and through the diminishing importance of school sports and PE), and greater focus on sedentary leisure pursuits like TV watching and computer/ video games.

This trend removed some, or most, of the responsibility for weight away from the young person

themselves, and onto these contextual factors. In some instances it was felt that the young person's immediate adults (e.g. parents) had failed them by not safeguarding against such factors, but mostly the blame was seen to lay with society and where it was heading.

"Ehm...so I don't think really, you know, it's not their fault, it's just modern life I think, just our diet is too rich if you like for the amount of exercise that they get." (PN04)

"...and the other factor obviously is the exercise, the fact that teenagers historically used to exercise and now they sit and play x-boxes and things." (GP03)

Modern life was also seen to have brought changes within the family that made healthy eating more difficult for young people, such as the working of both parents and a consequent greater reliance on convenience foods. Young people were seen to be out of the control of parents more frequently than had traditionally been the case, with the consequence that they took on responsibility for feeding themselves to a greater extent than young people in the past. However, even when parents did take direct responsibility for providing food, this modern life was seen by some to result in less healthy eating habits.

"The culture is, we're all working...years ago, you had mums at home, they did the house work, they took care of the kids, they made sure the dinner was ready...they may do a little bit of a cleaning job but that was it, the home was their thing. ... Nowadays, mum and dad both work. ... They don't want to start cooking so they open the freezer door and out comes a processed package of some kind, into the microwave, out onto the table, and everybody's in bed by eight o'clock fast asleep, ready for the next day, you know." (PN02)

Because 'modern life' was something that affected everyone across the board, it was seen to hold a large part of the responsibility for weight gain not just in adolescents but in the population at large. Because of this increased propensity for overweight, as discussed above, overweight and obesity was seen by the HCPs as becoming increasingly normalised. Therefore, modern life was also

considered to have a detrimental impact on the susceptibility to obesity in young people by making them less likely to see higher weight as abnormal. However, beyond normalisation as an effect of there being more overweight and obese individuals around to compare yourself against, there was also a sense that the campaigning against the stigmatisation of heavier individuals had resulted in a culture where it is no longer acceptable to chastise them. This made it more difficult for HCPs to address weight in the first place, and was also seen in relation to the fat acceptance movement which may lead to a reclaiming of heavier body weights as desirable:

“A lot of them tend to have bigger friends, a lot of the bigger girls. And certainly in family planning when they come in, a lot of them come in twos or threes then you find that they’re all a similar size and weight. ... Big is beautiful maybe, I don’t know.” (PN01)

“But as a group I think a lot of teenagers don’t see it as a problem at all, particularly. If all of their friends are larger then it’s seen as acceptable and normal and they’re not worried. It’s more when you’ve got the one overweight teenager with lots of slimmer, slimmer friends, yeah, that they find it more difficult.” (GP01)

However, beyond ‘society’ and ‘modern life’, young people were also seen to be the victims of their own families, in particular families where being big was seen as normal. The HCPs talked about overweight and obese adolescents as victims of their families both in terms of learning unhealthy eating and exercise habits which would predispose them towards heavier weight, and also as making it difficult to implement weight loss strategies. It was the experience of the HCPs that heavier parents were less concerned about the weight of their children, and therefore less likely to support weight loss interventions. Further, parents that were heavy themselves tended to see overweight as inevitable, something that ran in the family, and therefore be less open to the possibility for change.

“Unless they’ve got parents that are motivated to help then they’re fighting a losing battle aren’t they. It’s all very well saying “cut out the biscuits and crisps”, but if mummy’s still buying them for everybody else then you have to be all controlled to stop yourself eating.” (PN01)

“Often the parents will say this, you know “oh well, my parents were big so my child was big because of me, that’s just the way it is”, you know...” (PN03)

While this suggests that HCPs saw some parents as simply lacking knowledge about healthy lifestyles, others were perceived to over-feed their children despite ‘knowing better’. Some of the HCPs talked about this in particular in relation to parents giving in to the wishes of their children and letting them eat certain things because they wanted them, despite knowing that it might cause weight problems further down the line. Parents not being able to enforce healthy feeding, but rather giving in to the wishes of children when younger were seen to be another way that adolescents had become the victims of their upbringings, denied the opportunity to learn how to lead healthy lives.

“Yes it’s difficult because they’re going through big changes, big hormonal changes, big growth changes, both emotionally as well as physically, and it’s a difficult time. But if you don’t set those standards then, and look at the food issues, and try to encourage them to look the healthier way of going, then you’re setting up their health, you know, problems in the future.” (PN02)

The other major arena where young people were seen to be victims of their environment and failed by the adults that were in charge of their care was schools. However, there was a distinction between schools and families in ways that young people were perceived to be failed. While for families and parents, the HCPs talked mostly about unhealthy eating habits, but with regards to schools their main concern was a failure to provide opportunities for physical activity. Thus the HCPs appeared to see it as the responsibility of the school to a greater extent than the parents to make sure young people would receive adequate exercise. Schools were failing in this in their opinion by reducing physical education lessons and not prioritising school grounds that would encourage activity and active play.

“I just don’t think they do get enough opportunity to exercise quite honestly, in the modern world that we live in. I don’t think they necessarily get regular sport at school, I don’t think that they necessarily get a lot of outside school sport provided at the school or elsewhere.”
(PN04)

In contrast, in terms of diet many of the HCPs perceived schools to be a positive influence on young people, to the extent that they would even be encouraged to re-educate parents on healthy eating. They saw cookery classes as a positive way for adolescents to learn, independently of parents, how to look after themselves and their health. However, although this teaching had ultimately come from school and thus was provided by responsible adults in charge of caring for young people, one of the GPs reflected on the reversal of responsibility as potentially undesirable:

“But I just think it’s...it’s a bizarre world where children are telling parents “No don’t give me sweet things cause it’s not good for me”.” (GP04)

Adolescents in the consultation

Most of the HCPs described only occasional contact with adolescents as patients; they were seen in general to be a group that were well and therefore tended to not attend general practice very often. At the same time, many practitioners also conveyed the feeling that general practice was not a particularly teen-friendly service. Many thought that it might be an intimidating setting for young people and one which was not best set up to fit their needs. The difficulty in bringing along a friend to the consultation, inappropriate opening hours or general stigma of going to see the doctor were mentioned as possible barriers for young people needing to attend. Practitioners also referred to stereotypically adolescent behaviours like living in the here and now and not planning too much in advance as perceived barriers for young people to use their services. Because of this, some felt that alternative services would be better for this age group, services that could fit easier into young people’s lives.

“And they can go with their friends [in school based clinics] and, you know. Here, when they come on their own, it’s a bit nerve racking, sitting out in the waiting room with lots of people coughing and spluttering, thinking “I’m not ill really, why have I come to the doctors”, you know, they don’t see themselves as ill. Whereas in school there are lots of people like them, they could, you know access it.” (PN01)

In contrast, in line with fitting in with the needs of the adolescent patient themselves, one nurse in particular described the set-up she had organised in order to be as teen-friendly as possible:

“I like that drop-in. I always tell them, I’ve always got time. You come in I fit you in. You chat about whatever it is you want to chat about. Ehm...you pick up a lot of other problems along the way, not just the dietary issues.” (PN02)

In terms of outcomes, almost all of the HCPs judged a successful intervention with a young person as one where the patient had lost weight. Even so, there was a focus among some practitioners to stress the importance of behaviour change above weight loss; of seeing the need for establishing healthy habits as more important than actual weight loss – possibly because of the importance they put on adolescence as a portent for future health habits. Thus, intervention with an adolescent now was seen as important in large part because of the impact it would have on their future health. One of the nurses put particular emphasis on the impact on emotional well-being, and described seeing positive changes in this respect in young people that lost weight. To her, increased self-confidence and a regained sense of control were the most important outcomes in such cases; again much more valuable than actual weight loss.

Because of the need for behaviour change that is for the most part dependent upon the individual, the HCPs described the necessity of establishing relationships with their adolescent patients, of working with them and making sure they were comfortable with the situation. It was recognised that the health care setting might not always be seen to be particularly ‘teen-friendly’, and that some

young people may feel concerned or intimidated by attending the practice and speaking to a HCP. It was felt that having such negative experiences might lead to the adolescent associating any discussions around weight with feeling awkward or intimidated, which in turn might lead them to avoid the subject instead. Thus an important part of the HCPs' role would be to alleviate any potential fears.

“He was allowed to talk out his worries. Ehm...and I was able to say to him “look, it’s nothing for you to be concerned about, she’s [the dietician] there to help, you tell her what the sort of things that you like, come in with a list”, you know, “this is what I like; how do I make it healthier?”.” (PN02)

With adolescents to a greater extent than adults it appeared that HCPs saw the need for grabbing opportunity and working with something once they had established a connection with a young person. Possibly because this type of connection was seen as something elusive with adolescent patients, and something that you had to work quite hard to achieve, once it had been found it was important to cultivate. Related to this was a sense of not letting obese and overweight young people just slip by, but that establishing a connection and gaining trust was a crucial factor for successful partnerships. This is also why the initial bringing up of weight as a problem, as discussed above, was experienced as so problematic – it was seen to be an easy way to break trust and alienate the adolescent again. This was why being able to read patients and judging the right time to step in was so important.

“Ehm, so you talk to the children that come through that I see...ehm, never really book in because they’re overweight, they book in for other issues. And while you’re there, if you can gain their trust, sometimes they will ask you. ...And he took that opportunity to, cause we started just chatting and got on quite well and perhaps he felt comfortable bringing up that issue. Another day we might not have got on so well, he might not have brought that issue up” (PN02)

Managing independence and responsibility

Although all the HCPs talked extensively about building trust and developing partnerships directly with the adolescent, they were also deliberating over how best to include parents or carers in the consultation without alienating either party. Many of the HCPs mentioned the importance of adolescence as a time when increasing autonomy and independence develops, and the impact of this greater freedom and control for the types of behavior that may impede or facilitate overweight and obesity. This was seen to be hugely important for how the family dynamics were managed, since it might be that choosing unhealthy options would be a sign of the young person's individuation.

"But how much responsibility, that depends on the individual child, and also how comfortable the family is with giving the child the responsibility. ... I'm sure to an extent the adolescent will still carry on with the patterns they've picked up in childhood and being younger. But maybe that's a time when some children who've had quite a good diet when they're given more freedom, will then, their diet will deteriorate. You know when they're off to school with their dinner money and can pick through what they want." (GP01)

"I mean, by and large up to about 9 and 10 all your calories come via your parents, but once you get to sort of 10+ then people can start topping up their calories from other sources, so even if your parents are only giving you healthy food at home you can still, if you've got access to money so you can top up with other stuff." (GP03)

This was the stage at which some of the HCPs saw parents starting to 'bring in' the adolescent children, to have someone external to the family unit talk to them and back up what they themselves had been saying. In this way the HCPs felt that they were expected to take sides with the adults and back up parental views and practices. In contrast, they appeared to see their role more as a mediating one between the adolescent patient and their parent(s), where rather than taking sides they wanted to engage the young person directly to start building an independent relationship with them. This was sometimes seen to be difficult to achieve if parents had other views as to the

autonomy of their child, and this appeared to be the case particularly for parents who 'brought' their children to the practice.

The HCPs divided up adolescent overweight and obesity into two distinct categories with regards to its origins. Either, it was to do with being brought up in a family that had habitually poor eating and exercise habits, in which case the parents as well as the children tended to be heavy and 'good' habits had never been modelled or established. In these cases, adolescents were seen as the victims of their parents, and establishing an individual relationship with them was considered important because it might take them out of the negative influence of their family to some extent. In the second scenario, adolescent weight problems were seen to start during adolescence and as a direct consequence of the young person executing their newfound freedom and control to engage in behaviours that were not conducive to maintaining a healthy weight. In these cases, young people were seen to be more the victim of society and the obesogenic environment, and to engage with them individually was considered a possible way to reinforce their independent status and therefore gain their trust. In the long run, that might result in individuals that chose healthy habits for themselves.

"I don't know what the research says about where people's dietary patterns come from, but I would imagine it is choices you make during adolescence and when you start to prepare food for yourself and buy food for yourself as an individual, rather than being catered for entirely by other people's choices. As a child that actually fixes what you do from now on. So I suppose you can hypothesize that by encouraging people to make healthy food choices during adolescence, you're encouraging a lifetime of sensible eating." (GP04)

Summary of theme 3

Adolescents in general were described by these HCPs in rather stereotypical ways; as emotional, rebellious and living in the here and now, thus being largely unable to take on board the future health implications of weight. All these perceived characteristics made consultations with

adolescents difficult, and meant that HCPs felt unsure how to best communicate with and engage adolescent patients. With regards to weight, although they acknowledged the greater amount of control adolescents would have over things like eating and exercising, and many believed such habits worsened during adolescence, the HCPs interviewed here did not hold adolescents themselves responsible for weight gain. Instead, they saw them very much as victims of their environment; either in the form of growing up in families where healthy food and exercise habits were not endorsed, or by the obesogenic environment in general. At the same time, when it came to responsibility for weight loss, practitioners believed adolescents themselves had to take on a large portion of the control for making that happen, and found the need for acting as a negotiator between adolescents and parents as one of the barriers to weight management consultations. However, many also believed that adolescence is a good time to instil healthy habits, and that if change could be made at this age it would be more likely to be maintained for life.

Chapter discussion

The research undertaken here was conducted in order to get an understanding of HCPs' experiences of providing help and advice for overweight and obese adolescents. The data presented here identified a number of barriers and facilitators to adolescent weight management consultations, with issues that were specific to the adolescent age group.

This research shows that a majority of the HCPs surveyed believed that obesity in adolescence affects both current and future quality of life; that it needs treatment; and that adolescents will not usually outgrow their overweight. This anchored their views regarding adolescent overweight and obesity as an issue with health implications which need intervention. This supports the findings from a systematic review that found a general consensus among practitioners on the importance of treating obesity in young people (van Gerwen et al. 2009). With regards to their own role in such

intervention however, the findings from both the survey and the interviews provided a mixed and somewhat ambiguous view on adolescent weight management by HCPs. On the one hand, of those surveyed, three quarters of GPs and just over half of practice nurses said that they would offer weight management advice to overweight or obese adolescents even if neither they nor their parent had outright requested it. On the other hand, only a fifth felt well prepared to manage such conversations and fewer than half found it professionally rewarding. This fits in with the overall sense in the HCP interviews that to provide weight management advice is somehow part of their professional role (though not necessarily an obvious part), but that the aspects surrounding such encounters are complex and frequently problematic. The major barriers that seemed to hamper HCP intentions of addressing weight with adolescents fell into two categories: (1) How to fit such consultations within their professional practice in a way that is relevant and congruent with professional identity, and (2) how to manage such consultations without causing more harm than good to the adolescent patient.

Most of the GPs and practice nurses identified adolescent overweight and obesity as related to their professional practice to some extent. The most obvious reason for this was because of obesity's relationship with physical health complaints like diabetes and CHD, which in turn were conditions that appeared unproblematic to fit into the remit of what it means to be a health care practitioner. This is however where obesity in general, and adolescent obesity in particular, became problematic – while being a precursor to disease, but not being a disease in itself, HCPs felt it to be less relevant for them to deal with, particularly in young people where co-morbidities were often completely absent. However, this reluctance to discuss weight was not just because of their own feeling that general practice should be reserved for strictly biomedical, illness-centred consultations, but also because they felt that this is what their patients would be expecting. Thus, the problem in bringing up such issues was not just because they felt this to be in conflict with their own sense of

professional duty, but because they saw their patients as believing this was something that was outside of their remit, not what they would want or expect from a general practice consultation. Their reluctance to address such issues may be a way of protecting the patient-provider relationship, since a discordance in expectations between practitioners and patients can result in less favourable patient views of both the practitioner and the consultation (Krupat et al. 2000). However, the justification for avoiding such consultations was based in their own subjective assumptions of what their patients wanted, and HCPs may not necessarily correctly judge the expectations of their patients (Street & Epstein 2008). Research from outside the UK has shown primary care practitioners carry out weight screening with children and young people at a much lower frequency than recommended (Gerner et al. 2006; Goldman et al. 2004), and it is likely that this concern to provide the kind of care their patients are expecting is partly responsible for that. This highlights the question of what general practice is for; whether HCPs need to stick to the roles they have traditionally been assigned and provide just the service their patients expect from them or whether they are allowed to step outside of this role and into a sphere of life that may be considered private and not their concern. It also demonstrates the necessity for clear understandings between patients and providers, since assumptions about patients' wishes directly impact HCP behaviour in the consultation. The importance of strong patient-provider relationships that are characterised by respect and trust is well documented in relation to both patient well-being and treatment outcomes (Street & Epstein 2008), and by bringing up a topic the patient does not see as relevant to the medical consultation, such trust and respect may well be broken. Again, the way this related to adolescent patients was seen to be particularly problematic – partly because of the absence of physical co-morbidities, partly because of parental protectiveness over their children, and partly because of the adolescents themselves being particularly hostile to such interventions. This demonstrates how aspects of trust and respect may be perceived to be particularly vulnerable to violation in weight management consultations with adolescent patients, which acts as a barrier to forming successful partnerships with them in the first place.

Other research has found Dutch and French HCPs report seeing childhood overweight and obesity prevention as part of their role (Gerards et al. 2012; Franc et al. 2009), however the interviews undertaken in this study illustrate that this is not necessarily a yes/ no answer. Similarly, others have found that HCPs considered it their role to flag up obesity, but the role of the parent to actually manage it (Walker et al. 2007; Isma et al. 2013), while the HCPs in the current study did not see it as clear cut. It is possible that part of the reason for this is that the studies referred to above did not differentiate between children and adolescents (Walker et al. 2007) or addressed children only (Isma et al. 2013), but that when talking specifically about adolescents, HCPs perceive parents to have a smaller role than with younger children and see themselves as partly responsible for aiding the development of an autonomous patient-provider relationship with their adolescent patients. Research referring to younger children has found practitioners to say that they would only address the issue of weight as a problem if the parent had raised it first, or if the practitioner had specific health concerns about the child (King et al. 2007). In contrast, while only a small proportion of HCPs in the current study agreed that they are professionally well prepared to treat obese adolescents, the majority of GPs stated that they would offer weight advice to an obese adolescent patient even if not specifically requested, and disagreed that the best role for GPs is to refer obese adolescent patients. It is possible that this indicates a different approach by HCPs to weight management in adolescents than in children. This is supported by research from the US which shows that just under a fifth of HCPs reported that they would speak to the adolescent alone (without a parent present) about obesity while less than 1% would do so for children aged under 12 years (Jelalian et al. 2003). Further, several studies have reported HCPs perceiving parents to be one of the barriers to effective weight management consultations (Barlow et al. 2007; Edvardsson et al. 2009; Larsen et al. 2006; Gerards et al. 2012), with some parents not realising the extent of their children's overweight, indicating that although they may feel parents ought to be held responsible, HCPs do not always trust them to take on that role. In the current research, lack of parental involvement was seen as less of a barrier than patient involvement, perhaps reflecting the acknowledged smaller role for

parents in managing obesity in adolescence. Further support for this is found in that parental involvement was also seen as less of a barrier by practitioners in this study than in research relating to child as well as adolescent obesity (Story et al. 2002). Others have found parental involvement in actual treatment to be smaller for adolescents than for children (van Gerwen et al. 2009).

The HCPs interviewed for this study talked about adolescent weight management, where it happened, as a project undertaken with individuals, because it fitted that particular consultation at that particular time. The fact that few HCPs in this study had experienced adolescents coming directly to them to ask for help meant that opportunities had to be seized at other times, and is probably part of the reason why weight is only intermittently discussed with overweight and obese young people presenting in practice (Cretikos et al. 2008). This individual, opportunistic method of working with overweight and obese young people does not readily translate into a structured means of tackling the obesity epidemic on a population level, and that is also not how the HCPs viewed their role as general practice practitioners. To some extent this model of working fits with the principles of 'making every contact count' (NHS Future Forum 2012), but it was clear that the HCPs saw intervention at literally every opportunity to be unrealistic. Weight-related health promotion efforts were seen to be appropriate and worthwhile only to the extent that they fit in with what is already going on in a consultation or with a patient, thus adhering to the principles of effective communication in health care settings (Street & Epstein 2008). This demonstrates how the individual focus of the medical model does not necessarily translate into stigma and victim blaming; rather than focusing on putting responsibility for their weight on the adolescent, the HCPs viewed this individual focus much more from a perspective congruent with the patient centred care model of patient-as-person – that whatever intervention was going to happen had to fit in with what was otherwise going on in that young person's life. Thus it is more in line with the perspective suggested by Adler & Stewart (2009) that looks at finding a balance between the medical model and the public health model of obesity, and suggests the individual is responsible for their weight only if they have adequate resources to support them in the weight loss endeavour. Further, the HCPs did not appear

to hold overweight and obese adolescents very much accountable for their weight, but rather tended to see them as victims of their environment. It has been suggested that the presence of illness in an individual renders others as seeing those individuals as either victims or perpetrators (Herek et al. 2003), and although there is strong evidence that overweight and obese adults tend to be seen as perpetrators (i.e. wholly responsible for their weight) (Puhl & Heuer 2010; O’Dea 2005; Adler & Stewart 2009), the same could not be said for these HCPs’ views of adolescents. Most of them recognised that adolescent patients need to take on a great deal of the responsibility for *losing* the weight themselves, but this did not extend to responsibility for *becoming* overweight or obese.

Just as weight-related health promotion was seen as something that needed to fit individual patients, the decision to engage in such consultations in the first place appeared to be very much a personal project. The HCPs who talked about the need for weight-related intervention and felt that it was something that they would do, did so because it was important to them personally rather than something they felt they should do out of professional duty. This contrasts with research which has found engagement in health promotion practice to be related to professional, rather than personal, identity (Laws et al. 2008). It may be that the extra sensitivity that adolescent weight consultations are seen to carry makes it a more personal matter for HCPs. The notion of weight management as a personal project also fits with the survey data which showed that a small sub-group of health professionals who were less likely to see referral as the preferred treatment option, felt better prepared to deal with weight management in adolescents, and reported finding such consultations more professionally rewarding. That individuals who agreed they were interested in further training were also less likely to see treatment futility as a barrier to treatment, and more likely to find treatment of obese adolescents to be professionally rewarding, indicates a belief among these HCPs that change is possible. This notion that child and adolescent obesity management is undertaken by a small, enthusiastic sub-group of HCPs is partly supported by other research. For example, Campbell et al. (2013) investigated rates of weighing and measuring of children aged 2-17 years by Australian paediatricians and found that frequency of performing such activities differed greatly between

different practitioners. This suggests that some have incorporated such measuring as part of their standard care, while others have not. In the current research, this sub-group was also more likely to say they had a good understanding of professional guidelines relating to weight management, indicating that personal interest might lead them to seek out information which in turn enables a greater sense of self-efficacy for providing such advice. Greater awareness of guidelines relating to weight management counselling has been found to be associated with more positive attitudes towards providing such services (Kolagotla & Adams 2004). Increasing self-efficacy for weight management consultations with children and young people has been suggested as one of the most important training objectives for HCPs working with those age groups (van Gerwen et al. 2009), while the current training in obesity management in general in the curriculum for medical students has been criticised as inadequate (Hall 2010). Previous research has found perceived competence to be strongly correlated to self-reported actual treatment of childhood obesity by physicians (Jelalian et al. 2003), and both skills and knowledge are related to the provision of patient-centred care (Hobbs 2009). However, with regards to actual treatment strategies, those endorsed by the HCPs in this study were largely in line with those recommended by NICE and other guidelines (Gibson P et al. 2006; NICE 2006). This suggests that the treatment strategies suggested in such documents are already accepted within the HCP community. However, since the majority of those that reported having ever used such guidance to treat obese adolescents had found them useful, it is possible that they serve a function in validating and reinforcing previously held beliefs, possibly enhancing self-efficacy for obesity management. This is supported by the fact that those who did report having a good understanding of NICE in relation to adolescent obesity were more likely to agree to being professionally well prepared to treat obese adolescent patients. The biggest differences between professional groups were found in relation to perceived barriers to treatment, with practice nurses more likely to see lack of knowledge and skills as barriers than GPs, but less concerned about relevant support services. Practice nurses were also more likely to state eating disorder concerns as a barrier. This indicates that any training and guidance provided for health professionals needs to

take into account the varying needs and concerns of different professional groups, as guidance that address issues that are not seen as problematic may be considered irrelevant and 'saying nothing new'.

The personal characteristics of the HCP are known to influence communication in practice (Abramson et al. 2000; Hall et al. 2005; Binns et al. 2007); in the current study this was mostly evident from HCPs talking about having personal experience of weight problems and therefore feeling more enthusiastic or empathetic about the issue. This contrasts somewhat with research that shows normal BMI HCPs to be more likely to counsel patients about obesity than HCPs who are themselves overweight or obese, and also to report higher confidence in undertaking such consultations (Bleich et al. 2012). This research however referred to patients in general and not specifically to younger people; it is possible that the impact of practitioner BMI functions differently for patients of different ages. When dealing with adult patients, HCPs may be more likely to compare themselves directly to their patient because they feel themselves to be more similar to them, while social comparison may be less of an issue with younger patients. Other research has shown that HCPs who themselves undertake certain health promoting activities, like physical activity, are more likely to counsel their patients on those topics (Abramson et al. 2000). Similarly, HCPs rated as 'fit and healthy' have been found to be more likely to counsel children on obesity-related topics than those who are not (Binns et al. 2007). Research with adult populations indicates that people find practitioners perceived as fit and healthy to be more credible and motivating (Frank et al. 2000).

To be able to adequately perform their duties in congruence with their professional role, HCPs need access to appropriate resources such as weight charts and other tools. The survey presented here, as well as the accounts from HCPs describing themselves as seeking out such resources for themselves, suggest that such resources are not generally available to them. Similar findings have been found in research with Canadian primary health care providers (He et al. 2010), and suggest that greater

access to age appropriate resources for weight identification and management may be paramount for better preparing HCPs to manage overweight and obesity in adolescents.

Methodological limitations

Although self-complete surveys are one of the most efficient ways of eliciting data from a large number of respondents, this method not without drawbacks. Since respondents choose whether to take part or not, response rates for this type of surveys can be low. In the current study, just over one fifth of GPs responded, which is not atypical for this kind of research but nevertheless excludes a large proportion of potential respondents. Further, it is possible that those HCPs that did respond are different in some way to those that did not and therefore the results presented here may not be representative of all GPs and practice nurses in the UK. There are issues with self-report questionnaires in that respondents may try and present themselves in the best light possible. Since few of the HCPs in this research reported a good understanding of the issues they were questioned on, such biases might be small.

Similar issues can be said to apply to the interviews in that interviewees were wholly self-selected and therefore may represent HCPs with a particular interest in the topics under investigation. Therefore, the results here may be indicative of a 'best case scenario' that represents primarily the views of HCPs with a special interest in adolescent obesity. Conversely, it may also be that those HCPs that find the issue of adolescent weight management unproblematic and not something they reflect on may also have excluded themselves from the study.

Chapter 5: Interviews with young people and parents

Introduction

This chapter describes interviews conducted with three adolescents who at the time of interview either were or previously had been overweight or obese, as well as with two parents of such adolescents. The literature review identified the limited amount of qualitative research investigating adolescent experiences of weight management in non-clinical populations, and interviews were undertaken to explore the issues brought up as potential barriers by the HCPs from a young person's perspective. Because most young people spend a large part of their adolescent years living at home with their parents, and many are accompanied by parents when seeking health care, parent interviews were also conducted. The perspectives of parents of adolescents are rarely sought, but considering the partial responsibility HCPs gave to parents in adolescent weight management, their experiences can bring further insight into the process.

Doing research with children

Eliciting the experiences of children and ensuring that they are given a voice on topics that affect them are issues addressed by the UN Convention on the Rights of the Child, which states that:

"States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."(UN General Assembly 1989)

Yet, it has been argued that in everyday life, children are rarely given the opportunity to voice their opinions or to challenge the stereotypes that they are commonly associated with (Grover 2004;

Graham 2004). Issues affecting children are shaped by adult agendas without due consideration to how such issues are experienced and interpreted by children and young people themselves (Grover 2004).

According to Morrow & Richards (1996), ethical concerns in conducting research with children are centred around two areas: (1) consent, and (2) protection of the research participant. With regards to consent, concerns tend to centre around who is consenting for the young person and whether the young person is able to voice their own wishes and have those wishes respected. Social research in the UK tends to give parents the right to refuse their child's participation in research until the child reaches 16 years of age. However, even if the parent consents, the child or young person still has the right to refuse participation if they so wish. For children, to an even greater extent than adults, ensuring that appropriate information regarding the research project has been given is essential, as is checking to ensure that this information has been understood (Mauthner 1997). Further, children need to be reassured that they can change their mind about participating at any time without repercussion. Obviously, this is also essential when undertaking research with adult participants, however the power imbalance between children and adults means that some or many children and young people may feel that they need to do as they are told by adults, or fear they will let someone down if they change their mind at a later stage in the research process.

With regards to protection of the participant, again many of these issues are the same for children as for adults – children, too, may become distressed when discussing certain topics, they may disclose more than they would like, and are as likely as adults to associate the particular topic under investigation with other 'unplanned for' topics. Children may, however, be less likely than adults to be able to articulate their concerns should such things happen, and again may feel unable to speak up if the power imbalance is too great. It has been argued that to mediate the power imbalance between the adult researcher and the child participant, there is a need for flexibility to adapt to the child's agenda, to let them tell their stories on their own terms (Mauthner 1997). In the current

research, when adolescents indicated any sign that they may be disclosing more than they had anticipated, the interview was temporarily halted to check whether they wanted any information deleted or disregarded.

The research undertaken here considered the accounts of not just adolescents, but parents as well. Although child-parent dyads were not interviewed together, it was recognised that there may be specific ethical considerations to consider when asking different members of one family to recount their experiences of the same issue. Larossa (1981) argued that there is a risk within family research of the family 'exposing itself to itself'; of issues being brought up that some family members may prefer remain hidden, or of tensions being brought out in the open causing direct conflicts. In the current study, adolescent and parent accounts of particular events sometimes stood in stark contrast to each other, but because neither parents nor adolescents were told what the other party had said such discrepancies would not be obvious to them. In no instance did adolescents disclose information that was considered potentially harmful to the extent that the parent should be told.

Methods

Recruitment

It was important for the purposes of the study that the adolescent participants consisted of young people who had experienced being overweight or obese. Links had been established with two community-run weight management programmes aimed specifically at teenagers, and permission was granted by programme leads to access and recruit young people and parents through these programmes. The benefit of this recruitment strategy was in being able to get in touch with young people who were certified overweight (a requirement for attending the programmes), without having to state outright that participants were chosen because of their weight. The recruitment letter framed the reason for requesting participation in the research in terms of exploring the

experiences of young people attending programmes (which were billed to be about health and fitness rather than weight). This method was hoped to reduce the stigma that might be felt by young people for being singled out because of their weight status.

Programmes ran for 12 weeks each, and contained between 4 and 12 participants at different stages. At one site, parents were involved intermittently during the course of the programme, while at the other parents only attended the first and last sessions. Both programmes involved nutritional training by qualified staff, as well as fitness sessions incorporating various forms of physical exercise.

During one of the first (though not the very first) sessions of the programme, participants were given an information pack consisting of letters for adolescents and parents (Appendix 2 & 3) explaining the aim and procedures of the study together with a reply slip that could be posted back to the university by interested parties. It was explained that participation was voluntary and in no way affected their participation in the programme, and that all data would be kept confidential and not shared with programme leads or anyone else. It was explained that participation was restricted to young people aged between 13 and 17 and their parents, but that parents and adolescents could participate independent of each other – i.e. a parent was welcome to be interviewed even if their child chose not to, and vice versa. Interviews were offered in the home, in association with a programme session (on site), or any other place of the participants choosing. The aim was to recruit 4 adolescents and 4 parents.

Despite repeated attendance at several programmes, only one adolescent and one parent was recruited this way. One more programme participant and his mother expressed an interest, however this participant was only 10 years old and therefore ineligible. One more parent returned an expression of interest slip, but could not be reached despite several attempts at contact. During this time, a chance meeting at a conference where the research was discussed led to contact with a local youth club. The youth club lead was interested in the research since she had a number of young people at her club who were overweight and who had discussed their feelings around this with her.

Prior to letting any formal recruitment take place, the youth group lead explained the study to the young people involved and gained their permission for formal recruitment letters (Appendix 2) to be given out. Following this process three young people in total agreed to be interviewed, as well as one parent.

Ethical approval

Ethical approval for adolescent and parent interviews were given by the University of Hertfordshire ethics board for psychology (Appendix 9).

Participants

Table 5.1 describes the characteristics of the participants

Rosie: aged 13, was attending a local council-run weight management programme after being 'pushed' into doing so by her mum.

Richard: aged 18, had over the last year lost around 20 kg in weight on his own initiative, used to be bullied because of weight and acknowledged comfort eating in the past

Dana: aged 15, had made small attempts at weight loss, was concerned not just about weight but size in general (being very tall for her age), and was very self-conscious about appearance and what other people thought of her.

Sophie: aged 15, agreed to be interviewed but at the point of actual interview appeared to be highly uncomfortable with the situation. Her body language (curled up on a chair, arms wrapped around her in protective pose) indicated defensiveness, and she would not make eye contact but kept staring at the floor for the duration of the interview. In response to questions she would respond with singular 'yes' or 'no' if such answers were possible, but open-ended questions were met with 'I

don't know'. After the first few minutes, the digital recorder was switched off in the hope that this would put her more at ease, but this made no difference. The interview was terminated after less than 10 minutes as it was deemed unethical to carry on.

Sarah: the mum of Rosie; by her own admission the one who instigated Rosie's participation in the weight management programme

Jenny: Richard's mum; had been concerned about his overweight and suggested to him that he might need to lose weight, but now that he had she was more concerned about him losing too much too quickly.

Table 5.1 Participant characteristics

Participant	Age	Weight status	Interview setting	Recruited via
Rosie	13	Overweight	Home	Weight management programme
Richard	18	Previously overweight	University	Youth club
Dana	15	Overweight	Youth club	Youth club
Jenny	41	Overweight	Youth club	Youth club
Sarah	40	Normal weight	Home	Weight management programme

Interview schedule

The interviews were all semi-structured, based around an interview schedule (appendix 10 (young people) & 11 (parents)) designed to probe participants' experiences of adolescent weight management. For young people, questions explored issues relating to the meaning of weight, experiences of weight management, and barriers and facilitators to weight loss. The parent interviews explored similar themes, as well as the meaning of being a parent in relation to a young person who either was or had been overweight or obese. In line with the recommendations for

carrying out interviews to gain rich accounts of participants' personal experiences (Willig 2013), the schedule was used flexibly within each interview, and the interviews were guided by the stories the participants were telling. Using this approach the themes of the interview schedule were explored with all participants, but to varying extent depending on their own personal experiences.

Themes: Young people

Young people's experience of weight

Three main themes were identified from the young people's interviews, each with their own sub-themes (table 5.2). The young people talked first and foremost about ***being visible*** as an integral part of what it meant to be an adolescent and how weight impacted on this. Secondly, the ***meaning of weight*** was discussed, mostly in terms of social hierarchies and the impact on the here and now as opposed to the long-term. Finally, the theme of ***breaking free*** positioned weight in the context of one of the most salient aspects of adolescence, that of developing autonomy and independence through increased control and responsibility. Each theme will be discussed in turn.

Table 5.2: Themes identified in the young people’s interviews

Major theme	Subthemes
Theme 1: Being visible	Being exposed
	Being judged
Theme 2: Meaning of weight	Social hierarchies
	What matters now
Theme 3: Breaking free	Control and choice
	Responsibility

Theme 1: Being visible

Across all the young people’s accounts, the theme of being visible was highly salient. This was partly tied in with a general adolescent angst of feeling watched and worrying what others think about the self, but also more specifically to being visible because of the weight, something shameful that goes against what you ‘should’ look like. The sub-themes of *being exposed* and *being judged* were also identified here.

Being exposed

All the young people interviewed were aware of their size increasing their visibility, and although they all felt that this would be something others would immediately notice about them and be aware of, having this stated outright by others was another matter and a cause for fear and discomfort.

Having your own weight made apparent to you was a reason for the young people to change their behaviour, to try and avoid further attention being put on it. Rosie described being bullied for her

weight in primary school, and therefore resorted to measures such as hiding her body when possible to avoid drawing further attention to it:

“... I used to get like a bit, people saying nasty things back to me, and that...to me about my weight in primary school...and I was much larger than I am now, cause I think I’ve grown a bit so I’ve kind of grown out a little bit now... but I was like really, really chubby, and I was a little bit overweight I think. So...ehm...I think that did I was always a little bit like I used to not get changed with everyone else, and go and get changed in the toilet, I was a little bit self-conscious.” (Rosie)

There was a general feeling that to comment on someone’s weight was to make a negative statement about that person’s looks. Even when the concern was about health (as described below when Richard’s mum commented on his weight), someone making a comment about weight was associated with being seen for the wrong reason, for being something that is unacceptable according to mainstream norms. This sensitivity was acknowledged to be particularly relevant for teenagers for whom looks were so important. Richard frequently reflected on the developmental process of caring what other people think about you, something he felt had started for him in early adolescence and been an important aspect of his attitude towards his body. Similarly, Dana described “not caring so much” about what other people thought when at primary school, but felt that this had become much more important with the transition to secondary school. Although Rosie had been bullied for her weight in primary school, she felt that younger children would be far less susceptible to being traumatized by others noticing their size than may be the case with teenagers and older children. This led her to suggest that having discussions about weight would be better with younger children as they would not yet understand the importance of weight for looks:

“I think like, it is quite a sensitive topic. Like, for younger children, they don’t really understand it, they don’t understand the difference between like...maybe some do but most of them they don’t really care how they look yet so it’s better to kind of get it into younger

children's minds before they start looking at being [inaudible]. Cause I think it is kind of a sensitive topic for older children.” (Rosie)

Although having weight being made apparent was something that was perceived as hurtful generally, it also depended on the context, who said it, and for what reasons. Having someone point out your weight was seen as acceptable (if still hurtful) if it came from someone who cared for you and had your best interest at heart, as described by Richard in relation to his mum:

“Obviously I felt a bit hurt. Cause, you know, people saying ‘you’re fat’, you know, it’s not the nicest thing to say to someone. But then I thought she must, there’s obviously a reason why she’s saying that, she wouldn’t say it for no reason, so then I looked at myself and I thought ‘yeah, she’s right’, and she’s only saying it because she cares, she doesn’t want me to get ill or whatever, so... yeah, there’s a reason, she meant it in the right way”

By contrast, Dana who was hyperconscious about being seen for her size, appeared to have ambivalent feelings about her close friend commenting on her weight. While it was not perceived to be in the spirit of support, and was acknowledged by Dana to be done in a way that was hurtful and judgmental, because of the close friendship she described the experience as ‘honest’ rather than any form of bullying behavior:

“I’m best friends with her but she’s honest with me, if I say ‘Emma, do I look fat in this top?’, or ‘does this look ok to go out in?’ - ‘no you look fat’, or she will say ‘you look ugly, not pretty, you have a...’[...]I know, she’s a good friend to me and all, but... when she says stuff like that obviously it’s going to put me down but then she’s being honest with me so at least I know the truth.” (Dana)

However, having weight being made apparent could also act as an incentive for losing it, as demonstrated by Richard:

JM: *What sort of age would you say that you were when you started thinking about...?*

Richard: *Ehm, it was in my year 11 photo, we had a photo done at school, ehm, you know one of those they send home, and you couldn't see my neck.*

JM: *Oh.*

Richard: *And I was like 'Eugh! That's a disgusting photo'. It was after that, I decided that I was going to shift the pounds."*

The young people interviewed also feared being singled out because of their weight. This was something that they discussed in particular in relation to public perceptions of the need for overweight people to lose weight, so that both Dana and Rosie described having had discussions about weight and healthy eating in assembly and feeling as if the talks had been aimed directly at them, something that had made them feel extremely uncomfortable. The issue of being singled out was seen to be a particular problem if it was done in a way that would make you visible to your peers (such as a general talk to the whole year group) rather than something done one-to-one. However, even if the mention about weight was done in private, a feeling of being 'picked on' could occur as Dana described feeling initially apprehensive when she had been approached about being interviewed; a feeling of being singled out because of her weight.

Being judged

The discomfort at having your weight exposed and being singled out because of it linked strongly with a fear of being judged because of your size, something the young people had both experienced in the past and were concerned would happen again in the future.

One aspect of this was the fear of being judged because of what you eat. Diet is strongly interlinked with people's perceptions of overweight people, and it was felt that the fact that you were bigger meant that you could not make certain food choices, or that the whole issue of eating anything

became taboo. Dana had developed such a fear of being judged for what she was eating that she had practically stopped eating in front of people.

“...if I see people staring at me I will be put off my food completely, I can’t eat, I can’t eat in front of people. I just feel so conscious and horrible, it’s like the way I’m eating, I eat weird. And I can’t, when I go to restaurants with my friends I can’t order what I normally order with my family, cause I’m scared they’re gonna say something about it, or...” (Dana)

Dana expressed a strong need to suppress her natural behaviour; both in the types of foods she could eat (as expressed above) but also the amounts:

“...say that I had pizza and my friend had [inaudible] and I was still hungry, I couldn’t say ‘I’m still hungry, I’d like more’ even if they offered me some. I just could not do that, I’d feel so uncomfortable.”

From Richard’s account it was clear that the fear of being judged for eating certain foods in front of others was to do with a perception that overweight people shouldn’t eat certain things:

“...if I go eat McDonalds now [that he has lost weight], no one thinks anything of it, but as soon as you see a fat person in McDonalds eating fish and chips you’re all like ‘oh look, fatty’s eating chips again’.”

Rosie didn’t speak about being judged for the foods that she ate, but she had a very clear fear of getting judged on her physical appearance and her abilities linked to that. When she spoke about taking action to reduce her weight, her biggest fear had been to look foolish in front of other people, for being the one least capable or least attractive. This she felt was such a strong barrier that what was needed the most in encouraging other young people if wanting them to join weight management programmes would be to ensure the intended participants would be aware that they would be in a situation where everyone was in the same boat. This would mean reassurance that you would not stand out from others, and that you would not be judged on your ability to do things

such as participating in certain sports. Dana also spoke about being judged for her size in relation to playing sports, but rated her own ability in this area much more favourably than Rosie. Her experience had been that of someone who was good at sports after years of practice, but being assumed to have no ability because of her size:

“The first time we did sports like this year, cause I wasn’t in the same group, no-one wanted to be on my team because obviously they judged me. Next lesson they all wanted to be on my team in netball because they thought how good I was...” (Dana, 15)

It was clear that the young people interviewed felt that being overweight meant people always noticing them for this, defining them for the fact that they were overweight and making assumptions about their character and abilities because of it. Partly this ties in with what would be considered normal adolescent development whereby young people go through a stage of heightened awareness of their visibility in relation to other people, and fearing to be judged negatively because of this. Being overweight exacerbated these feelings.

Interestingly, the person that appeared to be the most conscious and concerned about other people looking at her, Dana, had adopted a personal style in terms of clothes, hair and make-up that ensured that she stood out from the crowd and would be noticed regardless of her size. She reflected on this, showing a great amount of self-awareness:

“And that [style of clothing] kind of drawn, draw attention to you a bit more which I thought ‘do I really want this?’, then I thought ‘why should I care what people think?’. So I know what people see is going to be true and what they say to me is obviously true, so why should I care anymore so I just done that. But still, in restaurants I will go to the corner. (laughing)” (Dana)

This reflects a sense of being able to choose the identity for which people see you and base their opinions on. Thus, for Dana, it is perhaps not so much about being visible per se, but being visible for the wrong reasons. The overweight identity is not one that she has chosen, but one that would be

immediately obvious to others and therefore the first thing many would base their impressions on. By contrast, the out-group style of dress is an identity she has actively chosen, which affirms her membership of a certain group, and something which therefore feels true and right to her. She has no problem being judged for an identity that she feels aligned with and has control over.

Richard, who was the oldest of the young people interviewed, recognised that his fear of what other people thought of him had reduced as he got older, and he was no longer as concerned even though a certain amount of fear still lingered:

“I mean I don’t care that much of what people think of me now, ehm, I’ve sort of grown past it a little bit, but I’m still sort of conscious of people looking at me and think I’m fat, ehm... But then I think, I suppose any older people would as well, I mean...”

Thus, the remaining fear of being judged for being fat was something he perceived to go beyond ‘normal’ adolescent angst and to be a reality for all overweight people, regardless of age.

Theme 2: Meaning of weight

Noticeable throughout the young people’s accounts was the everyday lived experience of what weight meant to them specifically, but also to young people more generally. It was clear that weight is not just an issue for those who are overweight, but something that permeates the experience of being an adolescent in general. It was seen as a contributor to **social hierarchies**, and as a barrier to that most coveted of attributes: good looks. Being overweight was perceived to determine not just personal sense of self, but also how they viewed other young people, including those who were bigger than they were. Because of the importance to peer relationships and to how you are viewed,

young people also talked about the importance of weight in terms of **what matters now** rather than something to reflect on for future health.

Social hierarchy

Weight was seen to be an important determinant of position within social hierarchy in the peer groups of all three young people interviewed. How you compared in weight to others mattered for your standing within the group and consequently also for how you felt about yourself. Something that was referred to across the interviews was the importance of relative weight, not just in the difference between 'skinny' and 'fat' people, but also as a gradient of how overweight you were. Thus, Richard would talk about not being 'that fat', and Rosie described 'being chubby, maybe a little bit overweight'. It was clear that while all of them acknowledged that their weight was higher than they deemed acceptable, or than what the 'healthy norm' would suggest, they were keen to position themselves as low down on that spectrum as possible. This distinction makes perfect sense when considering the importance of weight to the relationships and positioning in social groups of young people.

The girls in particular spoke about how weight was used as a 'weapon' by other girls for establishing their position. They found it particularly distressing to be exposed to the kind of public, but covert, comparisons often made by girls in the peer group.

"When that happens in our group I walk away cause I don't feel...oh, what I really, really hate is all these girls in PE who stand there in front of the mirror, they stand in front of the mirror and they pull their t-shirts up and they're going 'I'm so fat, I'm so fat', and to one of my friends I actually, I said 'if you're fat, what am I?'" (Dana)

"People care about how you look and how much you, you weigh like... and a lot of people, they put themselves down, like, even when they are thin, just for attention, and then when they'll go round like "oh I'm so fat", then it kinda makes other people think, "well I'm like two

times the size of them”, and they’re calling themselves fat so I must be really fat. You know what I mean?” (Rosie)

The comparisons were seen to be covert as it was the perception of both Rosie and Dana that these comments were made as a way for ‘skinny’ girls to assert their own skinniness and, by extension, attractiveness. In contrast, the desire to remain invisible (as described under theme 1) of the overweight girls meant that such public comments on the own body would never be made by anyone who was genuinely unhappy with the way they looked. In this way, both Dana and Rosie saw the assertion of skinniness as a way for these girls to control the peer group hierarchy and affirm their own positions as being at the top of those hierarchies.

The importance of weight for hierarchies did spill over into being positioned not only low on the ladder, but into reasons for outright bullying – something all three young people had experienced:

“You know, I was bullied, and, you know, I didn’t like it. Obviously. Ehm... So yeah, I didn’t wanna be the fat kid. Not that I was ever that fat, but fatter than other people. So therefore, that’s a reason for them to pick on you.” (Richard)

Although it is clear from Richard’s account that weight was one reason he was being bullied, he also explained that the reason he had gained weight in the first place was because of comfort eating because of being bullied, thus indicating that the weight gain happened as a consequence to bullying. This demonstrates the inter-linked nature of weight-bullying in these young people’s experiences – you are in a low social position within the peer group either because of weight or for some other reason, which then leads to comfort eating which gives the bullies more reason to pick on you:

“And what would happen is kind of vicious circle; I’d go to school, I’d get taken the mick out of, I’d come home, eat food, put on weight, and then it’d all happen again cause I would put on more weight, people would take the mick, then I’d eat more, then I’d put on weight, literally going round and round.” (Dana)

Comfort eating was described particularly by Dana and Richard, and both of them explained it as partly the compensation for lack of social support. Across the interviews, the young people never described themselves as discussing weight with friends in the sense of wanting to lose weight or taking action; for the girls it was just about what came up in social comparison, or getting feedback from friends on the acceptability of outfits. However the descriptions of using food to feel better clearly indicate a need for support that is not being met and instead is being substituted:

“It [food] is a lot of a comfort thing, yeah. I feel like I can relate to that more than friends”

(Dana)

Richard had not discussed his weight with anyone before his mum brought it up as a potential problem, and saw it as *“nobody else’s business”*. He talked about himself during the stage of early adolescence (when the bullying was initiated) as having no friends, not talking to anyone, and turning to chocolate for help. He rationalised his decision to go for sweet things by citing scientific evidence that chocolate contains chemicals to elevate mood, thus making his choice of ‘support’ logical even if he acknowledged that *“it don’t really help”*. Richard’s interview also suggested that weight and having friends was strongly interlinked in his experience; having no friends while overweight but having gained some as the weight came off. While recognising this is a complex relationship, he perceived having friends now as a reason not to put the weight back on:

“Because I didn’t really speak to anyone... obviously I spoke to people, but I wouldn’t really call anyone then that was my friend. But obviously now I do, I have friends now. Ehm... so it sort of made me, not wanna be like them but...not be overweight. Because, I lost a bit of weight, and then I was like ‘oh, I have some friends now’. And obviously that’s just because they got to know me, not because I lost weight, but then I felt good about that.” (Richard)

Weight loss had also had a positive impact on Rosie's friendships, but in her case it was down to having made new friends through the weight management programme that she was attending. These friendships had been important to her for several reasons. They had reassured her that doing exercise and 'looking silly' in front of other people was not always an inherently negative experience as long as individual abilities were respected and everyone had the same objectives. Further, through the programme she had the opportunity to interact with girls a bit older than herself, friendships she otherwise would not have had the chance to cultivate. Maintaining these friendships was even an incentive for her to continue with the programme, and appeared to be the primary benefit she saw from attending (she spoke about the friendships and social support to much greater extent than actual weight loss).

"there were three girls but then one of them left, and there's two girls that I, in older years in my school so they kind of stuck up for me and like looked after me and talked to me which is good because I went in to school and I didn't know anyone, so..." (Rosie)

As well as peer relationships having greater importance during adolescence than they previously have, it is also the time when opposite-sex relationships become more important – something that was related by all the young people interviewed. For Richard, comments made on his weight loss were of particular importance when from girls:

"Once I lost it was 'oh Richard, you've lost, you've lost a bit of weight', you know, when I was, you know... not to sound stupid, but it was it, it was nice you know with girls saying 'oh, you've lost a bit of weight' and I thought 'oh that's quite nice'." (Richard)

For the girls on the other hand it was particularly about the fear of looking foolish or unattractive in front of, or being judged by, boys. Rosie spoke about not wanting to get sweaty in front of others in general, and boys in particular, as she saw it as impacting negatively on attractiveness. She was also concerned about being seen as incompetent if attempting to take part in sports. Dana, who

confessed to having huge problems eating in front of people for fear of getting judged, admitted to this being a particular problem when it came to boys:

“Boys, I will not eat, I could if I was with boys for a whole week I would not eat, literally I would not eat, I would starve.” (Dana)

What matters now

As has already been made clear in the above theme, the impact on social relationships is one of the most important issues for young people when considering weight. Where you stand on the weight spectrum reflects where you are positioned in the social hierarchy, something that is highly important to the everyday lived experience for adolescents in general. By contrast, while all young people reflected on the relevance of weight for health, this was not important to them for two reasons: (1) because health consequences are not necessarily visible on the outside, therefore their consequence for social rank are negligible, and (2) because they perceived health consequences to be in the future and therefore not a priority in a world where getting through each day is a challenge in itself.

The idea of the ‘inside’ (not important) v the ‘outside’ (very important) is something that was discussed by all. Richard varied to some extent from the girls in this respect since throughout the interview, he stressed the importance of health and need for young people to understand the relevance of this – however, when discussing his own weight and his motivation for losing weight he very clearly described this in terms of the impact it had on him in how he appeared physically to other people. Thus, it appeared that his focus on health was something he could reflect and focus on only once the weight had actually been lost.

Rosie provided a very candid account of how health really is of a low priority for young people’s considerations of what matters in their lives. Although she had previously discussed her own fear of appearing incompetent when performing sports, it appeared that this was more because the

negative associations of looking foolish than any kind of notion that being good would have a positive impact on social standing. Instead, she described the purely looks-based meaning of weight to herself and her peers:

“I have girls in my class that are really thin, but they can’t run for as long as some girls that are bigger than them can. But no-one really cares about that, while the bigger girls will be like “oh you’re so thin” the skinny girls won’t be like “oh you’re so healthy”. No-one says that.” (Rosie)

Similarly, Dana admitted to having put very little consideration to health when it came to weight. She justified the focus on the outside with a view that your appearance would also reflect overall health, so that a focus on improving the outside would automatically lead to improvements on the inside as well:

“But my mum keeps telling me stuff about the inside, she was talking obviously about the fat round your heart and all this stuff.. but, I was thinking, if I sort the stuff on the outside, hopefully that will sort on the inside.” (Dana)

In contrast, Richard was very concerned that just because the weight might have gone on the outside, he wasn’t yet necessarily healthy on the inside. His perception was that it would take much longer to fix the inside than the outside, and this was made all the more disconcerting since the inside problems were nowhere near as accessible and easily assessed as the outside ones. He strongly felt that this was an area where more education was needed, especially for younger children. Rosie described getting some health messages primarily about food and diet through the weight management programme she was attending, and she felt that the way it had been presented (focusing on immediate health consequences such as nutrition deficiencies and weight gain) were more appropriate than long-term health messages that might impact on adult health:

“It’s like when we straighten our hair, like, that our hair can go bad but that’s so long away we don’t really care. It’s the same sort of thing, within like, diseases and stuff like that. So when we see like the short-term effects that could happen like, within like a couple of months or whatever. Then we kind of think, “well, that could happen to me by my next birthday”, know what I mean? And that kind of makes it more serious.” (Rosie)

The importance of the here and now was demonstrated by Richard when he described his very rapid weight loss. His concern had been to get to a size that was acceptable to him, and in order to do that he did, by his own admission, “stop eating”. Although he went to great lengths to justify his small food intake as “not being hungry” and the importance of not eating if not hungry, there was also an underlying recognition that his approach was bordering on unhealthy. This was further emphasized at times in the interview where he recognized that he found it difficult to judge whether he has lost ‘enough’ weight or not, and continued to eat rather restrictedly. He talked about his mum in particular being concerned that he was losing too much, but justifying this with “I’m happy”.

Taken in another direction, the importance of here and now is also demonstrated in the idea of comfort eating, where placating the discomfort that is being felt at the time is more important than the long-term goal of weight loss. While Richard appeared to have made a very clear-cut choice and cut out unhealthy foods completely, Dana still struggled with how to manage the uncomfortable feelings in a way that did not involve eating. This resulted in guilt and shame after indulging in binging, but there was a sense for Dana of not having control over her behaviour in this domain, and not being able to delay gratification even though the repercussions were practically immediate:

“Especially when I get upset, I will, soon as I get upset straight away I will think ‘I need food, I need food’ and I go to the shops and I buy basically the whole shop, go home eat it all and then think ‘why did I just do that? I wasn’t hungry and I just wasted all my money and I could have bought something with that’. And it’s just not done anything for me except it’s going to make me put on weight.” (Dana)

“I think ‘I don’t care’, at that moment I do not care, my head is focused on food.” (Dana)

For Rosie too the long-term gains of weight loss were difficult to fit in with the here-and-now priority of maintaining friendships, which may involve eating at places that were frequently less than conducive to weight loss. In this respect it was particularly difficult if your friendship group consists of people that are smaller and therefore do not need to consider the health aspects of food. Rosie in particular appeared to divide people into 'skinny' and 'chubby' girls, like an indisputable natural law that there was little that could be done to affect:

"Ehm, they don't eat that healthy, my main friends are really really slim, they're like [inaudible] whereas the people [inaudible] because they're still really skinny, or they're just naturally like that, they've just got fast metabolism and they're just not...they just don't get fat." (Rosie)

However, despite the low priority of health to these young people, there was a sense that when it came to encouraging young people to lose weight it would still be preferable to focus on health rather than looks. In fact, what might be most accessible to young people might be to focus directly on behaviours, and food choices in particular (food was discussed almost exclusively by all three, with very little emphasis on physical activity). This might take the form of giving suggestions for acceptable alternatives, as suggested by Rosie (something she had experienced through the programme she was attending), or in going deeper and understanding the need for support that might not be met for some young people, and which might result in comfort eating.

Theme 3: Breaking free

Running throughout all the accounts were issues that were related to being a young person and developing through adolescence. The final theme relates directly to some of the most pertinent

aspects of adolescence, such as the developing sense of autonomy, gaining **control** over your own actions and behaviours, and the boundaries between parental and personal **responsibility**.

Control and choice

All three young people recognised the increased amount of control they had gained over their own lives. They now possessed the freedom to make choices that would impact on their weight to a much greater extent than had previously been the case. Obviously the extent to which control was realised differed between the young people dependent on their age, but all recognised areas where they could now make choices they had previously not been able to. Consistent with the interviews overall, this was primarily in the area of food and diet.

All three discussed the freedom of going down to the shops and buying whatever they wanted (although for Rosie this was to some extent restricted by financial means). Having their own money meant that things that had been restricted when they were younger, such as crisps and sweets, were now easily available. But the newfound freedom of being able to do this was also perceived by Rosie to mean being restricted to choosing certain types of foods since her limited finances would typically stretch just to things perceived as unhealthy. Thus, in order to be able to execute the control and autonomy she had now gained, she felt forced to make choices that might not be optimal to her weight goals:

“Ehm, it’s difficult because like there are healthy things, but if I just want to go and buy like a sandwich for a pound I can’t do that, like they are two pounds or whatever, but instead I can go to McDonalds and buy some chips for a pound and it’s the same, like same thing, it still fills me up, but it’s cheaper and I don’t have the money to buy the more healthy things.”

(Rosie)

It is important to recognise that the ability to have control over what you buy outside of the home is hugely important for adolescent sense of autonomy – executing this ability is a marker of growing independence. Food as a means of socialising also increases during adolescence, meaning that the ability to engage in this means maintaining bonds with the peer group. Therefore, if the only foods that are within the budget of the adolescent are the unhealthy ones, these are ones that will be chosen because the context and meaning of having food with your friends is more important than the food itself.

The idea of having choices restricted for you was further emphasised by Rosie in that because the ‘norm’ was on unhealthy foods, making healthy choices at school became problematic:

“No-one really eats that healthy, no-one really cares. So it’s kind of like... I’m trying to eat but then because no-one else cares they don’t really cater for people who try to eat healthy.”
(Rosie)

The amount of food eaten is also a marker of control. Both Richard and Dana talked about the amount eaten as something out of control, although for Richard that was something in the past while Dana was still struggling with the comfort eating:

“I feel guilty after I’ve done it, I feel guilty and I think ‘oh my gosh, why have I just done that when I agreed to myself that I wasn’t going to eat that much, and now I’m going to put on more weight.’” (Dana)

“Cause I used to be down the shop every day and have a family sized bar of chocolate and three packets of sweets. And I used to eat that every day. And to me now, that’s ‘oh, how the hell did I eat that?’. But I did.” (Richard)

Control was a very strong theme running through Richard’s interview in terms of his own weight loss. While talking about his previous comfort eating and being bullied, there was a sense of having been somewhat helpless – the full reason for why he had initially been bullied did not seem very obvious to him, it was something that had just happened by (un)luck of the draw, even though later

his weight gain became a focus for the bullying itself. Similarly, when talking about both what and the amount of food he used to eat to alleviate the stress, he now displays a certain amount of disbelief, indicating a sense of being out of control. By contrast, when deciding to lose the weight, he suddenly seemed to have taken full control of the situation and forced through changes that are notoriously difficult to stick to such as avoiding certain foods and reducing portion sizes. However, the way he describes himself “if I decide to do something, I do it” suggests a great amount of self-control that is reflected in his extremely guarded attitude to food now (and the concern by others, and maybe even himself, that he is now not eating enough).

Meanwhile, Rosie had also been changing her dietary habits and losing weight, though her progress had been much slower and less drastic. For her, however, control had been regained by being given acceptable choices and alternatives to the foods she would normally eat. Before attending the weight management programme her perception about changing diet and exercise habits had been all about being forced to make choices that she would not want to make, thus not having any real control over her situation. In contrast, what she described the weight management programme to have done for her was to show her both that there were healthy foods that she could enjoy and that she would not have to forego her favourite foods completely, and also that there were indeed forms of exercise that were acceptable to her as well:

“Cause I think when, when I can choose the sort of exercise that I like and that my friends like and that’s not forced like PE it’s more enjoyable, and I’m not just like fixated on the fact that all PE is horrible, we have to do all the stuff that they want to do and that I can actually do the stuff that I like as well. So it’s kind of made me more optimistic about, that I won’t just hate all exercise.” (Rosie)

This further demonstrates the importance to Rosie about not being forced to do things you do not enjoy, of having your personal preferences acknowledged and accepted as valid, and therefore having a greater amount of control than what is typically experienced at school.

For Dana, meanwhile, exerting control was all about concealing the body and not making herself visible to people in general. When sitting down, if possible she would put pillows around her body to make it invisible to others. She became distressed unless she could sit at a table that allowed her to hide her stomach underneath the table top, and in restaurants she would always go to the corner and 'hide'. Further, it is possible that her choice of a certain style of out-group clothing and make-up was an attempt to control the image that other people saw – away from the overweight self towards one defined by musical taste and group belonging; a chosen self.

However, at the same time that Dana described outright feeling out of control when it came to comfort eating, her status as a semi-independent adolescent simultaneously meant that she had personal control over the foods she chose to eat. She demonstrated this by explaining how she could go to the shops and buy whatever she wanted, away from the eyes of her mum, and then even hide food in her room to further exert control over what she ultimately chose to eat. This reduction in dependence on parents is further demonstrated when she talks about cooking her own food – even though this sometimes lead to out-of-control experiences of cooking more food than she needs.

Responsibility

Strongly interlinked with the notion of control is the concept of responsibility – who is ultimately responsible for making changes to food and exercise habits? Who is responsible for the weight loss?

To take on responsibility for an aspect of the body such as weight means having an understanding that you yourself have the ultimate control over the factors that impact weight. As demonstrated above, all three young people acknowledged a certain amount of control over their food choices even if that control was sometimes perceived as limited by things like financial means or availability.

A sense of responsibility towards the self is also demonstrated in admissions of guilt at having eaten

too much, since guilt is a feeling borne out of having done something you could (and should) have done differently.

The comments made (or perceived to be made) by other people towards overweight implied a certain amount of responsibility for weight:

“when I did that [buy and eat large amount of food] it was ‘oh my god you fatty’ and make a big deal out of it” (Dana)

Dana’s reluctance to eat in front of other people can be seen as a way of taking responsibility for her own weight. Controlling the self in front of others in order not to be judged implies the sense of being held responsible for the weight outcome. The way Dana’s mum spoke to her about her weight also indicated that she held Dana responsible for her own weight:

“And then I speak to my mum and my mum’s like ‘you tell me you want to lose weight and you can do it, but you start moaning at me saying you want, you, you want to lose weight and then obviously you can’t, and then you’re fussy, you eat, you want to eat things like...”
(Dana)

When Richard decided to lose weight, he took full and personal responsibility for making that happen. By his own admission, he did not tell anyone what he had decided to do and it was not until the weight loss became noticeable that people started asking him about it. Because much of the reason for his weight gain had been down to the control he held over food and diet, taking responsibility for weight loss was straightforward for him – cutting out all the junk food which he had previously purchased for himself, and cutting down on portion size of the foods he was given at home. Richard was very clear about not having been overweight until he got the means to make himself so, and stated outright that “mum never overfed us”. Thus, he took full and personal responsibility for his weight gain as well as the subsequent loss. Similarly, when reflecting on young

people more broadly, Richard drew a distinction between adolescents and younger children in terms of the amount of responsibility that could be placed on the individual for weight gain.

“so yeah I think there’s a big difference between sort of teenagers eating and small children, because you can, you decide what you’re going to eat when you’re 14. You decide that you’re going round the shop and buy food. When you’re seven, your mum gives you too much food and you eat it all up because that’s what you’ve been told to do by mum, so yeah...yeah I think it’s completely different.” (Richard)

Rosie was the youngest of the participants interviewed, and while it was clear that for all three young people their parents had been involved in their weight loss efforts to some extent (Richard’s mum voicing concern; Dana’s mum criticising her food choices and her dad helping her out with healthy breakfasts), Rosie’s mum appeared to have been most directly involved in instigating changes. She was the one that had suggested that Rosie attend the weight loss programme, and her reasoning behind this was the reduced physical activity Rosie was currently doing – to this end she was taking responsibility for change happening in Rosie’s life.

Other than the initial ‘push’ from her mum to get her to attend the programme however, Rosie is showing examples of taking greater responsibility for implementing healthier choices in her life, such as ‘looking into’ going to the local gym (an activity that she has chosen for herself and which she feels fits in better with who she is than the traditional sports which make her worry about looking foolish) at another point she describes finding an app that helps her find healthier alternatives to foods she likes – again demonstrating responsibility for her own choices. At the same time, Rosie ameliorates her sense of responsibility for her own overweight by dividing people into different categories for weight – so that some girls are ‘naturally skinny’ for example, meaning that the fact that she is herself is overweight is partly down to bad luck rather than something she has full control over.

Being able to take on responsibility was however contingent on being able to see the reasons for changing behaviour, and as discussed above these were almost always discussed in terms of the here and now rather than long-term health consequences. Thus, Richard decided to change his weight because he wanted to fit in with his peer group and wanted to be able to enjoy his upcoming holiday without having to hide under clothes. Although appearance was seen as the prime (if not sole) motivator for weight loss among all the young people interviewed, Rosie also discussed short-term health consequences such as deficiency diseases as a reason for taking on responsibility for changing behaviour, and Richard reflected on the importance of exercise for health:

“to me it was like ‘eugh, exercise, why would you want to do that? You get all sweaty and hot which is horrible, why would you want to do that to yourself?’. And then I thought ‘actually no, that’s a good thing for you’, cause... you should use your heart, you need to exercise to keep your heart going.” (Richard)

The conclusion however is that for taking responsibility for changing weight related behaviour, outcomes that were located in the immediate future were needed.

It was clear throughout the accounts that the boundaries of responsibility were still being negotiated for all three young people. Although all took on some personal responsibility for both their weight and their behaviours, this was felt to be shared to varying extent with parents. Reflecting on young people more generally, Rosie stated:

“Well I think like, becoming independent, like most teenagers don’t make their dinner, ehm...so like obviously if the parents are like, making burgers and chips every day the teenagers are not going to go “no that’s unhealthy”, they’re just gonna eat it because they probably won’t cook anything else, you know what I mean?” (Rosie)

She extrapolated on this by concluding that it was parents' responsibility to make sure that food eaten in the house would be healthy (because this was usually controlled by the parents) while snacking and eating outside of the house was the responsibility of the teenager themselves.

"So I think like, it's not the parents responsibility to like ask them all the time "oh you haven't snacked?"." (Rosie)

It was also apparent that Rosie appreciated not always having full control over her food intakes, because this meant she had less responsibility for her choices. Recently, her school had changed the system for school meals so that rather than being given money for food her mum now topped up an account for her which meant she could also see what foods Rosie chose to buy. This she felt had made her make different, healthier, choices, and she actually saw this as a good thing. Thus, she was happy to relinquish some of her new-found adolescent control back to her mum, as it meant having less responsibility. Dana appeared to be more conflicted about the boundaries of responsibility between herself and her parents – she indicated that she had 'had a go' at her mum in the past for not forcing her to eat the same food as the rest of the family and instead letting her make her own (which she recognized to often be healthier than what her mum would cook), but at the same time she was strictly enforcing control by always cooking her own food. She recognized that this often resulted in arguments over food between herself and her parents, perhaps reflecting the difficulties in the struggle over responsibility she was experiencing.

"I'll say 'why can't I make this' or 'why can't I have that', and then my mum will start shouting, and then my dad will start having a go at me for talking to my mum badly, you know..." (Dana)

The issue of borders of responsibility was slightly different in Richard's case. Because he had already lost the weight and now was in a position where his mum was concerned about him eating too little

rather than too much, this had become an area of conflict. However, just as he had in his initial decision to lose weight Richard still displayed a reliance mainly on himself to be able to judge what was right or wrong for him:

“Ehm, I just need to sort of need to change the fat into muscle. I’ve still got a little bit, but... that’s me, thinking I’ve got fat, when mum says to me ‘you haven’t got anything on you’ I’m going ‘well that’s the way it will work’.” (Richard)

Summary

The young people interviewed discussed weight in the context of their everyday lives – the themes that are explored here are ones that are arguably important to any young person’s life, but it was clear that their experience of being overweight had coloured their experience of what it means to be an adolescent in all those areas. Thus, while most adolescents are concerned about being visible and what other people think of them, the young people interviewed described weight as an integral part of how you are perceived, and judged, by others and felt that this was something that impacted on your social standing. Their insistence on positioning themselves as ‘not that fat’, or ‘chubby, maybe a bit overweight’ further demonstrates the importance of not being right at the extreme end of the weight spectrum – you can still be ‘better’ than somebody else. Further, weight impacts on friendships in terms of being bullied and your choices around social activities – can you join in with your peers in situations where your weight is likely to lead to sanctions, such as eating in McDonalds?

All three interviewees demonstrated an awareness of their growing autonomy and control and reflected on how this had impacted on the behaviours that they associated with their weight, such as buying your own food. While control might be welcomed and embraced, it can also lead to conflict when it is associated with too much personal responsibility, and for some a slight reversal to less personal control may at times be desired. Thus, the nature of being an adolescent, and the

developmental changes that come with it, are integral to how weight is both experienced, and subsequently how it might be best addressed for young people.

Experiences of parents

Two mothers were interviewed for the study, and shared their experiences of their children’s struggles with weight and weight management. Two overarching themes were identified in these interviews; *having a good life* and *being a parent*. Each had their own subthemes (table 5.3) and are discussed below.

Table 5.3: Themes identified in the parent interviews

Major theme	Subthemes
Having a good life	Meaning of the body
	Finding a balance
Being a parent	Responsibility
	Monitoring
	Making changes

Theme 1. Having a good life

One, or maybe even the overarching theme in the interviews with Sarah and Jenny was their concern for their children to be able to live happy and carefree lives where weight was not something they would have to worry about. This concerned both being concerned about the impact weight had on their children in being able to do things and possibly restricting the range of activities they felt able to participate in, and also the emotional impact of weight because of traditional ideals

about what body sizes are acceptable. Under this theme the sub-themes of *meaning of the body* and *finding a balance* were identified.

Meaning of the body

It was very clear in both Jenny and Sarah's accounts that they were far more concerned about their children being worried about being overweight than they were about the actual weight in itself. At the same time, both acknowledged that their children were (in Sarah's case) or had been (in Jenny's case) overweight to a level where they had felt the need to intervene. They were concerned that being overweight would restrict their children's lives in terms of what they were able to do, both in the here and now and for the future. The emotional aspect of being overweight was perhaps the biggest hindrance they saw to their children's happiness in the here and now, with both describing the shame their children had experienced over their appearance. Sarah felt this had been something that had affected Rosie particularly before she joined weight management programmes and started gaining more confidence:

"I must say that when she first started going to Mend she used to, like, beat herself up about her weight. She wasn't very kind to herself." (Sarah)

Beyond the emotional implications, both had experienced their children altering their behaviour to avoid certain activities where their weight might be made obvious, such as participating in sports or doing things like going to the beach while on holiday and having to reveal their bodies. For the future, Jenny in particular expressed concern about her son being physically restricted from doing certain things if the overweight had persisted, such as running around and being active with any future children he might have.

“I didn’t want him to not be able to join in or do stuff in his life because he’s overweight, and I didn’t want him to get overweight as a kid and then end up just being a fat adult forever, you know, and being unhealthy and all the rest that comes along with that.” (Jenny)

There was a strong sense for both that they saw the overweight in their children as a possible obstacle to them leading happy, carefree lives, and because of this they had taken steps to try and encourage weight loss. For Jenny this had meant making direct comments to Richard to let him know she had noticed the weight creeping up, while Sarah had been very careful not to mention weight at all. Instead, she had suggested that her daughter join the local weight management programme on the pretext of getting more exercise. Both believed that talking directly about weight to their children could have negative consequences; Jenny was concerned that her direct approach might be responsible for what she saw as unhealthy weight loss in Richard, while Sarah was concerned about Rosie developing ‘hang-ups’ over her body; of her constantly worrying about her weight and the way she looked.

“I think maybe I might have said stuff the wrong way to him that bothered, you know that, then suddenly felt like he was this fat person, you know, and I don’t know...” (Jenny)

“Because I don’t talk to her about her weight, I don’t want to know how much she weighs, I don’t think it’s relevant, you know, I took the batteries out of the scales because she was weighing herself too much.” (Sarah)

The stigma attached to being overweight is clearly recognised by both mothers, and there is a sense that to mention weight would be perceived by their children as a judgment, an attack on their self-worth. They recognised the adolescent years as especially sensitive for being concerned about looks, and that weight is often a big part of that. Sarah in particular talked about the concerns of teenage girls in relation to size and weight, and felt that her daughter had had a lot to deal with in terms of comparing herself to her peers, being bigger and feeling self-conscious because of this. They

recognised the role weight played among their children and their friends in terms of establishing social hierarchies and the extent to which it could impact on friendships and social standing in the peer group.

“... Yeah but definitely I was just more concerned for him on a personal level that he didn’t look at himself and think, you know... “oh they’re better than me because I look like this, or, you know...” (Jenny)

For both Sarah and Jenny it was important that their children would not define themselves by their weight; that it would not become the marker they set their life’s worth by:

“I really, I really you know I don’t want her to feel like her weight, or even her appearance, is what she is. Like, you know I have to have these conversations with her like when she’s being down on herself and stuff like, you know, it’s one small part of you, you know, you’re funny, you’re intelligent, you’re a good friend.” (Sarah)

Both mothers were aware of their children having been bullied in the past, and saw some association between the bullying and the weight; another confirmation for them of the importance of weight in navigating social relationships. Jenny expressed concern that the fact that Richard now had a much bigger social circle than before he lost weight had somehow become manifested as a direct cause-effect relationship for him so that he now would keep trying to lose ever more weight in an attempt to get an ever better life and more friends. She was now very concerned that Richard has gone too far in the other direction with losing weight, not eating enough and getting too thin (although by her own admission she knew that he was in the healthy BMI range). Sarah on the other hand felt that Rosie had moved away from a focus on her weight; she still worried about her appearance but for other reasons than the weight. Sarah attributed this partly to Rosie having participated in a weight management programme that had first and foremost improved her confidence and given her healthy skills to manage her weight, but also by giving her new friends with

whom she felt confident and competent, other young people in the same boat meaning that the weight was no longer the be-all and end-all.

The idea of weight being a taboo topic to discuss with young people is also evident in both Jenny and Sarah's attitudes towards seeking help with weight management and the acceptability of health care professionals discussing weight with their children. Although Jenny had mentioned her concern to Richard when she thought his overweight was getting a bit much in an attempt to steer him towards healthier lifestyle and weight reduction, she had not felt the need to seek professional help at that point – something she however had done later, in discussing her concern about his weight loss with a nurse. She was also far less concerned about the impact of talking to Richard about weighing too little than she was in talking to him about weighing too much, again showing the stigma attached to overweight. To be underweight might be as much of a health concern as overweight but does not hold the same negative connotations, and is not taboo in the same way. Similarly, Sarah's biggest concern in having HCPs discussing weight with Rosie was the fact that they would be mentioning the weight in the first place, something that she did not do. She was concerned about Rosie feeling singled out or judged:

"I wouldn't want them to talk to her about it, or not about her weight, like if they wanted to talk about, 'oh, you know, we're just giving this general advice', and that she didn't feel like it was directed at her, ehm, that would be alright, but for them to talk to her directly about her specific weight, ehm, I'd be a bit worried about that." (Sarah)

Throughout both interviews, their children's weight was talked about very much as being relevant for emotional well-being in the here and now as well as for the future. The impact of weight on physical health was not something that featured strongly, if at all, in their stories – it was focused solely on the ability to lead a happy and 'free' life:

"I mean obviously if he'd have got very big then, then you're thinking he could have a heart attack, you know, or all that sort of side of it, ehm... he, he wasn't that big that I was

becoming that concerned about it, I was being more concerned for him on a, you know, a personal development level that he, that he would grow up feeling... you know, happy with himself and who he was. Cause I didn't have that, and I would like... I didn't want to see him feel like that about himself, and... yeah, I just didn't want him to feel, feel crappy really."

(Jenny)

Finding a balance

Strongly linked to the idea of the importance of maintaining a healthy weight for the happiness of their children was the notion of achieving a balance. The need for balance was discussed by both Jenny and Sarah in several contexts. First of all, they both expressed a hope that learning to manage weight now, at this age, would mean that their children would develop a natural balance between healthy behaviours (which were seen as necessary) and less healthy ones (which were seen as more pleasurable) so that this would become second nature to them, something they would not really have to think about. This involves making a judgment call on what is healthy or not, and such judgments were usually around the amount and types of foods eaten (good v bad) and exercising (engaging in v refraining from). What both really wanted for their children was the ability to engage in at least some behaviours that they wanted to without needing to be restricted or constantly monitoring themselves. If this was achieved, there was a sense that both mothers believed their children's lives would be happier and more carefree:

"I just want it to be a balanced part of her life, I don't want it to be something that I, I certainly don't want her to be going through [inaudible] this diet, that diet, constantly battling, I just want her to enjoy food, enjoy life, without having to see it as the enemy, you know?" (Sarah)

"You know, and I don't want him, I would like him to go "oh well I was a bit overweight there and I lost the weight and now I'm alright. And now I'm having a perfectly normal relationship with food". Rather than chopping and changing, messing about and yo-yo'ing, which I think it's what I've probably done since I started, you know, since I had [other son], for the last 15 years." (Jenny)

This balance was talked about both in terms of substituting less healthy foods with healthier ones, as well as balancing food and exercise. Sarah talked about exercise very much in the sense of compensating for eating less healthy, or large amounts of, food. This was why she had initially focused on the physical activity aspect of the weight management programme Rosie was enrolled in; the fact that it would provide the exercise that Rosie was not doing voluntarily.

“I’ll say to her ‘you do too little exercise, you can’t, you can’t keep eating things that are high in calories, ehm, if you want to be able to do that you need to do more exercise’. So I try and, I, you know, I never ever say things like ‘you are fat’ or ‘you will get fat’ or, I always talk about, ehm, you know, if you want to intake that many calories you need to burn off that many calories. So that’s how I will kinda have those conversations.” (Sarah)

Meanwhile, Jenny was concerned that Richard’s focus on food in his weight loss endeavour had become obsessive and overly restrictive. She felt that if he had incorporated more exercise he would not have needed to eat as little as he now did, and may have developed a more ‘normal’ relationship with food. Thus, exercise may provide a balancing role both by compensating for bad foods, but more generally in negating the need to worry too much about food intake in the first place. Again, this need for balance was talked about by both in terms of its positive impact on emotional well-being to a much greater extent than for physical health outcomes. However, Jenny also expressed a worry that eating healthily and exercising went beyond just weight to a wider impact on health more generally:

“And... you know, still I worry that he’s not, he’s not eating health... just because he’s lost the weight I don’t know how healthy he is if I took him for a health check to see what his cholesterol was and all the rest of it. I mean he hasn’t got, you know, the weight so that’s one thing, but you can still be slim and be just as unfit, can’t you, you know, and that’s what concerns me.” (Jenny)

The reason both mothers had intervened as they found their children gaining weight were tied in with this desire to promote balance in their children's lives. But at the same time, there was a fear that intervention in itself could tip the balance in the opposite direction. This was what Jenny experienced in her relationship with Richard; that by suggesting he might need to lose weight she had pushed him to become overly concerned about food and weight. Sarah's concerns about Rosie developing hang-ups over her body, as described above, was indicative of similar fears. Thus both mothers found themselves in a delicate balancing act in showing concern but not to the extent where behaviour would become disordered in the other direction. The idea of weight easily getting out of control was another feature of this balancing act; that if not constantly monitored and 'policed', body weight would easily escalate. In the other direction, Jenny described being alarmed at Richard's sudden weight loss, and the fear this brought that he might go too far in the other direction:

"I mean... when I spoke to him about not eating I felt like a, a slight panic point, you know? With it, that "Oh my god, how do I sort of get a handle on this, I don't want to suddenly wake up and there's a skeleton coming down the stairs", you know? Ehm... so maybe I'm more concerned about people being too skinny [laughing], I don't know..." (Jenny)

Theme 2. Being a parent

The concerns described by Sarah and Jenny above lead in to the second major theme across the interviews; that of what it means to be a parent in the context of having an overweight adolescent. Under this theme three sub-themes were identified. First and foremost the sense of **responsibility** you have as a parent for your children's well-being. Strongly interlinked with the notion of responsibility were the direct actions undertaken by both mothers, in the form of **monitoring** and **making changes**

Responsibility

The decision to intervene in their children's weight gain was for both Jenny and Sarah to some extent borne out of a certain sense of responsibility. However, in line with the first major theme of ensuring well-being, this responsibility was not so much about having a responsibility to not have an overweight child (as a marker of good parenting) as it was about their responsibility to ensure their children's happiness. Thus it stemmed from care and nurturing rather than any form of control. At the same time, the sense of not actually having control over their children's weight and behaviours were at times described as frustrating by both. For Jenny at the present time that lack of control focused more on Richard's sudden weight loss and how she felt she might have failed in her parental responsibility duties:

"I was trying still to get a little bit of a handle on it before it got out of control. Ehm, and it never suddenly exploded where he suddenly was really, really overweight, whereas the other way, he just suddenly weren't... And I was like "oh my god, I wasn't...". It was like the train had run away with me. You know?" (Jenny)

Meanwhile, in relation to his previous overweight, her sense of responsibility appeared to be not so great; she did not feel that she had overfed him (and qualified this by explaining that none of her other children were overweight), and when she became concerned she had brought up the issue with him. Her sense of responsibility for Richard's (as she saw it) unhealthily low food intake stemmed from her worry that the way she had gone about intervening in his weight gain had resulted in his weight loss. In contrast, the overeating that had resulted in his original weight gain was not something that she had even been overly aware of and did not express any sense of responsibility for.

For both Jenny and Sarah, their children's entry into adolescence and greater freedom to choose their own foods had resulted in a loss of control. This ability to keep certain things hidden or secret

from parents was recognised by both as a normal part of being a teenager, and extended for Sarah into letting Rosie keep most of the details about the programme she attended to herself. Sarah even theorised that if she were to try to find out more about the ins and outs of the programme, asking questions and insisting on details, Rosie might lose interest and motivation. Letting her keep it as ‘her’ thing, separate from parental involvement, Sarah believed would keep Rosie more connected and committed to the programme. However, while out-of-the-house food might be outside their control, both mothers felt that they were still responsible for providing healthy food in the house.

“Cause even though teenagers obviously have a lot more choices about what they eat, cause they are by themselves a lot more, you know, pretty much, you know, the food that’s in the house is being bought by the parent” (Sarah)

Both Sarah and Jenny were very careful to present themselves as ‘aware’ parents; they were not in denial about their children’s weight. Jenny was keen to point out that although she considered herself to be overweight, no-one else in the family was and she was aware that Richard’s weight was getting problematic. One of the reasons (beyond granting Rosie autonomy) that Sarah stated that she did not feel the need to be too heavily involved in the weight management programme was because she knew everything she needed to know about healthy eating and exercise – she mainly felt that Rosie might be more open to those messages if they came from someone else other than herself.

“I almost feel like that’s probably some of the reasons, one of the reasons she doesn’t tell me some of the things they’ve said, because they’ve probably said the sort of things to her that I say to her, and she’s not going to want me to know that, cause.... It’s gonna like be validating the things I’ve said to her.” (Sarah)

While wanting to monitor to a certain extent, there was also a recognition throughout of their children’s growing independence and the need to respect and nurture that without losing insight

completely. This ties in with what they both felt was a large part of their parental responsibility regarding their adolescent children's weight – preparing them for the future, enabling healthy lifestyle habits that would maintain that balance that they were both so eager for their children to achieve. While their children were still living at home, both felt that they had a certain control over food intake, keeping an eye out for any extreme behaviours, and being able to monitor progress. Once they move out of home, however, if there was a problem already it may escalate out of control:

"I suppose what I worry about is that, ehm, actually, if she doesn't learn good habits about what she eats now, once she can afford to buy all her own food and she hasn't got my influence in her life, actually her weight could rocket. Ehm... because she does no exercise. So I just feel like she hasn't really got the balance right so I sort of, I suppose I, I worry" (Sarah)

"I did use to discuss that with him before he lost the weight, the concern that when he goes to live on his own he can just buy whatever he wants, and then where's the... where's the regulation on what's healthy and not. I mean I know we have to grow up and make them choices for ourselves, but I mean as a parent you're trying to, hopefully, instil that a bit." (Jenny)

Monitoring

The sense of parental responsibility towards their children's well-being led to a certain amount of monitoring by both parents. Monitoring was done as a means of knowing what their children were eating (diet and eating habits were discussed to a greater extent than exercise), keeping track of their activities and keeping a check on weight. In relation to food, Sarah talked about her experience with the lunchtime system in place at Rosie's school, which meant she could check what Rosie had eaten during the day. This system provided her with some peace of mind that her daughter would eat better during the day than if she was completely unmonitored as had been the case before, and that if she did not Sarah would know and could confront her. She had put sanctions in place when she had found Rosie making too many unhealthy choices, and appeared to take quite a hard line on

what she found acceptable for her daughter to eat. At the same time, she sometimes found discrepancies between the system reports and what Rosie told her, meaning that she was not always sure who to trust.

“It does give you like a bit more knowledge but it’s also quite confusing cause she’ll say ‘I didn’t eat that, I didn’t eat it’, and you sort of think ‘you must have done, it says there, says it there’ but then you, you know, you’re like ‘oh maybe she didn’t, maybe the till system is wrong’, or... I don’t know.” (Sarah)

Both mothers presented themselves as very aware about healthy lifestyles, and made sure to explain that the foods they cooked in the house were healthy. Neither of them felt that their children did, or had, eaten unreasonable amounts in terms of regular meals, and therefore felt that snacking or foods eaten outside of the house was mostly to blame for the weight gain. Sarah felt sure that Rosie had previously used part of her lunch money to spend on sweets which is why she felt happier now that she could monitor where the money went more closely, but Jenny was more at a loss as to explain Richard’s weight gain. She conceded that he must have bought and eaten things without her being aware of it, but other than restricting snack foods available in the house she did not appear to have tried to monitor his food intake too closely while he was gaining weight.

“I just noticed him putting on weight, I didn’t notice him eating more. Though obviously he wouldn’t have just suddenly put on weight, I suppose, I don’t know.” (Jenny)

Related to this, both mothers experienced that their children’s eating habits were far more difficult to monitor as they became teenagers and spent more time out of the house, and had their own money. They accepted this as a necessary part of adolescence however, and saw that their children needed more privacy and autonomy as they grew up. While Sarah admitted to being very strict when monitoring Rosie’s food choices at school, she allowed her much more independence with the weight management programme she was attending, which Sarah was very careful not to ask too

much about. She felt it was important that Rosie had that as her own thing and worried that if she monitored this part of Rosie's life too closely, she might be put off continuing. However, it is also reasonable to assume that she felt less need to monitor this aspect since it was set up to promote a healthy lifestyle in the first place.

"But it's a tricky one, isn't it, because you know, I don't want to discourage Rosie from doing it so actually if they were like 'oh, we're gonna tell your parent everything' I think that might discourage her so I think I need to trust her to kind of take in what she's been told and... do something about it, really." (Sarah)

Monitoring also extended beyond behaviours and occurred directly to their children's bodies. Although Sarah was very careful about not wanting Rosie to be monitoring herself with regards to weight (throwing out the scales), she was clearly keeping an eye on her and deciding when the weight looked like it might be getting out of hand. This 'getting out of hand' was also what Jenny had been concerned over for Richard; it was not the weight in itself that she had been overly concerned about, but more that it might get worse and to a point where 'getting back to normal' would be very hard work. Thus, she described her monitoring of Richard's body mostly in terms of making sure he did not get beyond a certain point, and when she had been concerned that point might be getting close she had intervened. Similarly, her monitoring now was done mostly to make sure he did not get beyond a certain point in the other direction, and become too slim. For both mothers, then, monitoring of their children's bodies were done to some extent so that their children themselves would not have to, and to protect them from becoming hung up or overly obsessed with monitoring themselves.

Making changes

Because of their concern over their children's weight, both Sarah and Jenny had seen it as their responsibility as parents to intervene and try and get them to make changes for the better. They were both concerned about causing distress to their children, so any changes that were to be undertaken had to be presented in a way that did not risk alienation. This resulted in a significant amount of negotiation. Because of the perceived need for balance in their children's lives, both mothers had developed a habit of negotiating over foods. Sarah saw her relationship with Rosie to be often characterised by having this negotiating role where she would try and find ways to get Rosie to eat things that in Sarah's mind were healthier. This involved making compromises and meeting in the middle so that they could agree on foods that were acceptable to both. Jenny meanwhile described mainly trying to get Richard to eat something, so for her it was about accepting things that she would consider less healthy just for the sake of him eating something (e.g. nutella) – similarly to how Sarah would negotiate with Rosie to eat something more healthy. Thus, for Jenny this negotiation was about 'better than nothing' while for Sarah it might be 'better than chocolate'. Having to accept these less optimal choices, and drawing boundaries over what is good enough had thus become part of both of their relationships with their children.

"And I might say 'the only thing you're allowed is an apple', and she'll be like 'oh, can I have some raisins?', she'll negotiate with me. So then I don't mind her having like a little box of raisins, but even then I think, you know, it's not as good as an apple, but yeah, I will let her have a box of raisins. It is only a box of raisins after all, it's not like it's a bar of chocolate."
(Sarah)

A certain amount of negotiation could also be seen in how Sarah had presented the weight management programme to Rosie; accepting that she had cut down on her active extra-curricular activities, and the fact that she had more freedom to choose for herself what she ate, but as a compromise attend the programme to get enough exercise. Jenny had been less forceful in

suggesting changes; she had suggested Richard attend different programmes, or join the gym, but had not pushed him to actually do so. Her involvement in his habits was restricted to things she could actively control, like what foods were kept in the house.

Neither Sarah nor Jenny were actively against outside agents discussing healthy lifestyles with their children as long as it was focused away from weight and onto behaviours. They did however see any changes made in their children's lives to be primarily their own responsibility as parents, and would consider outside help only if it fell in line with their own views of a need for balance and avoiding stigma. At the end of the day, their children's happiness and emotional well-being were far more important to them than weight.

Summary: Parents

The interviews with the two mothers presented here revealed that their first and foremost concern regarding their children's weight was their well-being. They had both been worried about their adolescents becoming increasingly overweight, and this worry was partly down to concerns about health and partly for emotional well-being. At the same time, their overarching concern about discussing weight with their children was also that it might impact on their emotional health, and so they preferred discussions centred on health and behaviour rather than weight per se. They strived to promote a balance in their children's lives, wanting them to be happy, carefree and unconcerned about weight. However, they also discussed engaging in various forms of monitoring and negotiation with their children over both diet and exercise, but attempted to do so in ways that would not imply that they saw weight as a problem. This was done in line with how they saw themselves as parents, and being responsible for their adolescent children's well-being. Outwardly however they were keen to present themselves as knowledgeable and aware parents, not in denial about their children's overweight. Thus, there was also a balancing act to be achieved for the mothers themselves, with

regards to which aspects of their children's health would take precedence for how they chose to approach them.

Chapter discussion

The interviews with the adolescents demonstrated how the meaning of weight for them was very much tied in with how they appeared to others and, consequently, their social standing. To manage weight was described in different terms; a way to regain control and being in charge of your body on one hand, or a perpetuation of negative feelings towards the self when 'failing' on the other. The sense of being in control however also had different meanings in different contexts – it could mean having 'total' control in overcoming the body's signals to eat leading to rapid weight loss, but it could also mean having more options so that 'healthy' doesn't always mean 'unpalatable' or 'boring'. The increased sense of control that being in charge of weight brings could be particularly important to adolescents who have very little power in society in general (Pardeck & Pardeck 1990; Graham 2004), but it can also mean that adolescents are particularly reluctant to give up control once it has been gained. From a developmental perspective, the achievement of control is associated with increased understanding of cause and effect (Walker 2001) and the ability to affect outcomes in one's own life is a large part of what marks the transition into adulthood (Schulenberg et al. 1997; Zimmerman & Cleary 2006). Having a sense of autonomy is strongly interlinked with perceived personal control, and research has shown that health promotion messages that are framed to enhance autonomy are more readily accepted by adolescents, as well as resulting in better adoption of health-related behaviour (Williams et al. 1999). This is in line with self-determination theory (Deci & Ryan 2008) and shows that communication that can engender a sense of autonomy over weight is likely to result in better outcomes. Further, the young people in the current study described how increased autonomy and control of weight loss and associated behaviours had resulted in the development of alternative (not overweight) possible selves, and the facilitation of such possible

selves could play a key role in helping adolescents adopting healthier lifestyles (Aloise-Young et al. 2001; Ouellette et al. 2005).

To the mothers that were interviewed, adolescent weight management was very much about parental responsibility and doing what they could to make sure their children would be able to live happy, carefree lives that were not defined by weight. This wish for their children to remain free of being defined by weight manifested in two ways: first, the possibility of their children being restricted in what they could, or felt that they could, do or not do, which in turn was divided into being physically restricted and being psychologically restricted. Secondly, that even if weight was lost and their children gained a more 'normal' weight, they would spend their lives worrying about weight, about putting it on again, and again having to restrict their lives because of it. Thus their biggest concern was being able to help their adolescent children achieve a balanced relationship with food and weight, instilling habits that naturally lead to weight maintenance so that it would become something they would not need to reflect over. This concern about weight ruling lives is not something that is recognised as a problem in guidance on weight management for young people, but it was something that the mothers interviewed for this study saw as far more important for their children's well-being than the weight in itself. Whether it is possible to have a completely unproblematic relationship with food and weight while living in a society where both are hugely salient and receive extensive media coverage is, however, debatable.

The views of the HCPs that adolescents would be less likely to be concerned about their weight if they were in friendship groups where most people were a similar size was borne out by the young people's descriptions of the role of weight in social hierarchies. They compared themselves to others, and being 'not as big as' someone else put them in higher status relative to that person. Similar, although inverse in terms of size, findings have been reported in relation to young men and muscularity (Grogan & Richards 2002). This tendency to compare the self to significant others will impact on self-concept, since the way people view themselves is influenced by how they see

themselves in relation to others (Markus & Wurf 1987). Social comparison begins during pre-adolescence (Ruble et al. 1980) and becomes more pronounced as adolescence progresses (Kroger 2004). Negative self-concepts are known to be associated with internalised problem behaviour in females in particular (Ybrandt 2008) and so this social comparison is a potential precursor to low emotional affect in overweight or obese adolescents. This further demonstrates the necessity for HCPs to fully understand the social context of a young person attempting weight loss; in certain friendship groups being bigger may not mean loss of status and so motivation for losing weight may be less. The emotional impact of weight is also likely to be reduced under such circumstances. Conversely, even if weight loss is achieved, this may not be seen as a significant success if the adolescent is still bigger than most of their peers (Hester et al. 2010).

Overweight and obese adolescents frequently experience stigmatisation over their weight, and expect comments made on their weight to be meant as criticism (Curtis 2008; Griffiths & Page 2008; Holt et al. 2005; Grogan & Richards 2002). Therefore, to just bring up the weight without placing it in the context of health, and without offering any follow-up, might be damaging in just the way HCPs and parents feared, while bringing it up and offering help in a non-judgmental way (focusing on behavioural strategies) might be seen as helpful. At the same time, it needs to be recognised that for adolescents, health consequences that may or may not occur several years down the line are not necessarily going to be a strong incentive for weight loss. By their own admission, weight mattered to them because of its impact in the here and now.

Although the parents interviewed for this study were somewhat reluctant to HCPs discussing weight with adolescents, they also stated a belief that getting diet and exercise advice from someone other than the parent may make the adolescent more likely to adhere to such advice. This is likely to be particularly relevant for adolescents; parents have reported HCPs to not have anything new to contribute above what they themselves are already doing within the family (Edmunds 2005), but for adolescents having the same message come from someone else may be useful in itself. Parents have

been found to find screening and reporting of children's BMI useful (Bennett Johnson et al. 2009; McLean et al. 2007), and report changing eating and exercise behaviours accordingly (Grimmett et al. 2008; Bennett Johnson et al. 2009). It may therefore be the case that as long as weighing and measuring is done routinely, and not just with those adolescents that look overweight, it would be acceptable or even welcomed by parents as the stigma of being singled out because of appearance is reduced.

The meaning of surveillance in relation to weight is also important; monitoring of health related behaviours was reported by the parents interviewed here, but it is also clear from both the current and other research that young people monitor themselves when among other people, and avoid behaviours that would be seen as unacceptable (like eating certain foods) (Curtis 2008). Thus, young people may feel under constant surveillance with regards to their bodies, from parents, peers and the self. In the current study, this surveillance resulted in behaviours like secret eating, which could have implications for health care professionals when negotiating responsibility and control for weight management with parents and adolescents. Further, just the act of eating, whether healthy or not, can lead to sanctions from peers for overweight or obese young people (Curtis 2008), and any intervention needs to take this into account with regards to developing strategies and skills for managing such situations. HCPs need the understanding that weight management is about much more than just changing behaviours, because the act of changing behaviours can also have negative consequences for young people. Both HCPs and young people talked about weight mainly in relation to diet and eating. Physical activity was mentioned, but to a much lesser extent. This is somewhat in contrast with other research which has found HCPs to see lack of physical activity as the primary causative factor (Harvey et al. 2002) and being more likely to recommend changes in physical activity than in diet as a form of intervention (Fogelman et al. 2002; He et al. 2010). In this study, the young people talked about school based physical activity being problematic because the lack of options, and because they were expected to perform poorly by others and were therefore monitored for this assumption to be confirmed. In contrast, when seeking out, or being guided towards, alternative

forms of activities where the pressure to achieve was removed, enjoyment in participation increased. Because of their frequently negative experiences in school sport, overweight and obese young people may need to be given the opportunity to try out alternative forms of activities to find they can actually enjoy them (Daley et al. 2008). Physical activity may also be more likely to be sustained when demand for competence and ability to perform is removed (Brooks & Magnusson 2006).

If the responsibility for weight loss is meaningfully going to be shared between young people and parents, it is essential to understand how this is experienced by the parties involved. As could be expected based on the ages of the young people interviewed, the experience was that responsibility and control were still being tested and negotiated with parents in different areas. All the young people interviewed recognised that their eating habits had changed as a consequence of gaining more independence and being free to buy snack foods for themselves. Because of this, they, as has been reported by other young people (Grogan & Richards 2002), saw a large part of the responsibility for their weight, and weight loss in particular, to lie with themselves. The parents that were interviewed felt a strong sense of responsibility towards their children's health and wellbeing, and to provide the best for them in terms of diet. Both of the mothers felt that they had a good understanding of proper nutrition and that they did well in terms of what they offered their children at home, but both also recognised that they had less influence over their children now that they were older, and that they could not control what they were eating outside of the house. Parental monitoring naturally becomes more difficult as adolescents spend less time together with their parents than they did in younger years (Larson & Richards 1996; Shearer 2005), and parental influences become less important (De Goede et al. 2009). Some forms of parental monitoring over food are associated with healthier food choices in younger children (Clark et al. 2007), so parents' concern over unhealthier eating habits forming when monitoring is no longer possible is valid. However, the relationship between monitoring and food intake in children is complex, and dependent on variables like mothers' own eating behaviour and weight (Ogden 2003; Birch & Fisher

1998), and restrained eating in parents has been linked to overweight in younger children (Hood 2000) further supporting the notion that parental eating habits impact health behaviour and weight in children. The monitoring described by mothers in the current study was presented as rather discreet; it was a form of keeping tabs on their children for their own awareness as much as anything else. However, strict monitoring and control of diet by parents has been linked to restrained eating and symptoms of eating disorders (Carper et al. 2000; Haycraft et al. 2014), and it is important that HCPs have an understanding of these factors when addressing weight with adolescents and parents together. The concern the mothers in the current study showed for what might happen once their children left home and were completely out of their reach showed their sense of parental responsibility to lay the ground for good habits that would stay with their children for life. The conflict that many of the HCPs reported seeing between adolescents and parents (both when weight was discussed and in relation to other matters), was indicated in the parental accounts of negotiation and frustration with how to get their children to eat well. Parents frequently report a deterioration in communication and increasing conflict as children go through adolescence (Pardeck & Pardeck 1990), and may feel that adolescents will do the opposite of what they tell them just to mark independence (Shearer 2005). Therefore, as indicated in both the parent and adolescent interviews, information and discussions about weight may be received more favourably if they are delivered by individuals other than parents, which fits in with the natural progression for young people at this age to move away from relying on their parents and instead create their own lives. The health care setting should thus be seen as one of the contexts where adolescents will start to negotiate this independence, and where a supportive partnership between young people, parents and HCPs will be ultimately conducive to foster independence and autonomy. At the same time however, the young people's accounts also suggested that the newfound freedom they had achieved was not always regarded as unequivocally positive. When some of this freedom was taken away from them and put back into the hands of parents, they would protest outwardly while inwardly feeling a sense of relief that the responsibility for making healthy choices had been

temporarily put on someone else. Adolescents may not always feel ready for such an adult level of responsibility (Hester et al. 2010), and it is congruent with theories of personal control which state that individuals are happy to relinquish control in situations where they believe that putting someone else in charge will result in more positive outcomes (Walker 2001). It also supports research which shows that both autonomy and attachment to parents predict psychosocial adjustment and emotional affect, showing the importance of both for adolescent well-being (Noom et al. 1999). Largely, this negotiation of responsibility can be seen as a healthy process in the normal development of adolescent autonomy, but discrepancies between parental and adolescent perception of competence in relation to health behaviours will impact on negotiation of autonomy (Butner et al. 2009), and HCPs can play a role in facilitating such negotiations in the health setting. This would manifest through involvement of both parents and young people in weight management discussions, perhaps by suggesting areas of responsibility for both, and by addressing young people directly rather than through their parents.

Methodological limitations

One issue that is frequently discussed in qualitative research is how many participants are 'enough' for a study. Qualitative research never aims to be representative of large populations in the way that quantitative studies do, but rather to gain deeper understanding of particular issues through personal experiences. Nonetheless, there are guidelines for sample sizes depending on the particular qualitative methodology used. For IPA, Smith, Flowers and Larkin (2009) recommend 8-10 participants for a study, or smaller numbers in studies that have layers such as investigating one particular issue from the perspective of different stakeholders. The current study fall within this remit, however it would have been desirable to achieve recruitment of 4 interviewees each of parents and adolescents. The variations in the accounts between interviewees demonstrate the

diversity in experiences between adolescents that are overweight, as well as among parents, and further interviews could have provided even richer data.

Chapter 6: Survey of young people

Introduction

This study investigated help-seeking for weight management and barriers to treatment among adolescents aged 16-19 years. The studies described in chapter 4 and 5 identified that both HCPs and young people identified reasons why seeking help for weight management might be problematic for adolescents. This study aimed to get a greater understanding of adolescent help-seeking intentions and barriers to accessing help regarding weight management.

Research suggests that adolescents may have many unmet health needs and do not always get to discuss the issues that are most important to them when accessing health care (Klein & Wilson 2002). They experience many barriers to accessing effective health care, including a perceived disinterest and lack of skills among HCPs in issues that are seen as important to young people (such as mental health) (Lim et al. 2012). Anticipated outcomes of seeking help have been found to affect actual help seeking for emotional problems (Vogel et al. 2005), demonstrating that in order for help seeking to be initiated, there needs to be a belief that the outcome of doing so will be positive and useful. This includes the belief that the person they are accessing for help will be able to provide appropriate and adequate support. The literature reviewed in chapter 2 identified that adolescents may perceive general practice and other health care settings as being more appropriate for physical health concerns than other issues, and that some would be reluctant to seek help for non-medical concerns. There is also evidence that adolescents find HCPs to be less effective at managing non-physical concerns like emotional difficulties than physical health problems (Marcell & Halpern-Felsher 2005). However, to date there is little evidence of adolescent perceptions regarding

overweight and obesity in this regard; whether they perceive it as a health problem and whether they see general practice as an appropriate setting to manage it.

As in other populations, health care beliefs have been found to impact adolescents' decision to seek health care (Marcell & Halpern-Felsher 2005). To date, adolescent health beliefs and help seeking have been explored mainly in terms of traditional physical health concerns, risk behaviours (including substance use and sexual health), and psychological problems (e.g. Marcell & Halpern-Felsher 2005; Wilson et al. 2008). Higher perceived seriousness of a problem, as well as perceived capability of the HCP to manage the issue, predict higher consultation intentions (Marcell & Halpern-Felsher 2005). With regards to health beliefs in relation to weight, it has been found that obese adults seeking help for their weight tend to be older and to have experienced more severe consequences like pain and comorbidity (Fontaine et al. 1998); Tol et al 2014). This supports the idea that adolescents are less likely to seek help with their weight due to experiencing fewer effects on their health, as suggested by the HCPs in chapter 4 of this dissertation. Part of the aim of this study was therefore to investigate whether obese adolescents reported experiencing health problems as a consequence of their weight.

Trust and sense of relationship with provider are factors that further affect adolescents' perceived barriers to help-seeking (Wilson & Deane 2001; Cohen et al. 2005; Kadivar et al. 2014), and a stronger need for autonomy during this time period may also act as a barrier to help seeking among adolescents (Wilson & Deane 2012). Research demonstrates that adolescents are more likely to seek help from informal rather than professional sources (Cakar & Savi 2014), and research among adults shows that overweight and obese individuals prefer to try and manage their weight themselves rather than seek professional help (Tol et al. 2014). One aim of the current study was therefore to investigate the relative ratings of different sources (formal and informal) for help-seeking intentions.

Much of the literature around adolescent help seeking has focused on psychological health (e.g. Wilson et al. 2005; Aisbett et al. 2007; Boyd et al. 2007; Demyan & Anderson 2012). Psychological health issues do have some similarities with weight problems in that they are regarded as ambiguous as to whether they be considered health problems in the traditional sense or not (i.e. something one would seek help from a physical health professional for). Further, there is stigma attached to both issues (e.g. Needham & Crosnoe 2005; Puhl & Latner 2007; Eisenberg et al. 2009), and both are considered sensitive topics that HCPs find more difficult to address with adolescents in particular. However, research shows that adolescents may have more positive views of their providers, and more positive treatment perceptions, when health visits include discussions of sensitive topics (Brown & Wissow 2009). Confidence that sensitive issues are treated sensitively and that confidentiality is maintained is however paramount for enabling adolescents seeking help for such concerns in the first place (Burack 2000).

Study aims

This study aimed to explore intentions among adolescents to seek help from a variety of sources for help with weight management. Further, it investigated barriers to engagement in treatment in GP settings, as well as adolescents' perceptions of overweight and obesity as a medical problem, of their views of the impact of their own weight on their health, and their perceptions of the GP practice as a suitable setting for weight management.

The study also assessed adolescents' help-seeking intentions for emotional health. This is partly because much of the work regarding help-seeking in adolescents to date has focused on emotional health so that comparing intentions for this more established issue could be compared to the relatively novel one of weight management, but also because emotional health was identified in the previous studies by both HCPs, young people, and parents as being strongly interlinked with weight management.

Ethical approval

The study was approved by the University of Hertfordshire Ethics Board (protocol number HSK/PGR/UH/02236)

Method

Materials

A questionnaire was designed to address the objectives stated above (appendix 12). This drew partially on previously developed and validated scales for adolescent help-seeking, and partially on questions designed specifically for the current study.

General Help-Seeking Questionnaire (GHSQ)

Intentions to seek help for both weight-related and emotional problems were measured by the General Help-Seeking Questionnaire (GHSQ; Wilson et al. 2005). It was developed and tested in response to the dearth of instruments that measure help seeking *intentions* as opposed to just 'willingness' to seek help (Wilson et al. 2005), and is based in help-seeking specifically among adolescents.

As used in its original form (Wilson et al. 2005) it is a 10-item instrument that asks respondents "If you were having a (...) problem, how likely is it that you would seek help from the following people?" where for each potential help source option (intimate partner, friend, parent, other relative/ family member, mental health professional, phone helpline, doctor/ GP, minister or religious leader, would not seek help from anyone, and other) respondents are asked to rate likelihood from 1 (extremely unlikely) to 7 (extremely likely). Higher scores indicate higher help seeking intentions.

The GHSQ was developed with the recognition that different problems require different help sources, and can be adapted according to this (Wilson et al. 2005; Deane & Wilson 2007). Further, it can be modified to accommodate different problem types, and incorporate different help sources to meet sample characteristics and study requirements. This means that the number of items will vary from one study to another, depending on context. However, in order to maintain properties as a comprehensive measure of help-seeking, it is recommended that the GHSQ incorporates both formal and informal sources, as well as “none” (Wilson et al. 2005).

The GHSQ can be used as an assessment of overall help-seeking intentions by summing the scores on all items (except ‘none’) and dividing by the number of help sources suggested. It can also be used to look at intentions to seek help from particular sources included in the instrument (e.g. GPs) and so individual items can be looked at in isolation (Deane & Wilson, 2007).

Research has tested the GHSQ and found it to correlate with actual help-seeking (Ciarrochi & Deane 2001; Wilson et al. 2005; Wilson et al. 2008); although correlations are modest, which could be because relatively low rate of actual help-seeking noted among the populations studied (Wilson et al. 2005).

In the current study, the GHSQ for emotional health included 9 sources: intimate partner; friend (not related to you), parent, other relative, mental health professional, phone helpline, doctor/GP, minister or religious leader, none.

The GHSQ for weight included 9 sources: intimate partner; friend (not related to you), parent, other relative, mental health professional, internet/ magazines, doctor/GP, minister or religious leader, none.

Respondents were also asked whether they had ever actually asked for help for their weight and if so, from whom.

Barriers to Engagement in Treatment Scale (BETS)

The Barriers to Engagement in Treatment Scale (BETS) is an 11-item tool to identify “major barriers to young people engaging in treatment during the initial stages of a consultation or therapy session” (Wilson, Fogarty & Deane, 2002, pp4).

The items in the scale consist of statements describing potential barriers to engagement in consultation, and were developed following extensive research on young people’s barriers to GP services (Wilson et al. 2002). Young people respond on a likert-type scale for each item from 0 (agree) to 3 (disagree), with higher scores indicating higher barriers to engagement.

Research has found that lower perceived barriers are associated with higher incidence of intentioned and actual help-seeking, and that BETS scores can improve following interventions to address perceived barriers for help-seeking from HCPs for psychological problems (Wilson et al. 2008).

BETS was developed to be used as a tool by GPs to enhance their interactions with young people (Wilson et al. 2002), and is also used in research to assess young people’s barriers to engage with treatment (Wilson et al. 2008). It is a general (not issue-specific) measure that addresses how comfortable adolescents feel in the GP setting, and how accessible they perceive the services to be.

Perceptions of using GP services for weight management

Perceptions of accessing GP services to talk specifically about weight was assessed using four items: (1) I could talk to a GP if I was worried about my weight, (2) My GP would be able to help me if I wanted to lose weight, (3) A GP is the right person to talk to about weight, and (4) It would be ok for a GP to discuss weight with me even if I didn’t bring it up first. Each item was answered on a four point scale (agree, somewhat agree, somewhat disagree, disagree). The first three items were designed to tap into beliefs regarding the appropriateness of using GP services for weight

management, while the fourth item corresponded to one of the items in the HCP survey (Chapter 4) and was included to test the assumption among HCPs that young people would not want to bring up the issue of weight with them. The first three items were developed for this study while the final one was adapted from Trowbridge et al. (2002).

Self-rated health

Self-rated health was measured with one item that asks respondents: “Overall, would you say your health is...?”, with four response categories (Excellent, good, fair, or poor). The measure is well established for assessing self-rated health in epidemiological surveys (Idler & Benyamini 1997), and has been found to have good psychometric robustness when used with an adolescent population (Cavallo et al. 2006).

Body image and Dieting behaviour

Current engagement in weight reduction behaviour was measured with one item asking respondents: “At present, are you on a diet or doing something else to lose weight?”, where respondents could choose from the following options (1) No, my weight is fine, (2) No, but I should lose some weight, (3) No, because I need to put on weight, or (4) Yes.

Adolescents’ perceptions about their own weight and body size were measured using one item asking respondents: “Do you think your body is...?” where response options were (1) Much too thin, (2) A bit too thin, (3) About the right size, (4) A bit too fat, and (5) Much too fat.

Both items were taken from the Health Behaviour in School-aged Children (HBSC) questionnaire, which has used the items in surveys of several hundred thousand adolescents across Europe and North America since 2001 (Inchley & et al. 2016). The items were developed specifically for the HBSC study.

Weight, height and Body Mass Index (BMI)

Body Mass Index (BMI) was assessed by asking participants for their weight (in st/ lbs OR Kg) and height (in ft/ in OR Cm). All measures provided in imperial units were converted to metric, and BMI was calculated by dividing individuals' weight (kg) by their height (cm) squared.

Beliefs about weight

Beliefs regarding perceptions of weight as a health or medical problem was assessed using a three item measure. Respondents were asked: "Do you believe being overweight is a health/ medical problem...?" and then respond on a five category scale (never, rarely, sometimes, often, always) for each of (1) adults, (2) young people aged 13-19, and (3) children aged under 13 years.

Respondents' perception of weight in relation to their own health was assessed using the question "Have you ever felt that your weight has impacted on your own health or well-being?" (yes/ no).

Procedure

The questionnaire was developed to be accessible online, and was uploaded on SurveyMonkey (<https://www.surveymonkey.com/>). A link to the survey was then posted on facebook and twitter (encouraging others to share in their networks) asking for participants aged 16-19 years, as well as emailed directly to young people within the relevant age bracket (personal contacts) with a request to be shared among peers. The survey was available online for six weeks, at which point further promotion on social media etc. did not generate any further uptake.

At this stage, data was downloaded from SurveyMonkey into SPSS (v 21) using SurveyMonkey's data export tool.

Data analysis

After the data had first been downloaded into SPSS, frequencies were run on all variables to establish outliers, inconsistent and incorrect data. All inconsistencies were checked against the original data and adjusted or removed accordingly. Data was then analysed using cross tabs, correlations and comparisons of means as appropriate.

Results

Demographics

In total, 83 people completed the survey. After screening for age, 13 respondents were removed for being too old (> 19 years) and two respondents were removed for being too young (< 16 years), leaving 68 respondents. Of 60 respondents that stated their gender, 19 (28%) were male, 39 (57%) were female, and 2 (3%) preferred not to say. The majority (58; 97%) lived in England, one in Scotland, and one in Northern Ireland (eight participants did not answer the questions of where they lived). Demographic details are presented in table 6.1.

Table 6.1: Sample characteristics

	N	%
Gender		
Male	19	28
Female	39	57
Prefer not to say	2	3
Age		
16	7	11.7
17	7	11.7
18	25	41.7
19	21	35
Location		
England	58	97
Scotland	1	1.5
Northern Ireland	1	1.5
Accommodation		
At home with parent(s)	31	52
In student accommodation	29	48
Ethnicity		
White British	38	55.9
Indian	3	4.4
Pakistani	2	2.9
Traveller	1	1.5
Other Asian	5	7.4
Other black	1	1.5
Other white	8	11.8

BMI status

Nineteen participants did not provide sufficient data to enable BMI calculation. Among the remaining 49, BMI ranged from 16.6 to 36.7, with a mean of 22.9 (sd 4.27). Mean BMI was slightly higher for males than females (23.3 v. 22.5). BMI category by gender is provided in table 6.2, using the BMI classification provided by the World Health Organization (WHO)¹. A similar proportion of males and females were classified as being above 'normal' BMI.

Table 6.2 BMI classification by gender

	Male (n=15)	Female (n=33)	Prefer not to say (n=1)
Underweight	13.3% (2)	9.1% (3)	-
Normal weight	60.0% (9)	66.7% (22)	-
Overweight	13.3% (2)	18.2% (6)	100% (1)
Obese	13.3% (2)	6.1% (2)	-

In order to enable comparisons within categorical variables, the four BMI categories were combined into two categories of "overweight" (overweight + obese; OW) and "non-overweight" (normal BMI + underweight; NOW). While almost all participants that were classified as OW rated themselves as being 'too fat', some of the NOW also did so. Further, half of the NOW participants stated that they either were, or 'should' be, on a diet in order to lose weight (table 6.3).

¹ http://apps.who.int/bmi/index.jsp?introPage=intro_3.html& (accessed 19 March 2016)

Table 6.3: Body image and dieting

	Overweight (OW; n=9)	Non-overweight (NOW; n=36)
<i>Perception of body</i>		
Too thin	11.1% (1)	11.1% (4)
About the right size	0%	38.9% (14)
Too fat	88.99% (8)	50.0% (18)
<i>Currently on a diet</i>		
No	11.1% (1)	50.0% (18)
No, but I should lose weight	44.4% (4)	33.3% (12)
Yes	44.4% (4)	16.7% (6)

NB: Four missing due to incomplete responses

GHSQ

Both the GHSQ for emotional health and GHSQ for weight had good internal reliability (Cronbach's alpha 0.63 and 0.64 respectively). Removal of any of the items did not significantly improve reliability. The mean score for the GHSQ for emotional health was 3.75 (sd 0.86), while the mean score for GHSQ for weight was 3.06 (0.97), demonstrating that overall intentions for seeking help for weight were lower than intentions for seeking help for emotional problems (Wilcoxon signed ranks test; $p < 0.05$).

There was no significant correlation between BMI and GHSQ scores for emotional health problems (Spearman's Rho -0.088 ; $p = 0.53$), or GHSQ for weight (Spearman's rho, -0.207 ; $p=0.16$).

Investigation of individual help seeking sources within the GHSQ revealed that for both emotional problems and problems with weight, friends were the source reported as most likely to be consulted, followed by intimate partner. Seeking help from no-one was rated as more likely with regards to help for weight than for emotional problems (table 6.4).

Table 6.4: GHSQ scores

	GHSQ mental health		GHSQ weight	
	Mean	Sd	Mean	Sd
Intimate partner	5.04	1.87	3.77	2.01
Friend (not related to you)	5.18	1.43	4.29	1.90
Parent	4.27	1.69	3.44	1.87
Other relative	3.53	1.56	2.87	1.62
Mental health professional	3.77	1.77	2.33	1.67
Doctor/ GP	3.41	1.43	2.61	1.73
Minister or religious leader	2.33	1.80	1.51	1.22
Phone helpline	2.66	1.72	n/a	n/a
Internet/ magazines	n/a	n/a	3.62	2.25
I would not seek help from anyone	2.74	1.62	3.69	2.07

There was no significant difference between those who said they had asked for help with their weight in the past and those that had not in GHSQ scores for either mental health (4.19 (sd 0.93) v 3.66 (0.86); sd Mann Whitney U-test p=0.19) or for weight (3.61 (sd 1.04) v. 2.96 (sd 0.95); Mann-Whitney U-test 0=0.17).

No significant difference was found between male and female participants for either GHSQ for emotional health (3.71 (sd 0.99) v. 3.78 (sd 0.85); Mann-Whitney U-test p=0.75) or for weight (3.31 (sd 1.36) v. 2.92 (sd 0.74); Mann-Whitney U-test p=0.27).

BETS

Reliability testing revealed strong internal reliability for the BETS scale (Cronbach's alpha 0.78). The overall mean score for BETS was 1.1 (range: 0-3), suggesting relatively low perceived barriers to engagement in GP services. There was no significant relationship between BMI and BETS scores (Spearman's Rho 0.139; $p = 0.356$); between GHSQ for mental health and BETS (Spearman's Rho 0.135; $p = 0.355$), or between GHSQ for weight and BETS (Spearman's Rho -0.178; $p = 0.603$). Mann-Whitney U-test also revealed no difference in BETS scores between OW and NOW participants ($p = 0.604$).

Perceived health and actual help seeking

Although a slightly higher proportion of OW compared to NOW (33% v. 22%) reported having ever asked anyone for help with their weight, this difference was not significant (Fisher's exact test, $p = 0.666$). There was also no significant difference between groups with regards to saying that they felt their weight had impacted on their health (78% of OW answered yes compared to 74% of NOW; Fisher's exact test, $p=0.60$). However, when asked to rate their health from 'poor' to 'excellent', none of the respondents in the OW category rated their health as excellent (compared to 17% of NOW) and 67% of OW (compared to 23% of NOW) rated their health as 'fair' or 'poor'. Further, when the four categories in the perceived health variable were collapsed into 2 (combining 'excellent' and 'good' into one; and 'fair' and 'poor' into another), people rated as OW were significantly less likely to rate their health as 'excellent or good' than those NOW (33% v. 77%; Fisher's exact test $p=0.019$).

More than half (54%) of respondents stated overweight and obesity to be a health/ medical problem in adolescents 'often or always', compared to 64% for among adults and 42% for among children (table 6.5).

Table 6.5: Perceptions of weight as a health problem

	Never	Rarely	Sometimes	Often	Always
Overweight and obesity is a problem...					
In adults	0	6% (3)	30% (15)	42% (21)	22% (11)
In young people aged 13-19	0	8% (4)	38% (19)	34% (17)	20% (10)
In children under 13 years	2% (1)	16% (8)	30% (15)	28% (14)	24% (12)

There was no relationship between BMI and ratings of overweight/ obesity as a health problem for any of the age groups suggested (table 6.6).

Table 6.6: Correlation between BMI and perceptions of weight as health problem

	Spearman's Rho	p
<i>Overweight is a health/ medical problem...</i>		
In children aged under 13 years	- 0.054	0.717
In adolescents aged 13-19	- 0.072	0.628
In adults	- 0.102	0.490

For all four questions regarding talking to a GP about weight, OW young people tended to be somewhat more likely to agree that discussing weight with a GP would be possible and appropriate, however the differences did not reach statistical significance (table 6.7).

Table 6.7: Attitudes towards discussing weight with a GP

	OW (n=9)	NOW (n=35)	P value (Fisher's exact test)
I could talk to a GP if I was worried about my weight	67% (6)	63% (22)	1.000
My GP would be able to help me if I wanted to lose weight	67% (6)	60% (21)	1.000
A GP is the right person to talk about weight	67% (6)	49% (17)	0.462
It would be ok for a GP to discuss weight with me even if I didn't bring it up first	78% (7)	71% (25)	1.000

NB: 5 missing due to incomplete responses

Discussion

This study investigated health beliefs, help seeking intentions, and barriers to treatment for weight management among 16-19 year old adolescents in the UK. Overall, the findings suggested that although attitudes towards GPs ability to provide help for weight management were generally favourable, and perceived barriers to treatment were low, intentions to seek help for weight management were low in this sample.

Adolescents have been found to desire consultations on more non-medical issues by HCPs (Ackard & Neumark-Sztainer 2001), yet their actual intentions of accessing such help has been found to be low also in previous studies (Boldero & Fallon 1995; Wilson et al. 2005). The current study found a slightly higher score for emotional health help-seeking intentions than has been reported previously (Wilson et al. 2008), however, GHSQ scores were lower for weight than for emotional health, indicating lower help seeking intentions for weight. The mean score on the GHSQ for weight was

below the mid-point of 4, suggesting that overall intentions to seek help for weight leaned towards the 'unlikely' end. In contrast to previous studies on help-seeking (e.g. Deane & Todd 1996; Demyan & Anderson 2012), prior experience of having asked for help did not predict higher help-seeking intentions in the current study, although it is possible the sample was too small to detect a difference. Also in contrast to previous research (e.g. Garland & Zigler 1994; Schonert-Reichl & Muller 1995; Raviv et al. 2000; Demyan & Anderson 2012), the current study did not detect any differences in help-seeking intentions between males and females. It is possible that more in-depth questions regarding the nature of that help-seeking source, and whether formal or informal, would have helped shed light on this. Qualitative methods could be used to explore the nature of help-seeking for weight among adolescents, the processes and perceived helpfulness. Adolescents preferred informal over formal sources of help; which has also been found to be the case for help-seeking for emotional problems in previous studies (Grinstein-Weiss et al. 2005; Wilson et al. 2005; Cakar & Savi 2014). Intentions for seeking help from a GP received the lowest likelihood scores except that for religious leader, meaning that although adolescents may perceive such services as acceptable for weight management, they do not have intentions to seek them out. Further, vulnerable populations of young people are at increased risk for avoiding help seeking through the help negation process, which suggests that likelihood of seeking help decreases as psychological distress increases (Wilson 2010). There is also evidence that when trying to solve problems that has an ego-focus, children avoid asking for help in order to mask incapacity (Butler & Neuman 1995). Weight-loss may be considered an ego-focused goal if adolescents feel they know what they 'should' do to lose weight, and the outcome is centred on appearance. Focusing attention to mastering the behaviours associated with weight loss rather than the weight itself could help in this respect. Taken together this supports the importance for HCPs to engage in opportunistic conversations about weight with adolescents, especially since the data presented here suggests young people do not mind such conversations being initiated.

The barriers to engagement in treatment scores indicated that adolescents in the current study perceived barriers to be fairly minor. Further, both overweight and non-overweight young people were fairly positive with regard to rating the appropriateness of GP services for help with weight. As well as being used as a screening tool, BETS can also be used by GPs to assess young people's barriers to engagement in treatment prior to consultation, and this can be used as a way in to conversations about sensitive topics. Consultation time in general practice is limited, but if young people are encouraged to complete such a tool prior to the consultation, and if it could be used effectively by GPs (incorporating greater training), consultations may be more effective overall. It may also lead to increased confidence among HCPs in discussing sensitive issues with adolescents. Research shows that skills training can improve health care provision by HCPs for adolescents (Lustig et al. 2001), and that connecting HCPs with schools reduces young people's perceived barriers and improves intentions to seek health care (Deane et al. 2007; Magnusson et al. 2004). Training adolescents in effective communication with HCPs may also be a way to empower them to seek help (Towle et al. 2006). Interventions to improve young people's views of GP services with regards to accessibility/ approachability have demonstrated that such interventions are particularly useful for improving help seeking regarding psychological (as opposed to physical) problems (Wilson et al. 2008), which may partly be due to greater barriers and lower intentions for accessing help for emotional problems in the first place. This suggests that there is potential for increasing help seeking intentions also for weight among adolescents.

That individuals who are not overweight or obese see themselves as being too fat is supported by other research (Fitzgibbon et al. 2000), and although BMI and body satisfaction have been found to correlate, a non-overweight BMI does not necessarily equal body satisfaction among adolescents (Eisenberg et al. 2006). Social comparison and engagement with media promoting certain body types have been found to correlate with body dissatisfaction in this age group (Botta 2003). However, body dissatisfaction was still higher among overweight young people in the current study, suggesting that although it may be common among adolescents generally, those that are overweight

risk becoming particularly stigmatised. If bodies that are within the 'normal' or 'healthy' BMI range are still perceived as being 'too fat', the judgements of larger bodies become magnified. The fact that virtually all of the overweight adolescents, and 50% of non-overweight, rated themselves as 'too fat' suggest that the point at which bodies are judged to be an acceptable size is lower than that considered healthy by BMI. However, there is evidence that among young women at least, body satisfaction increases during emerging and early adulthood, suggesting that late adolescence (as investigated in the current study) may be a peak point for distorted body image (Eisenberg et al. 2006). The implications for HCPs are to be aware of this and not dismiss adolescent concerns about body size, as it risks them being seen as unsympathetic. Staying focused on what is considered healthy or not (as opposed to 'normal' or 'right') may help in this respect.

While there was no difference between overweight and non-overweight adolescents in terms of saying that weight had impacted on their health in the current study, the self-reported health item revealed that overweight adolescents reported significantly worse health than non-overweight adolescents. It is therefore possible that despite the perception that weight has not yet had time to have an impact on health among young people, health is nevertheless impaired although this is not consciously connected to the weight. It may be that specific and typical health problems are absent (which would account for not perceiving health consequences of weight), but that overall well-being is sub-optimal. Further, although young people were more likely to rate obesity and overweight as a health problem in adults than in adolescents, more than half of the respondents still thought it would be considered a health problem in young people 'always or often'. This contradicts the idea that adolescents do not see weight as a health or medical problem at all.

Strengths and limitations

Due to the small sample, some categories were collapsed to enable statistical testing; it is possible that some of the nuances of responses therefore got lost. Had a larger sample been obtained it

would have been possible to conduct sub-sample analysis, e.g. comparing overweight who were on a diet compared to those who were not. Further, because males were under-represented in the current study a larger sample may have enabled more in-depth investigation of gender differences. More than a quarter of the sample (27%) did not provide sufficient data for calculating BMI. A high percentage of missing data for height and weight is not unusual in surveys of adolescents in the UK; cross-national research shows that young people in England, Scotland, Wales, and Ireland have a higher proportion of missing data for height and weight than most other countries in Europe (Currie et al. 2012). This could be because adolescents in other countries are more regularly subjected to routine measuring and are therefore more likely to know their height and weight. It could also be that the stigma around body measurements is higher in the UK and Ireland than in many other countries so that adolescents are more reluctant to disclose this information.

Despite the missing data, the average BMI of the sample is close to what has been found in the Health Survey for England (HSE) for 16-24 year olds, although the HSE reported higher BMI among females than males in this age category (Moody 2013). The proportions of overweight and obese in the current study were lower than that reported for 16-24 year olds in HSE; possibly because of the wider age bracket in HSE (overweight and obesity was found to increase with age).

Conclusion

Young people reported low perceived barriers to engagement in treatment and were generally positive about general practice as a setting for weight management, but their help-seeking intentions for weight were low. Both overweight and non-overweight adolescents were receptive to discussing weight with a GP, and since overweight young people were significantly more likely to rate their health poorly than non-overweight, a general discussion about self-rated health may be a way in for HCPs to bring up the issue of weight in overweight and obese adolescents.

Chapter 7: Discussion

Introduction

This chapter will bring together the findings from the preceding studies: the survey of health care professionals, qualitative interviews with professionals, qualitative interviews with young people and parents, and the survey of young people.

It will start by outlining key findings, followed by implications for theory and practice. Finally, a reflective account of the research process will be provided.

Key findings

Across all the studies, it became apparent that the extent to which all the parties involved considered weight and obesity to be a medical problem that should be addressed in primary care was complex and ambiguous. It was quite clear that potential consequences of overweight and obesity were considered to be of medical relevance, but in the absence of such consequences weight was considered in a much more psychosocial perspective.

From the HCP perspective, weight management with adolescent patients was complicated because they did not perceive young people to want the issue addressed in primary care, and because they felt ill equipped to manage the emotional aspects they felt would be associated with discussing weight loss with adolescents. This reluctance to engage in such consultations with young people was primarily rooted in a fear of causing psychological harm to their patients, but also associated with their own views of the professional role.

From the young people's perspective, intentions to seek help with weight loss from any source was low, and particularly so for general practice. This was despite a majority of young people reporting low perceived barriers to engagement with GP services, and broadly positive attitudes towards HCPs discussing weight with them. However, both young people and parents echoed the concerns of HCPs that to have weight brought up as an issue could cause potential distress, although it also became clear that as long as such conversations were handled sensitively they would not be outright rejected.

Implications for theory

From all the studies presented here, it became apparent that obesity as a problem was seen within a biopsychosocial context to the extent that the 'medical' might be the aspect that was most frequently questioned. This had implications both for adolescents' intentions to seek help, and for the way weight was addressed within consultations.

Help seeking

The primary antecedent for seeking help, the recognition and definition of the problem (Cornally & McCarthy 2011) was supported in the current research in that almost all of the overweight and obese young people saw themselves as weighing more than they thought they should, and reported that they were doing something to try and change that. However, out of all the participants in both the interviews and the survey, only one reported having actively asked for help from a HCP.

Although this evidence for self-initiated action suggests that adolescents are managing their weight on their own, the interviews suggested they may not always have the adequate skills to do so. The experiences showed that one of the biggest issues in dealing with weight was not feeling able to control it, and not having the appropriate skills and strategies. This related both to not having

directly relevant skills with regards to eating or exercise, as well as not having adequate coping skills when dealing with other difficulties and thus turning to food for emotional support. To gain mastery and control over one's own life is an integral aspect of adolescent development (Schulenberg et al. 1997), and is also central to the concept of empowerment (Wallerstein 1992). Empowerment in health care settings means enabling patients to be in charge of their health, and "becomes a strategy that directly addresses the lack of control over destiny" (Wallerstein, 1992 pp200). This suggests that the needs of adolescents in terms of help with weight management are as much about support and enablement of being in control as they are about practical advice regarding weight loss strategies.

The decision to seek help has consistently been shown to be associated with gender in previous research (Garland & Zigler 1994; Schonert-Reichl & Muller 1995; Raviv et al. 2000), however the survey of adolescents found no gender differences in help seeking intentions for weight. It is possible that this discrepancy reflects the higher stigma around overweight and obesity experienced by young women as opposed to young men (Tang-Péronard & Heitmann 2008) which might inhibit their help seeking intentions to a greater extent and so balance out the gender differences usually found. Further, there is evidence that late adolescence is a peak point for body image distortion among women (Eisenberg et al. 2006), suggesting this is a particularly vulnerable time for experiencing stigma.

Theories of help seeking posit that it is more likely to be initiated when attitudes toward services are positive (Cramer 1999; Gulliver et al. 2010), however as demonstrated here, positive attitudes are not enough. Although the survey supported the idea that adolescents believe weight to have health consequences, the interviews suggested that adolescents distinguish between prevention and treatment, and that they see weight management to be purely about illness prevention which may not be seen as a legitimate reason for accessing general practice. This was also the perception of the HCPs with regards to adolescent beliefs about weight. The interviews illustrated that the fear of making weight visible may prevent adolescents from initiating conversations about weight. This

might be explained if weight gain is considered a personal failure, in that adolescents avoid asking for help in order to mask incapacity (Butler & Neuman 1995). The way young people talked about the meaning of food in the interviews suggests that they felt that they were held accountable for their weight through the choices that they made. The way they described other young people to talk about weight also supported the idea of weight as a personal failure. The fact that a majority of young people who were overweight reported being on a diet or doing something to lose weight supports the idea that adolescents felt weight was something that needed action, but stigma prevented them from asking others to help with this. This fear of stigma related to the health concern in question has been found to be a barrier to effective help seeking among adolescents also in relation to mental health problems (Gulliver et al. 2010). The preference for informal over formal sources of help found both in the current study and in previous research could be an expression of the desire to minimise threat and stigma (Grinstein-Weiss et al. 2005; Murray 2005; Cakar & Savi 2014).

However, part of the reason for the reluctance of young people to seek help for weight may be because of a lack of past help-seeking experiences. Both the survey and the interviews demonstrated that few of the adolescents had ever consulted anyone for help with weight, and particularly not formal sources like HCPs. Previous research has shown that positive past experiences are predictive of greater help seeking intentions (Demyan & Andersson 2012; Vogel et al. 2005; Gulliver et al. 2010), so this absence of experience leaves adolescents without any frame of reference for weight management consultations. The young people's interviews demonstrated that when someone had discussed weight with them in a sensitive manner, this had overcome some of their initial fears that to have someone else making the weight issue visible would by necessity be an unpleasant experience. This suggests that such positive experiences may increase intentions for help seeking partly through reducing perceived stigma. However, the reluctance of the HCPs to bring up

weight indicates that opportunities for experiencing positive weight management consultations for adolescents currently are few and far between.

Much of the research that has addressed adolescent help seeking is focused on mental health services and emotional distress (e.g. Cramer 1999; Gulliver et al. 2010), and although intentions for help seeking have been found to be low in such studies, intentions to seek help for weight were even lower in the current research. A part explanation for this may be that in contrast to weight management, there are dedicated services for young people's emotional health. Thus, the issue of mental health may be seen as more legitimate than weight, which could result in lower help seeking intentions (Murray 2005).

In contrast to the self-initiated action of help seeking, the HCPs frequently described adolescents attending for weight management reasons as having 'been brought' by their parents. This portrayed a rather passive role on the part of the adolescent, a role that was frequently reluctant or outright resistant. This shows the complicated position of adolescents, where they are alternating between being active agents in control of their own lives on the one hand, and still being subjected to the decisions made by parents or carers on the other. In this sense, it can be questioned who the 'patient' really is in consultations that involve adolescents – it was evident that patient-practitioner partnerships of the kind that engender power and responsibility sharing were difficult to achieve with an adolescent patient under such circumstances – in particular if the parent was reluctant to relinquish control, and insisted on being present during the consultation. This goes directly against the idea of empowerment (Wallerstein 1992). Parental involvement does not necessarily preclude the possibility of empowering encounters, as was demonstrated through the initial identification of weight as a problem described by the mothers interviewed.

The consultation

According to most definitions, patient centred care needs to include the dimension of taking a biopsychosocial perspective (Mead & Bower, 2000; Bauman, Fardy & Harris 2003). All the HCPs saw obesity in general as having mainly social and/ or psychological antecedents – particularly when discussing adolescents – and integrating those aspects as relevant was not problematic. However, the extent to which HCPs felt responsible for addressing such issues was more questionable.

Although most presented a view of a general practice practitioner as having to at least be responsive to patients who requested help with obesity, many also felt ill equipped to manage such issues (particularly psychological aspects), or that they were too far beyond what they could actually affect (particularly social aspects). In this way, HCPs were reluctant to fully integrate the psychosocial care aspects into their professional role. The fact that all of the professionals interviewed saw obesity as easier to both bring up and manage when it could be associated in some way to a more legitimately medical concern demonstrates this. Even when the ‘medical’ in question was not directly illness related but something that was already accepted within the remit for their professional identity, such as the provision of contraception, HCPs felt comfortable discussing weight to a much greater extent. This suggests that when taken out of a medical context, obesity became something contentious and unrelated to professional role – despite the fact that any form of help or treatment likely would be the same regardless of medical associations. The issue of legitimacy was also present in the young people’s accounts, and taken together this demonstrates how the absence of a tangible medical position for overweight and obesity impairs weight management consultations. The HCPs were correct in their beliefs that adolescents do not see weight management as a legitimate medical concern, however their extension of this belief, that adolescents are opposed to discussing weight with HCPs, did not find support in the studies presented here.

The young people’s interviews demonstrated that weight was a concern to them because of its impact on appearance, and while all were aware of the potentially negative health consequences of

weight gain this was not a priority to them. In contrast, the survey of young people presented in chapter six showed that a majority of adolescents consider overweight and obesity to be a health problem in people their own age. Further, their attitudes towards discussing weight with a GP were largely favourable, especially among overweight young people. This suggests that they would not find weight consultations to be out of place in general practice. Research from outside the UK has shown primary care practitioners to carry out weight screening with children and young people at a much lower frequency than recommended (Gerner et al. 2006; Goldman et al. 2004), and it is likely that this concern to provide the kind of care their patients are expecting is partly responsible for that. Instead, it risks missing opportunities for effective consultations. Further, since subjective, self-reported health may be worse among overweight and obese young people, even though they may not attribute this to weight, there would be legitimate reasons for HCPs to discuss weight as a health issue.

The importance of strong patient-provider relationships that are characterised by respect and trust is well documented in relation to both patient well-being and treatment outcomes (Street & Epstein 2008), and by bringing up a topic the HCP believes the patient does not see as relevant to the medical consultation, such trust and respect may be perceived to be at risk of being jeopardised. Again, the way this related to adolescent patients was seen to be particularly problematic – partly because of the absence of physical co-morbidities, partly because of parental protectiveness over their children, and partly because of adolescents themselves being perceived to be particularly hostile to such interventions. This demonstrates how aspects of trust and respect may be perceived to be particularly vulnerable to violation in weight management consultations with adolescent patients, which acts as a barrier to forming successful partnerships with them in the first place.

Another crucial aspect of patient centred care is the concept of seeing the patient-as-person (Mead & Bower 2000), which stresses the importance of understanding a concern from the perspective of the patient. The interviews demonstrated the importance of understanding the meaning of weight

to young people, and the impact this can have on decisions made in the consultation. For example, the use of food as compensation for social support in managing difficult situations or feelings of low self-esteem suggest that for weight management interventions to be effective, these issues need to be brought up and addressed, but this was also something that the HCPs feared and felt ill equipped to deal with. The idea of 'opening a can of worms' were used by several HCPs as something they would not know how to manage, and which they clearly saw as outside of their remit. Thus, the psycho-social antecedents that young people themselves identified as playing a role in their weight gain was something HCPs felt unable to manage. The traditional biomedical model would focus on the accepted antecedents to weight gain of overeating and under-exercising without going into context, while a fully biopsychosocial perspective would have to consider these less straightforward and more contentious aspects as well.

The reluctance to acknowledge weight demonstrated across all the qualitative studies, suggests that all parties interviewed held a view of weight that is inherently negative; that any associations with overweight are always going to reflect badly on the individual in question. The use of weight to secure status in social hierarchies described by the young people indicates the importance of this, and is supported by others who have found weight to be seen as one of the most salient causes for teasing and bullying among adolescents (Puhl et al. 2011). However, unlike other research (Teachman & Brownell 2001; Harvey & Hill 2001; Schwarz et al. 2003; Budd et al. 2011; Keyworth et al. 2013) the HCPs in the current study did not hold negative views of adolescents because of their weight; their reluctance to engage in weight management consultations were based primarily in wanting to avoid inducing stigma. This fear of being seen to criticise the overweight or obese adolescent was an important barrier to effective communication with this patient group; it meant that from the HCP point of view, any attempt to establish a supportive relationship was doomed to failure. On the other hand, a willingness (and preparedness) to address emotional aspects of any health concern is a prerequisite for good, patient-centred consultations (Street & Epstein 2008).

At the same time, the interviews with the young people in this study show that even if no comment is made, they themselves were still aware, and self-critical, of their own weight. In the current research, regaining control was seen as a positive component by those that had taken action to lose weight. This suggests that any immediate negative effects of making the weight visible might be offset if the follow-up contains support and appropriate strategies for managing the weight from there on. This however was one of the core things HCPs felt that they lacked; the ability to empower and provide such skills for young people. The one exception was one nurse who had managed to work directly with a young boy and helped him achieve weight loss, but even she seemed to be at a loss to describe how exactly this had happened, stating that it 'just worked'. It has been suggested that while empowerment has traditionally been viewed as something that is either 'given' to the patient by the HCP, or something that is 'created' within the individual, an alternative position would be to view it as a co-creation that develops within a true partnership (Aujoulat et al. 2007). The difficulties HCPs expressed in creating partnerships over obesity in general, and with adolescent patients in particular, may therefore be a real barrier to empowerment with this patient group. In this way it becomes a vicious circle: HCPs are reluctant to bring up weight with adolescents out of fear of causing harm; because of this a partnership relationship is difficult to develop, and without the partnership true empowerment and positive change are hard to achieve. Further, the HCPs in the current study adhered to a 'storm and stress' model of adolescence which was characterised by seeing adolescence as a time of turbulence and difficulty. Having an expectation that adolescents will be difficult and rebellious can become a self-fulfilling prophecy, associated with poorer outcomes in young people (Buchanan & Hughes 2009).

If the responsibility for weight loss is meaningfully going to be shared between young people and parents, it is essential to understand how this is experienced by the parties involved. As could be expected based on the ages of the young people interviewed, the experience was that responsibility and control was something that was still being tested and negotiated with parents in different areas. All the young people interviewed recognised that their eating habits had changed as a consequence

of gaining more independence and being free to buy snack foods for themselves. Because of this, they, as has been reported by other young people (Grogan & Richards 2002), saw a large part of the responsibility for their weight, and weight loss in particular, to lie with themselves. Parental monitoring naturally becomes more difficult as adolescents spend less time together with their parents than they did in younger years (Larson & Richards 1996; Shearer 2005), and parental influences become less important (De Goede et al. 2009). Some forms of parental monitoring over food are associated with healthier food choices in younger children (Clark et al. 2007), so parents' concern over unhealthier eating habits forming when monitoring is no longer possible is valid. However, the relationship between monitoring and food intake in children is complex, and dependent on variables like mothers' own eating behaviour and weight (Ogden 2003; Birch & Fisher 1998), and restrained eating in parents has been linked to overweight in younger children (Hood 2000) further supporting the notion that parental eating habits impact health behaviour and weight in children.

At the same time however, the young people's accounts also suggested that the newfound freedom they had achieved was not always regarded as unequivocally positive. When some of this freedom was taken away from them and put back into the hands of parents, they may protest outwardly while inwardly feeling somewhat relieved that the responsibility for making healthy choices had been temporarily put on someone else. Adolescents may not always feel ready for such an adult level of responsibility (Hester et al. 2010), and it is congruent with theories of personal control which state that individuals are happy to relinquish control in situations where they believe that putting someone else in charge will result in more positive outcomes (Walker 2001). It also supports research which shows that both autonomy and attachment to parents predict psychosocial adjustment and emotional affect, showing the importance of both for adolescent well-being (Noom et al. 1999). Largely, this negotiation of responsibility can be seen as a healthy process in the normal development of adolescent autonomy, but discrepancies between parental and adolescent perception of competence in relation to health behaviours will impact on negotiation of autonomy

(Butner et al. 2009), and HCPs can play a role in facilitating such negotiations in the health setting. This would manifest through involvement of both parents and young people in weight management discussions, perhaps by suggesting areas of responsibility for both, and by addressing young people directly rather than through their parents.

Implications for practice

The biggest issue concerning adolescent patients specifically was a general sense that this age group were characterised by emotional volatility, and that to bring up weight would be seen as a personal attack that could cause emotional harm. This concern around sensitivity applied to adolescents generally, and reflects a general sense of uncertainty among HCPs in dealing with this age group (Jacobson et al. 2001; Jacobson et al. 2002). However, weight was seen as being particularly problematic, and perhaps the most difficult issue to discuss with young people in terms of the risk for causing upset. This was grounded in the idea that to bring up weight would be to make it obvious that it had been noticed, and that this would be an automatically negative judgment on the young person, was to some extent supported by the adolescent interviews. The experiences of the young people suggested that to have the weight made visible by someone else, through a comment or action indicating that the other party had acknowledged the weight, was to make the burden of it worse. The parent accounts also supported this idea that to discuss weight with adolescents could be problematic, cause 'hang-ups' and preoccupation with body weight that might have negative consequences. Overweight and obese adolescents frequently experience stigmatisation over their weight, and expect comments made on their weight to be meant as criticism (Curtis 2008; Griffiths & Page 2008; Holt et al. 2005; Grogan & Richards 2002). However, the young people interviewed for this research stated that although their initial reaction to having weight made visible might be negative, if perceived as coming from a perspective of caring and support it might be acceptable. Thus, the communicative style and ability of the HCP to convey empathy would be more important

than the actual message, and being able to convey such characteristics would likely lead to greater trust and a stronger patient-provider relationship. However, HCPs would need to take charge of discussions at least initially since adolescents were found to be unlikely to ask directly for help with weight management, and non-assertive patients are less likely to receive patient centred care (Cegala & Post 2009). Although neither the HCPs nor the young people themselves saw health consequences as a particularly strong motivator for weight loss among adolescents, the young people interviewed here suggested that talking about weight in the context of health would make such conversations more acceptable to them, as it led the focus onto more neutral grounds. Thus, in the health care setting it may be more about using health consequences as the pretext for discussing weight, rather than trying to convince adolescents that health consequences in themselves are a reason for losing weight. In this way, discussing health consequences with overweight and obese adolescent patients would serve a purpose, even if health outcomes in themselves are not directly internalised by the young people in question.

Routine weighing, and a focus on process (weight related behaviours) as opposed to outcome (weight loss), could be a way to manage this. It might also be more acceptable to parents who are concerned about children developing concerns about the worth of their bodies. A focus on lifestyle rather than weight may be a way for HCPs to avoid stigmatising these adolescents (Russell-Mayhew et al. 2012; Golan & Crow 2004). Further, since emotional difficulties like depression may be linked more to perceived as opposed to actual overweight (Roberts & Duong 2013), routine weighing and reassurance of some normal-weight teenagers could potentially lead to a reduction in weight-related depression.

It would appear that more effort is needed from the HCP community to build partnerships with adolescent patients in general; the suggestion by some that adolescents should see the practitioner alone for at least part of the consultation (Payne et al. 2005) or even re-enrol with their GP as a new

patient in order to build an autonomous and individual relationship (Viner & Barker 2005; RCPCH et al. 2003) might be a way to achieve that. It could work to normalise such relationships not just for the patient, but also for the provider.

A lack of skills to enable young people and parents to manage weight is frequently reported by HCPs (Holt et al. 2011), and one problem here may be a lack of experience. The belief in one's own ability to perform certain actions (self-efficacy) is reinforced by practicing the behaviour (Bandura 1982), but most HCPs do not deal with overweight or obese adolescents on a regular basis, and when they do come into contact with them it is usually for reasons other than weight. This provides little opportunity for self-efficacy to develop naturally. In turn, if practitioners themselves do not feel confident managing the adolescent on their own, and there is no appropriate service to refer to (something many in the current research stated as lacking), the consequence of bringing up weight may well be a risk of harm. This risk was referred to exclusively in emotional/ psychological terms and reflects a general fear of stigmatising overweight and obese young people, which is recognised as having potentially severe consequences for emotional well-being (Puhl & Heuer 2010; O'Dea 2005). However, the current study revealed that as well as worrying about causing harm, HCPs were concerned that discussing weight might bring up emotional issues that the adolescent had already internalised in relation to their weight. Regardless of the origin of such emotional difficulties, like with obesity itself, HCPs felt a responsibility to address them once they had become exposed. Again, as with weight itself, this was an area they did not feel equipped to manage. Over a decade ago, Jacobson et al. (Jacobson et al. 2002) called for greater awareness and training for GPs with regards to mental ill health in adolescents; it would appear that these shortcomings are still present. The accounts presented in the interviews in the current research show that emotional difficulties were very much tied up with their weight and eating, and although this certainly is not true for all overweight or obese adolescents, a proportion will likely require emotional support for such underlying issues rather than focusing on the weight per se. Jelalian et al. (2007) observe in their literature review the high co-existence of obesity with psychiatric difficulties (including depression)

among adolescents, and suggest that mood needs to be taken into account when addressing weight with this age group. Others have suggested that psychological health should be an end in and of itself when addressing weight with young people (Russell-Mayhew et al. 2012). Taken together, this suggests that training in how to handle emotional aspects with adolescents may play as important a role as training in practical weight management strategies.

The research presented here demonstrates that adolescent intentions to help-seek for weight are low, which is why the principle of making every contact count (NHS Future Forum 2012) is important for adolescent weight management in general practice. Further support for this comes from the finding that the adolescents interviewed in this study suggested that being approached by health care professionals about weight might be more acceptable than being approached by others; because they at least would have a legitimate cause for concern that was not anchored purely in appearance. This illustrates that, with some overweight and obese adolescents at least, HCPs have a unique entry point for providing support for weight loss that other adults lack. This demonstrates the potential contribution HCPs can make towards a particular aspect of adolescent development, and supports the ideas behind developmental contextualism (Lerner et al. 1997).

The concern of HCPs about causing damage to young people by bringing up weight in the first place was echoed by the parent interviews. To make weight visible was thus seen by all the adults involved as being potentially harmful. This view was to an extent supported by the adolescents' concerns over having their weight being made visible, and being judged because of it. However, the accounts of the young people interviewed for this study also indicated that this negative reaction might be more an initial response, which if handled with care and compassion would not be overwhelming.

Personal reflections on the research process

Although all research is affected by the person undertaking the work – their background, interests, epistemological leanings – to some extent, this is very evident in qualitative research in particular. The extent to which rapport is built with participants (which in turn influences how open and at ease participants will be during the interview), the way the researcher asks questions, their own reactions to respondents' answers are all personal to the individual. We can undergo training to manage difficult situations that may arise during the interview, but as discussed above, qualitative research is often unpredictable and unforeseen events may necessitate responses based on personal experience to a much greater extent than training and preparation. The researcher's own background and current role also determine their position in relation to their research participants, which in turn impact on power dynamics and 'roles' within the research encounter. My own personal experiences in this area will be reflected on here.

Interviewing experts in a position of authority

Although my prior reading had led me to the assumption that general practice based HCPs probably did not have extensive experience of dealing with overweight and obese adolescents in their day-to-day practice, I was still very aware that I was about to interview them on a topic in which they were arguably much more expert than I was. Furthermore, they were all qualified professionals while I was seeing them in the role of student. The interviews were happening at a time when childhood obesity made frequent headlines and Jamie Oliver's campaign for better school meals was a popular topic for discussion, and to some extent I worried that people in general, and the health professionals in particular, would assume I was just jumping on the band wagon. For these reasons, it became important to me to present myself as someone who had prior professional research experience, and whose chosen topic stemmed from previous work rather than having been decided on at random. However, it soon became apparent that the HCPs that had chosen to be interviewed

had often done so precisely because of the interest obesity in children and young people was currently generating, and because they felt somewhat at a loss as to what they were supposed to do about it. Thus, the popularity of obesity as a topic was not something they would necessarily frown upon, but rather it was the reason it had become increasingly relevant to them on a professional level.

I was very clear right from the beginning of each interview that the literature at the time did not have too much to say about HCPs' experiences of providing weight management services for overweight and obese young people, and that their accounts would provide much needed insight. I explained my research background as more of an expert in adolescent health issues than in general practice.

There is always a question over how to open an interview, what question to ask first. I decided to open my interviews by asking participants why they had agreed to be interviewed and this turned out to be a very useful starting point. This question led participants to explain a little about their background and about their prior experience (or lack) of weight management with adolescent patients. From there, the transition into questions from the interview schedule flowed quite naturally.

The interview schedule was used flexibly rather than strictly. It was more important to me that interviewees got to tell their stories than questions being answered in sequence. By and large this did not mean that questions were omitted, although they may have been asked in different ways of different participants dependent on their individual experiences. One HCP interview stood out from the others; one of the practice nurses explained that her reason for taking part in the research was because she had recently worked closely with a 14-year old boy to help him lose weight, and she was keen to share this experience. Hence, her interview became almost a description of a case study. This interview was different to the others both in content, and also in structure since it was probably the one where I asked the fewest direct questions. At times, this was recognised by the

nurse who would stop herself and apologise for 'rattling on', but since her account was naturally covering most of the areas on the interview schedule I assured her that I wanted to hear what she had to say.

It is difficult to judge the power balance in the HCP interviews I conducted. Mostly, the HCPs appeared comfortable talking about their uncertainty and concerns in relation to adolescent weight management consultations. Only one of the nurses appeared to be a little defensive; she was recently qualified and it is possible that this made her feel judged or under observation to a greater extent than the other HCPs. By and large, the HCPs did not appear to feel a need to present themselves as infallible experts – quite the opposite. Nor did I feel judged or get the sense that they questioned my motives for undertaking the research; they were frequently interested in the work and several of the interviews ended (after the recorder had been switched off) on a note that was more conversational than research-focused.

Interviewing young people and parents

The first, and major, issue for my planned interviews with young people was actually recruiting them in the first place. I wanted to interview young people that had experienced overweight or obesity, but was unsure how to identify them without causing distress. One popular option for recruiting children and young people to research is to do so via schools, as there you in effect have a captive audience. I rejected this strategy however out of concern that to go to a school and tell students that I wanted to interview those that had experience of overweight could cause embarrassment and incur potential bullying of such students. I identified (via internet searching and word of mouth) a few community based initiatives that provided weight management services for children and young people – substantially more such programmes aimed at pre-teens than teenagers were identified, but after a few telephone conversations two such programmes agreed that I could approach the young people they worked with. I felt this strategy to be far preferable, since the young people there

would be already identified as overweight or obese (hence no need to verify by weighing or measuring), and the research could be seen as something naturally related to the programme they were attending rather than something being targeted at them specifically.

It soon became apparent however that the young people attending these programmes were more reluctant to be interviewed than I had hoped. Despite repeated visits to advocate for the research, none would come forward. Based on the interviews that subsequently did take place, I think it likely that just the mention of wanting to speak to these participants about their weight (even if this was implied rather than stated outright) put them on guard and possibly singled out for precisely the reason they did not want to be singled out.

In the actual interviews, there were certainly obstacles to overcome as well. One of the interviewees started out very defensive and on guard, but after a while seemed to be more at ease and would answer every question comprehensively. I had worried beforehand that getting the young people to talk extensively about their experiences might be difficult, but they all provided rich, thoughtful accounts. I started the interviews with young people in the same way as those with HCPs, and again this seemed to work well as an opening question.

My biggest concern in trying to level out any power imbalances between me and the participants was how to strike the right balance. I didn't want to seem too formal and grown-up so that they would not feel at ease, but I was almost more concerned that I would come across as trying too hard to be at their 'level'. I had to check myself during one interview, for example, when I spontaneously complimented one of the interviewees on her shoes (she had mentioned them in passing during the interview) – although this comment was not in any way a planned attempt to appear friendly or 'in the know', I was concerned that my remark might be taken as such by her.

There were things that came up in all of the interviews that might have been cause for concern; these related to reported experiences of bullying, emotional difficulties and disordered eating. In all cases however I was in contact with a parent or, in one case, youth worker who were aware of these

problems (this was something the adults disclosed to me either through interview or at other stages, without me specifically asking for the information). Because of this, I felt that any potential problems were being addressed without me needing to intervene and reveal potentially sensitive information, thus breaking confidentiality.

One of the planned adolescent interviews did not follow through, and this was the only really negative experience I had while conducting interviews. Although the girl in question had agreed to participate, it was clear from the start that she did not really want to be there. She would not make eye contact and answered questions with 'yes' or 'no' if she could get away with it, otherwise 'I don't know'. After a few minutes of this I switched off the recorder and asked if she was ok or wanted to quit, but she said she didn't mind continuing. I carried on the interview with the recorder switched off, thinking that might put her more at ease, but most questions were met with 'I don't know'. The whole situation felt very uncomfortable and I worried that she had felt coerced into taking part (the youth worker I had recruited her through was very enthusiastic about the study, and her best friend was another of the interviewees), so I terminated the interview. This failed interview provided much food for thought after – had I not been careful enough when discussing recruitment with the youth worker in question? Had I breached any ethical codes? Was there something I could have done to put her more at ease and get her to open up? I contacted the youth worker the following day to check that the girl in question was ok (she was), and discussed the situation with my supervisor and was reassured that I had taken appropriate action.

The parent interviews were possibly the ones where I sensed the most defensiveness, but not to an extent that made the interviews themselves problematic. It was more that the mothers I spoke to were very keen to portray themselves as aware and knowledgeable and doing the best they could for their children, which is understandable. Again, I find it difficult to judge the power balance in these interviews – the defensiveness mentioned indicates that they recognised the possibility of being misrepresented or judged, although they were still forthcoming in describing uncertainty and

worry. I have realised how much the fact that this research was undertaken for doctoral work influenced how I saw myself during these and the HCP interviews – I was concerned to come across as ‘just a student’ and much more worried to be seen as less expert and knowledgeable than I normally am when undertaking interviews as part of my professional academic role. It is also true that I am much more experienced in interviewing teenagers than adults, which probably contributed to my own role uncertainty in these interviews. Because of this, I might have worried more about my own lack of power than that of the adults I interviewed.

Chapter 8: Conclusions

Adolescent overweight and obesity management is a complex and multifaceted endeavour that poses significant challenges for HCPs. This dissertation has illustrated how the experiences of HCPs on the one hand, and adolescents and parents on the other, can begin to suggest how general practice can best serve young people who need and want to lose weight. If optimum services are going to be provided for this age group however, greater support and training for general practice based HCPs will be necessary. This will benefit adolescents not just in terms of managing their weight and health concerns in the here and now, but will empower them to feel more in control over their own health as part of their transitioning from a position of little control and autonomy into increasingly adult roles. The relationships established with HCPs at this age are likely to influence health care utilisation also in the future.

Contribution to knowledge

The research presented in this dissertation contributes to the knowledge base around health services provision for young people that are overweight or obese. It extends current understanding of how health care professionals experience giving weight management advice to non-adult patients by showing that there are specific issues that are of concern when dealing with adolescents as opposed to younger children.

Two main issues that inhibit adolescent weight management consultations in general practice were identified: (1) practitioners have concerns about bringing up weight with adolescents which prevents such discussions being initiated, and (2) adolescents are unlikely to consult HCPs specifically for weight.

When bringing up weight with adults (whether as patients or as parents) HCPs are most worried about causing offense, but when dealing directly with adolescents this turns into a more serious concern of causing actual harm. Because of the perceived importance of weight on body image and self-esteem (a notion backed up by young people themselves) HCPs worry that discussing weight with an overweight or obese adolescent may be emotionally damaging. This ties in with a strong overall sense of what adolescents are like, seeing them as inherently emotional and easily upset. This leads to HCPs feeling as if they have to tip-toe around young people, gauging the emotional climate to ensure that nothing is said that could damage the adolescent's self-esteem or sense of self. Thus a reluctance of HCPs in bringing up weight with adolescent patients appears to be grounded in a respect for 'do no harm'.

However, while the concern of causing harm may be the most salient barrier for HCPs in discussing weight with adolescents, the research also shows that the way health care professionals think about weight management in relation to their professional role and identity impacts on the extent to which they are likely to provide weight management services for young people. In particular, it illustrates how such consultations may be the results more of a sense of personal identity than professional one, as being part of 'who I am'. In this sense, then, weight management consultations become something that is undertaken because of personal interest (sometimes based in empathy and personal experience), something that requires a certain amount of 'enthusiasm' and is done as a personal project rather than because it is expected of you as a HCP. This is logical considering that weight management efforts undertaken with young people do not carry any points under the current UK GP contract. Further, GPs and practice nurses describe adolescents as difficult to engage into meaningful partnerships, which is a pre-requisite for effective health promotion and behaviour change efforts (NICE 2007).

The research further indicates that HCPs are resistant to undertake weight management consultations with young people with the objective of halting the obesity epidemic; it is not

something that fits in as a systematic and structured programme of public health work but rather is undertaken at an individual level; where and when it fits with individual patients and consultations. This approach is unlikely to catch every overweight or obese adolescent that passes through practice, but is congruent with the ideas behind Make Every Contact Count (NHS Future Forum 2012). Because there has been much research and debate around the reluctance of the health care profession to stray away from the strictly biomedical towards a biopsychosocial perspective more congruent with a health service based as strongly in health promotion as in treatment of illness, it is worth noting that this reluctance may not be based solely on a HCP view that this is what the health service should be about – the HCP interviews show that often, they believe that this is what their patients also want, and that health promotion efforts in relation to weight might be seen as irrelevant meddling. HCPs are concerned that this might cause offense, both to the young person themselves and to their parents (who may feel equally criticised), and that this in turn may damage trust and relationships that need to be maintained for effective provision of services in the future. Thus, this reluctance is based as much in a concern for the wishes and expectations of patients as in the HCP views of what is acceptable within their professional role.

Meanwhile, both the interviews and survey of young people demonstrated that intentions to utilise HCPs for weight management help and advice is low among adolescents. This cannot be explained by negative attitudes towards general practice services, but may be the result of lack of experience with such services, and a belief that general practice is an inappropriate setting for preventive health. The research shows that for adolescents, weight loss was strongly linked in with what it is to be a young person; that weight matters for everyday life as it impacts on self-esteem, involvement in activities, and social relationships. These aspects were not seen to be legitimate for general practice, and so HCPs were not the help sources adolescents would naturally turn to. There is support in their accounts for the idea of an emotional aspect to weight, but their ability to reflect on the reasons behind any discussion of weight also suggest that if handled carefully, bringing up weight with a young person would not necessarily be damaging. It is dependent on the way in which it is managed,

and in fact HCPs may be in a better position to discuss weight with young people than many others as they can legitimately locate weight in a health perspective, thus circumventing the idea that it is about appearance. If HCPs are prepared for the fact that bringing up weight with an adolescent may result in an emotional reaction, but that this can be mediated by the way it is addressed, they may feel better able to handle such situations in the first place. HCPs may also be reassured that a majority of young people find it acceptable for service providers to bring up weight as an issue even if they have not mentioned it themselves.

Meanwhile, both the accounts of the parents and the adolescents themselves demonstrate that other aspects of adolescence, such as developing independence and autonomy, also impact on the way weight management can be handled. This research particularly suggests an ambivalence shown by adolescents regarding their newfound sense of personal control, in that at times they may be secretly relieved to have some independence taken away from them again in order to adhere to better habits. This negotiation is a normal and healthy part of developing complete independence; testing boundaries and see where you are ready to stand on your own feet. This sense of negotiation could be equally applied to the health care setting.

Implications for policy and practice

Over the course of time that this research has been undertaken, the shift from a Labour, to a coalition, and then conservative government has seen changes in health care policy relating to overweight and obesity in the population in general. The last few years has seen a move away from endorsement of government intervention towards a greater emphasis on community action and individual responsibility (Department of Health 2010). Nonetheless, prevention and treatment of overweight and obesity in children, young people and adults alike is still seen as a necessarily multi-faceted endeavour with intervention at different levels and in multiple contexts. The health services, including general practice, have been described as key partners in tackling obesity (Department of

Health 2011). The approach endorsed by the HCPs in this research, to address weight with adolescent patients when it fits in with the consultation overall, is also congruent with the ideas behind Make Every Contact Count (NHS Future Forum 2012).

Despite the multi-level approach referred to above, when it comes to young people, much health promotion policy tends to focus on schools in particular as appropriate settings (Department of Health 2011). It is easy to see why, as children and young people spend a majority of their waking time at school, and are therefore pretty much a captive audience for health promotion intervention. Recommendations of healthy school meals and provision of physical activity opportunities are sensible, and are probably useful particularly in preventing young people from becoming overweight in the first place. However, the young people's interviews presented in this research also show the problems that the school setting provides for adolescents that are already overweight or obese; even something like a general talk about healthy weight in assembly can incur a feeling of shame and being stigmatised. It also shows that overweight and obese young people may be the least likely to actually participate in sports clubs for example, out of fear of being judged or seen as incompetent. Further, the three different accounts presented here illustrated three different experiences of becoming and dealing with overweight for adolescents, suggesting that in many cases just providing opportunities for better diet and more physical activity is likely to be ineffective. Some, though not all, young people will benefit from a more personal approach that can take individual circumstances into account and address underlying issues. In theory at least, general practice is an ideal setting for one-to-one, individualised consultations.

However, while the HCPs in this research indicated both through the survey and in the interviews that they saw a responsibility to at least flag up the issue of weight for overweight and obese adolescents, it was clear that they felt ill equipped to actually tackle weight management with this age group. Other research has recommended that more training and greater resources would be of benefit for HCPs, and the current research extends that knowledge with regards to what specifically

is lacking for effective consultations with adolescents. It would appear that the greatest resource for HCPs in this respect would be training in effective communication with adolescents; how to build rapport and how to address sensitive issues. By extension, this means greater training in how to address psychological concerns with young people, as this is what the fear around bringing up weight with adolescents essentially came down to. HCPs need to be prepared for an initial possibly emotional response to such discussions, but also be reassured that if handled sensitively such initial responses can be ameliorated. There is rightly much emphasis on the need to empower patients and ensure they have adequate resources to support them in taking responsibility for health (Adler & Stewart 2009), but equally HCPs need to be empowered to be able to manage consultations they currently experience as difficult (NICE 2007; Department of Health 2011; NHS Future Forum 2012; Department of Health 2010). In line with the idea presented here that HCPs undertake adolescent weight management as a personal project, it has been suggested that current training provision tends to be limited to a select group of self-nominating practitioners, and that training in 'practitioner confidence' in addressing weight is still a neglected area (Department of Health 2011). It may be that more general training in dealing with emotional distress and well-being could bridge some of the gap in the reluctance to be a practitioner that address weight.

With regards to what to do once the weight has been mentioned, HCPs might need access to specially trained dieticians, and/ or have links to programmes addressed specifically at adolescents. To give a general suggestion to 'do more exercise' likely will not be very effective for a young person who has had negative experiences with sports in the past because of their weight, but being able to refer them to a gym where they can get individual support (and not have to perform in front of others) could be a positive experience. This would require efforts to train physical educators in adolescent health and ensure that such specialists were linked with GP practices. Such initiatives are unlikely to be feasible in all locations, but may be beneficial for at least a proportion of adolescents.

Methodological limitations

The research presented here was undertaken to provide greater understanding of the experience of adolescent weight management by health care professionals, adolescents and parents. The overall objective was to gain an understanding of the role of general practice in addressing adolescent overweight and obesity, and to what extent general practice based HCPs can intervene with this particular age group. The HCP survey aimed to get an overall understanding of attitudes and current practice among HCPs, while the interviews were used to provide greater depth regarding the issues relating to adolescent weight management from all the parties involved. It is acknowledged that the response rate of GPs to the survey at 18% was low (although not uncharacteristically so for a survey of this professional group), and it may therefore be questioned how much can be generalised from the findings. However, the results are broadly in line with similar surveys that have asked about weight management for children and adults, suggesting that the sample was not unrepresentative in that respect. It had been the intention to interview similar numbers of adolescents and parents as HCPs, however this was not achieved. Even though generalizability is not an objective of IPA or qualitative research, more interviews could have provided richer accounts, especially of parent perspectives. However, the number of participants interviewed was not below that recommended for an IPA study on this scale; in fact, if anything it is somewhat higher (Smith et al. 2009). Further, it became apparent through the analysis that the adolescent and parent interviews were usefully seen as case studies to reflect how the HCP experiences related to individual circumstances. Therefore, it is felt that further interviews with adolescents and parents might be most useful as a separate, follow-on study from the current research. The response to the survey of young people was also low, and too low to conduct sub-group analysis within those who were classified as overweight or obese. Such analysis should necessarily be taken up by future studies to explore the differences between young people who are overweight or obese with regards to help seeking intentions and perceptions of general practice.

Further, while the HCP survey provided a reasonable split in responses between male and female GPs, 11 out of the 13 interviewees were female. Since the survey highlighted gender differences in the attitudes and practices regarding adolescent weight management, more interviews with male GPs would have been desirable. The same can be said for the parent interviews, especially since most research on parent attitudes and experiences tend to elicit the views of mothers.

Further research

Based on the above, greater understanding of the experiences of fathers and male GPs would fill a gap in research on adolescent weight management. Further, intervention research that investigated the effect of emotional skills and adolescent communication training for GPs on both precursors to effective consultations, such as self-efficacy, and actual consultation behaviour would test the theories born out of this research. The acceptability of consultations, framed in a health perspective, to adolescents should also be investigated. Patient centred care is an under-researched area in adolescent health, and future research on adolescent-provider communication could investigate this perspective.

To get a full account of general practice based weight management interventions for young people, future research should aim to identify those young people that have received such help for their experiences. However since both the HCPs and the young people themselves reported that they rarely accessed general practice for this purpose, recruitment may be difficult. An alternative would be to deliver an intervention whereby GPs and nurses within individual practices were encouraged to bring up and discuss weight management with relevant young people, and then assess the acceptability and outcome of such an intervention. The views of both HCPs and adolescents in this regard would provide further insight.

Concluding comments

General practice is not the solution to overweight and obesity among adolescents, but then no-one is expecting one organisation or programme to be able to manage this on its own. It is however recognised by government as one of the key partners, and as such should be adequately equipped and empowered to manage at least a proportion of overweight and obese adolescents. To encourage greater enthusiasm for this, policy may want to shift the language away from expectations in large-scale public health gains towards recognising the strength of general practice: working with individuals in terms of what is relevant for their lives. The current research shows that in this respect, general practice based HCPs would benefit in more training in working with adolescents in the practice, in how to communicate with this age group and work towards establishing independent relationships with them as they move into greater responsibility for their own health.

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Appendix 1

Study information letter for health care professionals

Telephone [phone number]
Fax [fax number]
Email [email address]



Dear [name],

Adolescent obesity and general practice.

We would like to invite you to take part in a study on the management of adolescent obesity in general practice. This study forms part of a Doctoral research project, which will investigate the opinions of health professionals regarding general practice as a setting for weight advice for young people who are obese, or are at risk of becoming obese. As you are probably aware, childhood obesity is currently generating a lot of interest and debate, and several recent policy documents have stressed the role of primary care in "promoting healthy living" to young people and their parents. Despite this, very little is known about health professionals' views on this matter in the UK. We believe that it is vitally important that the people who are responsible for the health care of obese young people are given the opportunity to share their experiences on this matter, in order that barriers, and facilitators, to good care for this target group can be explored.

Included with this letter is a brief questionnaire; this has been sent to all GPs and practice nurses working in general practices in [county 1] and [county 2]. Please take a few minutes to complete this questionnaire and return it to us in the pre-paid envelope. Everything that you write will, of course, be kept confidential.

In order to gain a more in-depth understanding of the views of GPs and practice nurses who may be in a position to work with obese adolescents, we would also like to conduct a number of face-to-face interviews with health professionals on this topic. At the end of the questionnaire, there is a space for you to leave your contact details if you wish to participate further in this study. If you do provide your details, a researcher will contact you to discuss this further, but you are not obliged to take part in an interview if you later change your mind.

If you have any questions regarding this study, please contact Jo Magnusson on [phone number], fax [fax number] or Email [email address].

Yours sincerely,

Josefine Magnusson
(Research Fellow)

Appendix 2

Study information leaflet for adolescents

What will you do with the interviews?

We will make summaries of what everyone has told us during interviews, and write this in reports and published articles. This is to let other people know what we have found, so that they know what young people think about these things. Often, a lot of decisions are made about health care that affect young people without having asked them about their opinions and experiences first, so we want to make sure that young people are heard as much as possible.

Do I have to take part?

No, it is completely up to you whether you want to take part in an interview or not. The more young people I can interview, the better for the research!

How can I take part?

Just fill in the form overleaf to say that you want to take part - if you are aged under 16 years, you need a parent to sign the form as well. Then tell the person who gave you this information and we can arrange a time and place that suits you to meet for an interview.

What is the research about?

Lots of young people are concerned about weight and health, but don't always know who they can talk to or where to go for help. We want to find out what you think might be **good ways of helping young** people, and what your own experiences are.

What happens if I take part?

If you do want to take part, I will contact you to arrange a time and a place for an interview. The interviews will be like a conversation, face to face, where we will talk about your own thoughts about health and weight, and what you think can be done to help other young people who perhaps don't know who to talk to about those things. They will probably last around 30-45 minutes, although that depends on how much you have to say and what you want to talk about. The interviews will be recorded, but they are completely confidential and no-one except me will have access to them. I am **not going to tell anyone else** what individual people have said during their interviews.

Everyone who takes part in an interview will receive a **£10 'love2shop' high street gift voucher**.

Complete and detach this page if you want to take part:

Yes I would like to take part in an interview about young people's health and weight!

Name:.....

How old are you?.....

Are you a Boy

Girl

How can I contact you?

Email:

.....

Telephone:

.....

Parent's signature (if you are under 16 years of age):

.....

CAN YOU HELP?

Researcher contact details:

Josefine Magnusson

Centre for research in primary and community care (CRIPACC)
University of Hertfordshire
College Lane
Hatfield AL10 9AB

Telephone: [phone number]
Email [\[email address\]](#)

We want to find out more about what young people think about keeping fit and healthy.

This is an invitation for you to take part in research on the views of people your age!

Thank you!

**For taking the time
to read this leaflet.**



Supervisor contact details:

Prof. Fiona Brooks

Adolescent & Child Health Lead
Centre for research in primary and community care (CRIPACC)
University of Hertfordshire
College Lane
Hatfield AL10 9AB

Telephone: [phone number]
Email [\[email address\]](#)

Please read on for a chance to get your voice heard, and receive a small voucher as a thank you for your help!

Appendix 3

Study information letter for parents

Research on health and fitness in young people: Information for parents

Dear parent,

You are receiving this letter because your child has expressed an interest in taking part in a research study I am doing as part of a doctoral degree. I am a researcher in child and adolescent health at the University of Hertfordshire investigating health, weight and wellbeing in young people. I am interested in finding out more about young people who have had concerns about their weight – why they are concerned, who (if anyone) they had talked to about changing their lifestyle, what things they think would be helpful to young people who want to change their weight or diet/ exercise, and what they think health care professionals and others can do to help. **I also want to interview parents** who have adolescent children that have been concerned about their weight, to find out about their views on young people and weight, and what they think can be done to improve healthy lifestyle services for young people. The overall aim of the research is to find out the best ways that professionals can work with young people when helping them to change their weight and/ or diet and exercise behaviours.

What happens if I decide to take part?

I am looking to interview **both adolescents and parents** but they do not have to be part of the same family – i.e. even if you decide to take part as a parent, your child does not have to take part as well, and equally your child can take part (with your consent if they are aged under 16) even if you yourself do not want to.

Together with this letter is also an information leaflet for your child about the research. If you and/ or your child are interested in being interviewed, please complete the form attached to this letter and return it to the person who gave you this information. I will contact you to answer any further questions you may have, and to arrange a time and place for interview(s) to take place. You and/ or your child can change your mind about participating in the research at any time. Interviews will be happening face to face at a time and place that is convenient for you and/ or your child, and will be undertaken separately for parents and young people. They are anticipated to last around 30-45 minutes.

Everybody who takes part in an interview (both parents and children) will receive a £10 'love2shop' high street voucher.

Confidentiality

All interviews are completely confidential and will be anonymous so that individual participants can't be identified from the data. Interviews will be digitally recorded, and the recordings will only be available to me. The recordings will be typed up (and these transcripts will be anonymised with all names changed) and shared with a small number of other researchers working on the same project but will not be accessible outside of this small research group. Quotes from the interviews may be used when the research is reported, but not in a way that anyone who has participated could be individually identified.

How the data will be used

This work is undertaken as part of a research degree (PhD), and the results will be used as part of my final dissertation for this degree. The results will also be shared at conferences and through written reports and publications.

Review of the study

This research has been reviewed and approved by the School of Psychology Ethics Committee at the University of Hertfordshire (protocol no: PSY 11/11 JM). I have also completed a Criminal Records Bureau (CRB) check, which is required of anyone working with children and young people.

THANK YOU FOR TAKING THE TIME TO READ THIS!

If you have any further questions, please contact me:

Josefine Magnusson

Centre for Research in Primary and Community Care
University of Hertfordshire
College Lane
Hatfield
Herts AL10 9AB

Tel: [phone number]
Email: [\[email address\]](#)

Research Degree supervisors:

Professor Fiona Brooks (tel. xxxxx xxxxxx)
Dr Wendy Wills (tel xxxxx xxxxxx)
Dr Nick Troop (tel xxxxx xxxxxx)

Yes I am interested in taking part in an interview!

PARENTS

My name is.....

I am a father mother other (please say what)

What is the best way to contact you to talk about an interview?

Email.....

Telephone.....

Appendix 4
Interview consent form

Participant Identification Code for this study:

CONSENT FORM

A study looking at seeking help with diet, exercise and weight in young people

Researchers:

Josefine Magnusson

Please initial box

1. I have read and understand the information leaflet about the study. I have had enough time to think about it. The researcher has answered any questions I have.
2. I understand that it is my choice whether I take part in the interview. I understand that I can stop taking part at any time and that it won't affect my care.
3. I agree for my comments in the interview to be used in the study. I understand that my comments will be anonymous.
4. I agree to take part in the interview.

Name of participant

Date

Signature

Name of researcher

Date

Signature

When completed, 1 for participant, 1 for researcher

Appendix 5

Health care professionals' questionnaire



Obesity in adolescence: The role of general practice

*We would like to find out the views of general practice staff
regarding the treatment of obesity in adolescents.*

This survey will take no more than 10 minutes to complete!

**For this study to be successful we need
as many people as possible to take part.
Everything you write in the questionnaire is confidential.**

**Please complete and return this short questionnaire
in the prepaid envelope.**

**All returned questionnaires will be entered into a draw to win
Marks & Spencer vouchers!**

Researcher contact details:

Jo Magnusson

CRIPACC, University of Hertfordshire, College Lane, Hatfield, Herts AL10 9AB

01707 285992/ j.e.magnusson@herts.ac.uk

Please answer the questions below by ticking the answer that best represents your view.

1. Adolescents and obesity

	Always	Often	Sometimes	Rarely	Never
a. Adolescent obesity needs treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Obese adolescents will outgrow their overweight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Adolescent obesity is more amenable to treatment than adult obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Obesity in childhood or adolescence affects current quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Obesity in childhood or adolescence affects quality of life in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Treating adolescent obesity

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
a. GPs' and nurses' time would be best spent in this area by preventing obesity in children and young people in the first instance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Counselling adolescent patients who are obese, or at risk of becoming obese, is generally professionally rewarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The best role for a GP is to refer obese adolescent patients to other professionals rather than attempt to treat them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I would only offer advice regarding weight control when an adolescent patient requests it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I would only offer advice to an obese adolescent patient if their parent requested it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I would offer advice to an obese adolescent patient even if neither they nor their parent had specifically asked for it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I am professionally well prepared to treat adolescent patients who are obese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I would be interested in further training in treatment of child and adolescent obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Barriers to treatment

Do you consider any of the following as barriers to treating obese adolescent patients?

	Always	Often	Sometimes	Rarely	Never
a. Lack of patient motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Lack of patient involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lack of parental involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Lack of clinician time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Lack of reimbursement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Lack of clinician knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Lack of treatment skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Lack of support services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Treatment futility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Eating disorder concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Guidelines for management of adolescent obesity

a. Do you feel that you have a good understanding of the NICE guidelines in relation to the implications for adolescent obesity?

Yes No

b. Are you aware of any other *government* guidelines available for the treatment of child and adolescent obesity?

Yes No Which? Please write.....

b. Are you aware of any *professional* guidelines available for the treatment of child and adolescent obesity?

Yes No Which? Please write.....

c. Have you ever used any such guidelines for treating obese adolescent patients?

Yes No Which? Please write.....

d. If you ever have used any such guidelines, did you find them useful?

Yes No

5. Treatment options

Which of the following do you consider appropriate for treating adolescent obesity?

	Always	Often	Sometimes	Rarely	Never
a. Use of behavioural management strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Modification of eating practices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Modification of physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Modification of sedentary behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other <i>Please write</i>.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Assessment

In determining adolescent obesity, do you have access to *age-standardised* charts for:

- a1. Body mass index (BMI)? Yes No Don't know
- a2. Waist circumference? Yes No Don't know

If yes, do you feel confident in using such charts in practice?

- b1. Body mass index charts Yes No
- b2. Waist circumference charts Yes No

7a. How many obese adolescents do you estimate that you have seen (for any reason) in your practice in the last 6 months?

Please write.....

7b. And how many do you estimate you have treated for obesity or related conditions?

Please write.....

8. About you

a. What is your position at the practice?

GP Practice Nurse Other Please write.....

b. Gender: Male Female

c. Age: Under 29 30-39 40-49 50-59 60+

10. How would you describe your ethnic origin?

- | | |
|--|--|
| <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> White – British |
| <input type="checkbox"/> Black – African | <input type="checkbox"/> White – Irish |
| <input type="checkbox"/> Black – African-Caribbean | <input type="checkbox"/> White – Other |
| <input type="checkbox"/> Black – Other | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Other Please write..... |
| <input type="checkbox"/> Indian | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> Pakistani | |

If you have any further comments relating to the management/ treatment of obese adolescents in general practice, please write them here:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

NOW PLEASE TURN OVER!!

Appendix 6
REC Ethics approval

**Hertfordshire 2 REC**

Location Code Q7
QEII Hospital
Howlands
Welwyn Garden City
Herts
AL7 4HQ

Telephone: 01707 362585
Facsimile: 01707 394475

29 September 2006

Ms Josefine Magnusson
Research Fellow
University of Hertfordshire
Centre for Research in Primary and Community Care
College Lane
Hatfield, Herts
AL10 9AB

Dear Ms Magnusson

Full title of study: **The role of general practice in dealing with adolescent obesity: The views of health professionals**
REC reference number: **06/Q0204/104**

The Research Ethics Committee reviewed the above application at the meeting held on 27 September 2006.

Ethical opinion

The Committee noted that in the patient information sheet it referred to review by the Hertfordshire 1 REC, which needed to be changed to Hertfordshire 2 REC, which you agreed to do.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to complete Part C of the application form or to inform Local Research Ethics Committees (LRECs) about the research. The favourable opinion for the study applies to all sites involved in the research.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application		29 August 2006
Investigator CV		25 August 2006
Protocol	1	25 August 2006
Covering Letter		25 August 2006
Summary/Synopsis	1	25 August 2006
Compensation Arrangements		01 August 2006
Interview Schedules/Topic Guides	1	25 August 2006
Questionnaire: Obesity in adolescence: GP role	1	25 August 2006
Letter of invitation to participant	1	25 August 2006
Participant Information Sheet	1	25 August 2006
Participant Consent Form	1	25 August 2006
Educational Supervisor's CV		20 June 2006
Educational Supervisor's CV		08 August 2006

Research governance approval

You should arrange for the R&D Department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research at a NHS site must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

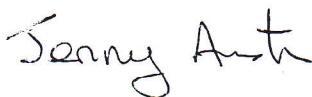
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q0204/104

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



Mrs Jenny Austin
Committee Co-ordinator

Email: jenny.austin@nhs.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
Standard approval conditions (SL-AC2)

Copy to:

Andy Penn
Research Grants Administrator
Research Office
University of Hertfordshire, Q217
College Lane
Hatfield
AL10 9AB

Sue Hall, Administrator for RM&G
Hertnet
University of Hertfordshire, Q217
College Lane
Hatfield
AL10 9AB

Appendix 7
RM&G approval



Bedfordshire **NHS**
Primary Care Trust

Gilbert Hitchcock House
21 Kimbolton Road
Bedford
MK40 2AW
Tel: - 01234 795 714
Fax: -01234 342028

Josefine Magnusson
Research Fellow
University of Hertfordshire
Hatfield
Herts
AL10 9AB

1 March 2007

Research Proposal: Ref: 06/Q0204/104 Adolescent weight management in General Practice

Dear Josefine

Following review of your application I am pleased to inform you that the PCT is happy for the first 2 stages of your research to take place. Members of the Research governance group did make the comment that your proposal had a relatively short literature review considering that the topic is an area of high priority for the NHS. This is something you may wish to consider when writing up the study.

I now need to organise an honorary contract for stage 3 of the research. Please note that until that contract is in place you will not be able to proceed with stage 3, hence the reason for issuing approval for stages 1 & 2 only at this time so as not to hold up your research. Once we have the honorary contract I will issue a further letter. In the mean time I will request a CRB check form from HR and send that onto you to complete and return asap. I'm sure you'll appreciate that as you will be interviewing children this will need to be an extended CRB check.

Your research project will be placed on the Bedfordshire Research Register and you will be required to complete monitoring information during the course of the research, as requested. Please note that failure to respond to requests for monitoring & audit data could result in withdrawal of approval. You may also be required to attend the PCT's Clinical Governance Committee to discuss the research.

Should any adverse incidents occur during the research, the PCT's Adverse Incident Procedure should be used. You should also be aware of the PCT's Health and Safety at Work Policy and Data Protection and Handling policies.

Please contact me should you have any further queries.

Yours sincerely,

A handwritten signature in black ink that reads "Rosie Straughair".

Rosie Straughair
Clinical Effectiveness Manager

Appendix 8

Health care professional interview schedule

Interview schedule.

Questions for health professionals.

(Greet participants and thank them for agreeing to be interviewed. Explain that interview will be tape recorded and double check this is ok.)

1). Adolescent obesity as a problem

- What do you think about all the attention that has been directed on child and adolescent obesity recently?
 - Do you think obesity in adolescents is a problem?
 - What do you think is the biggest risk factor for adolescents becoming obese?
 - What would be your concerns for an adolescent patient who was obese?
 - Physical health
 - Emotional well-being?
 - Do obese adolescents need to be treated? Why do you think that is?

2). Treatment

- What is your experience of treating adolescents who are obese?
 - How do you feel about treating adolescent obesity?
 - Do you worry about eating disorders in dealing with obese adolescents?
 - Would you consider obesity to be a form of eating disorder?
 - What could be some of the difficulties in treating adolescent obesity?
 - What treatments do you think are most effective for obese adolescents?
- Would it be appropriate to bring up the issue of weight with a young person who was clearly overweight or obese, even if they did not mention it?
 - When would it be appropriate? What would be the best way of bringing it up? **OR**
 - Why would it not be appropriate?
- What do you think are the differences between treating adolescent and adult obesity?
 - What special requirements (if any) do you think adolescent patients have compared to adults?

○

3). Experience and further training

- Do you feel that you have enough experience in advising adolescent patients who are obese on their weight?
- Do you feel comfortable dealing with obesity in adolescents?
 - Would you rather refer obese adolescents to someone else?
 - Who?
- Would you like more training in dealing with obese adolescents?
 - How could more training help you?

4). Whose role is it to deal with obesity in adolescence?

- Whose responsibility do you think it is to address adolescent obesity?
- What role do you think that general practice staff such as yourself should play in dealing with obesity in adolescence?
- Is adolescent obesity best addressed by the GP or the nurse? What about other professionals?
 - In your experience, who within the practice is expected to deal with weight management advice for young people?
- How involved do the parents need to be?

5). Policy

- What do you think of the response of the department of health to reports of increasing obesity in children and young people?
- Are current DH documents (e.g. NSF for children and young people, Choosing Health) clear in how obesity in this group should be addressed?
- What do you think of the NICE guidelines on obesity? How do they help you in your everyday practice?

6). Finish

- So, what do you think would be the best strategy for addressing adolescent obesity generally? Role of
 - Parents
 - Government
 - Media
 - NHS

- School
- Is there anything else that you would like to say about obesity in adolescents, or the role of general practice in addressing adolescent obesity?

Thank them for taking part.

Appendix 9
UH Ethics approval

SCHOOL OF PSYCHOLOGY ETHICS COMMITTEE APPROVAL

Student Investigator: Josefine Magnusson

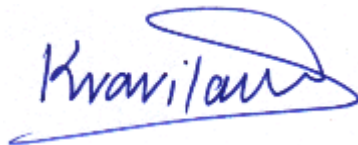
Title of project: Help seeking for adolescent obesity management: The experiences of health care professionals, adolescents and parents

Supervisor: Fiona Brooks, Wendy Wills & Nick Troop

Registration Protocol Number: PSY/11/11/JM

The approval for the above research project was granted on 24 November 2011 by the Psychology Ethics Committee under delegated authority from the Ethics Committee of the University of Hertfordshire.

The end date of your study is 31 October 2012.



Signed:

Date: 24 November 2011

Professor Lia Kvavilashvili
Chair
Psychology Ethics Committee

STATEMENT OF THE SUPERVISOR:

From my discussions with the above student, as far as I can ascertain, s/he has followed the ethics protocol approved for this project.

Signed (supervisor):

Date:

Appendix 10

Young people interview schedule

Interview schedule young people

(Greet participants and thank them for agreeing to be interviewed. Explain that interview will be tape recorded and double check this is ok.)

What made you agree to take part in the research?

Why is it that you want to lose weight?

Probe for health reasons, social pressure etc.

How do young people talk about weight?

Do you discuss weight loss with friends?

Probe for:

- Things/ situations that made participant consider own weight as 'problem' (e.g. looks, being teased, feeling unfit, comments from parents, suggestion from GP etc.)
- Had they asked for/ sought help from anyone?
 - What was that like/ what happened then?

Have you tried losing weight?

What happened?

Is losing weight difficult/ easy?

Why?

Probe for:

- Practical changes made (e.g. exercise, eating habits)
- Way they think about weight related behaviour
- Emotional health
- Fitness/ weight
- Way think about own body

How would your life be different if you lost weight?

Probe for:

- Anticipated outcomes in terms of looks, fitness, health etc.
- Why are those outcomes important to you?

What have been the things that have made you change (triggers)?

What do you think about regular health services, e.g. GP, providing this type of support?

Probe for:

- Experiences with GP services overall
- What would be positive about services provided through GP?
- What would be negative?
- Do they see obesity/ overweight as a medical issue? Do they feel general practice is appropriate setting to deal with weight management in young people?

What is important when asking for help with weight from a health professional or other adults?

Probe for

- Way they are treated
- Knowing who and 'how' to ask
- What is difficult about seeking/ asking for help?
- 'Good' and 'bad' ways issue of weight can be brought up by staff
- How does it feel to get diagnosis of 'obese' or 'overweight'? what does it mean for own identity?

Do you discuss weight with family/ parents?

Probe for

- Control
- Changes in communication with parents/ siblings

Is there anything else you would like to add that we haven't already talked about?

Thank you!

Appendix 11
Parent interview schedule

Interview schedule parents

(Greet participants and thank them for agreeing to be interviewed. Explain that interview will be tape recorded and double check this is ok.)

Tell me a little bit about why you agreed to be interviewed?

How do you feel about your child being overweight?

Do they see it as a problem or not?

Probe for health concerns, emotional well being

When did you first notice your child being overweight?

Were there any changes in behaviour (e.g. eating more, doing less exercise)?

Have you noticed any changes since child became teenager

Probe for:

- Eating/ exercise habits
- Way they think about weight
- Emotional health
- Way they think about body

Have you discussed weight with your child?

Why/ why not?

Did child ever bring it up?

How did you feel about that?

How did they react?

Have you ever discussed concerns about child's weight with a health care professional?

What happened?

Alternatively – Why not?

Probe for:

- Experiences with GP services overall for adolescent health
- What would be positive about services provided through GP?
- What would be negative?
- Do they see obesity/ overweight as a medical issue? Do they feel general practice is appropriate setting to deal with weight management in young people?

What is important when asking for help with weight from a health (or other) professionals?

Probe for

- Way they are treated by staff
- Knowing who and 'how' to ask
- What is difficult about seeking/ asking for help?
- 'Good' and 'bad' ways issue of weight can be brought up by staff
- How does it feel to be told child is 'obese' or 'overweight'?

What do you think is the best way for adults to discuss weight with adolescents?

In what way do you think your child's life would be different if they weren't overweight?

How much responsibility do you think can be placed on adolescent for weight loss?

Probe for

- How they as parents can facilitate responsibility in their teenage children
- Feelings around own responsibility
- Guilt? Powerlessness/ helplessness? Not very worried?

Is there anything else you would like to add that we haven't already talked about?

Thank you!

Appendix 12

Young people's survey

Welcome to My Survey!

This is a survey for young people aged 16-19 years about health, weight and health services. Before you decide whether to take part in this study, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision as to whether to take part.

This questionnaire asks some questions about which people you would go to for help if you were concerned about weight or personal issues, and how you feel about visiting your GP. It also has some questions on what you think about your own weight and body. The purpose of the study is to find out more about how GPs can help young people that have concerns about their weight or health. It is completely anonymous and confidential, and it will not be possible to trace your answers back to you as we will not ask for your name. You do not have to answer all the questions if you do not want to, and can skip questions or stop completing the questionnaire at any time without giving a reason. Your answers will help us to plan services for people your age.

After the data is collected, it will be analysed and written up as part of a postgraduate research project. The results will be shared through the research report (dissertation), and disseminated through academic conferences and journals. The data will be stored electronically in password protected files accessible only to the researcher. The study has been reviewed by The University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority; protocol number HSK/PGR/UH/02236

This research is undertaken by researchers based in the Centre for Research in Primary and Community Care, University of Hertfordshire. If you have any questions about the study, please contact the principal investigator Josefine Magnusson on j.e.magnusson@herts.ac.uk or 01707 281215. The study is part of a doctoral research project, and you can also contact the research supervisor, Wendy Wills, on w.j.wills@herts.ac.uk or 01707 286165

Thank you for taking the time to read this and for helping with the research!

* 1. I have read and understand the information provided about the survey

I agree

* 2. How old are you?

- Younger than 16
- 16
- 17
- 18
- 19
- Older than 19

3. Are you...?

- Male
- Female
- Other
- Prefer not to say

4. How would you describe your ethnic origin? *(Please select one answer only)*

Asian or Asian
British

Black or Black
British

Mixed

White

Other/ prefer not to say

Ethnicity

5. Do you currently live...

- At home, with parent(s) (including step-parents, foster parents or other carers)
- In student accommodation
- Other independent accommodation (e.g. by yourself or with a partner)
- Other (please specify)

6. Where do you live?

- England
- Scotland
- Wales
- Northern Ireland
- Outside the UK

7. Please let us know how you feel about visiting the GP

	Agree	Somewhat agree	Somewhat disagree	Disagree
I know what to expect when I go to see a GP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel comfortable talking to a GP I don't know very well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe a GP has time to listen to my problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm happy about my family knowing if I've visited a GP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If I tell a GP about my personal problems, I believe they will keep it a secret	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think GPs are interested in emotional problems as well as physical health problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe a GP can understand my thoughts and feelings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm not embarrassed to talk about my problems to a GP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm not worried about telling a GP how I truly feel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting a GP's help means I don't have to work out my problems alone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What I think and how I feel emotionally are important enough to talk to a GP about	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?

	Extremely unlikely		Unlikely		Likely		Extremely likely
Intimate partner (boyfriend, girlfriend)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Friend (not related to you)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other relative/ family member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health professional	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Phone helpline (e.g. Samaritans, Young Minds)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doctor/ GP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Minister or religious leader (e.g. priest, rabbi, imam, chaplain)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would not seek help from anyone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I would seek help from someone else. Please write who:

9. Do you think your body is...?

- Much too thin
- A bit too thin
- About the right size
- A bit too fat
- Much too fat

10. Are you currently on a diet or doing something to lose weight?

- No, my weight is fine
- No, but I should lose some weight
- No, because I need to put on weight
- Yes

11. If you were worried about your weight, or wanting to lose weight, how likely is it that you would seek help from the following people?

	Extremely unlikely		Unlikely		Likely		Extremely likely
Intimate partner (boyfriend, girlfriend)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Friend (not related to you)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other relative/ family member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health professional	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Internet/ magazines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doctor/ GP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Minister or religious leader (e.g. priest, rabbi, chaplain)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would not seek help from anyone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would seek help from another not listed above	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you would seek help from someone not listed above, please write who:

12. Have you ever asked someone for help with your weight?

Yes

No

If yes, who?

13. Talking to a GP about weight

	Agree	Somewhat agree	Somewhat disagree	Disagree
I could talk to a GP if I was worried about my weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My GP would be able to help me if I wanted to lose weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A GP is the right person to talk to about weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be OK for a GP to discuss my weight with me even if I didn't bring it up first	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. Do you think being overweight is a health/ medical problem...?

	Never	Rarely	Sometimes	Often	Always
In adults	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In young people aged 13-19	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In children aged under 13 years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. Have you ever felt that your weight has impacted on your own health or well-being?

- No
- Yes

If yes, in what way?

16. Would you say your health is...?

- Excellent
- Good
- Fair
- Poor

17. Have any of the following ever happened to you because of your weight?

	Never	Rarely	Sometimes	Often
Been physically bullied (e.g. hit, kicked or spat on)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been called names	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been excluded by friends/ other people your age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. How much do you weigh? (Please enter EITHER stone/ lb OR kg)

	st	lb	Kg
Weight	<input type="text"/>	<input type="text"/>	<input type="text"/>

20. How tall are you? (Please enter EITHER ft/ inches OR cm)

	ft	in	cm
Height	<input type="text"/>	<input type="text"/>	<input type="text"/>

21. If you have anything else you would like to add about the topics brought up in this survey, please list them here

Thank you very much for completing this survey!

If you have any concerns about your health or weight, please discuss them with your GP.
You can also find more information and support online at Youth Health Talk (<http://www.healthtalk.org>)
or NHS Choices (<http://www.nhs.uk/livewell>)

If you have any further questions please contact Josefine Magnusson on oj.e.magnusson@herts.ac.uk or
01707 281215
or Wendy Wills on w.j.wills@herts.ac.uk or 01707 286165

Appendix 13

Search strategy

Search strategy

The research presented in this dissertation developed out of an initial idea to develop an intervention for weight management for adolescents in general practice. However, initial searching on this topic revealed a dearth of evidence regarding effective interventions, and very little evidence of either health care professionals' or adolescents' views and experiences. Subsequently, searches of relevant data bases (PubMed, CINAHL, Cochrane Library, PsycInfo, PsycArticles, and google scholar) were undertaken using combinations of the search terms: adolescen*, teenage*, young people, young person, GP, nurs*, general practice, practitioner, weight, obes*, overweight.

This was followed by subsequent searches on the terms attitude*, view*, belief* in combination with the above.

This led to further exploration of the literature regarding consultation encounters, health care communication, clinical decision making, and patient centred care.

In preparation for the survey of young people presented in chapter 6, additional searching was undertaken to include the terms: adolesc*, young people, young pers*, teenage*, help seek*, barrier*, treatment, health care, general practice, service*

Literature was also identified through reference lists of already accessed literature, and through 'cited by' and 'related articles' features of different data bases.