IN ADULTS, obesity is commonly defined by a Body Mass Index (BMI) of 30 or more. For children in the UK, the British 1990 growth charts are used to define weight status (Cole et al., 1995). In this research we adopted a definition of childhood obesity as ‘having excess body fat and being well above the child’s ideal weight based on their age, height, build and sex.’

Obesity has been described as a ‘global epidemic’ (World Health Organisation, 2000), and the Health Survey for England (Department of Health, 2006) reports that between 1995 and 2003 the prevalence of obese and overweight children aged 2 to 10 years increased (9.9 per cent to 13.7 per cent and 22.7 per cent to 27.7 per cent respectively). Reilly (2009) suggested that children’s services need to address this issue to alter the trajectory of children, re-routing them from the forecasted increase in childhood obesity that is predicted to rise significantly by 2050. In 2008 childhood obesity was demonstrated to be an area of growing concern for the UK Government. A cross-Government strategy was launched in order to combat this ‘lifestyle disease’, which was said to be threatening our health and quality of life in addition to generating spiralling health and social care costs (Department of Health, 2008). A national target was set to halt the growth of obesity in children under 11 years of age by 2010. Recent reports show that this trend may be reaching a plateau (The NHS Information Centre, Lifestyle Statistics, 2011).

Despite these early indications there is still a considerable amount of work to be done to achieve the Government’s aspiration (Department of Health, 2010) reversing ‘the rising tide’ of childhood obesity (Department of Health, 2009, p.7). This responsibility is shared jointly by the Department of Health and the Department for Children, Schools and Families (Department of Health, 2010). In addition the Children’s Workforce has a responsibility to ensure that every child is supported to meet the five outcomes outlined by the Government – to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being (Department for Education and Skills, 2004).

Obesity has not responded to health, education or disease models of treatment. Therefore, in order to address this ‘global epidemic’, obesity has been redefined as an ‘ecobiopsychosocial interaction’ (Anderson & Phelps, 2009, p.750). Obesity in childhood is increasingly recognised as more than a
health and medical issue and, therefore, requires the attention of a variety of professionals, including educational psychologists. Our research supplements previous research on childhood obesity and focuses on the psychological aspects of childhood obesity from the child’s perspective. It is hoped that this research will help to give a voice to children, enhance our understanding of these issues and inform multi-agency interventions contributing to the Every Child Matters outcomes (Department for Education and Skills, 2004).

**Psychosocial effects of obesity**

Obese children are often stigmatised (Kraig & Keel, 2001; Latner & Stunkard, 2003), and subject to negative stereotyping and discrimination by their peers (Cramer & Steinwart, 1998), resulting in emotional consequences such as low self-esteem, negative body image and depressive symptoms (Braet et al., 1997; Calamaro & Waite, 2009; Hesketh et al., 2004; Koplan et al., 2005; Miller & Downey, 1999). Negative attitudes towards obesity may originate in childhood and there is evidence that children’s attitudes are deteriorating in that stigmatisation has been shown to have increased over the past 40 years (Hill & Silver, 1995; Latner & Stunkard, 2003; Staffieri, 1967). This could reflect cultural values permeated through the media and other social influences that ostracise obese people and reify their positions on the margins (Ferris, 2003).

Evidence suggests that modern inactive lifestyles play a central role along with diet in the aetiology of obesity (Brown & Witherspoon, 2002; Prentice & Jebb, 1995). Suggestions to counter young people’s inactivity in school have been provided by Ketteridge and Boshoff (2008). The possible consequences of childhood obesity include reduced likelihood of marriage, having lower household incomes and higher rates of poverty than normal weight peers (Gortmaker et al., 1993). However, it would be inappropriate to assume these findings apply to all obese children. Wills et al. (2006) reported contradictory findings concerning the negative consequences of obesity. Their findings challenged perceptions that being overweight/obese is related to body dissatisfaction and that young people have a fear of fatness. In this study adolescents rarely mentioned health related consequences of their own or others’ fatness and there was a general acceptance of body size and shape in an obese and overweight group. While this can be construed positively to reflect the acceptance of diversity and rejection of extreme dieting, thinness, eating disorders, anxiety and attention seeking related to perceived body fat, it is also disconcerting. Young people in the study stated fervently that it was their personal responsibility to control their body size, shape and food consumption. However, if they do not perceive this to be a problem then it is unlikely that they will be motivated to change and adopt a healthier lifestyle. Parental attitudes may also be of relevance since these show high congruence indicating the transference of specific attitudes towards physical activity (Anderson et al., 2009).

Parents of young obese children often do not recognise or feel concerned about their children’s weight problems (Baughcum et al., 2000; Wake et al., 2002). However, it is possible that some of these obese children were ‘healthy obese’. Recent research shows that 10 to 25 per cent of obese individuals are metabolically healthy due to preserved insulin sensitivity (Bluher, 2010). Nonetheless, this is a small proportion and only considers the physiological impact of obesity. It could be argued that one of the problems with childhood obesity could be related to ignorance or denial of the negative consequences from an individual and family perspective. On the other hand, parental acceptance and lack of concern regarding weight issues can be a protective factor for the self-esteem of overweight children (Davidson & Birch, 2001; Stradmeijer et al., 2000). Therefore, there is a balance involved in accepting or challenging obesity and the potential cost to children’s mental and
physical health, as well as recognising the impact of obesity at a national level (Zametkin et al., 2004), which is estimated to be in the region of £990 to £1225 million (The NHS Information Centre, Lifestyle Statistics, 2009), combining the costs of obesity itself and its consequences.

**Obtaining children’s views on obesity**

Bromfield’s (2009) review of research in the area of childhood obesity emphasises that overweight and obese individuals are likely to suffer negative consequences impacting on their ability to achieve the five Every Child Matters outcomes and calls for further research to address this problem. Causal factors relating to childhood obesity can be located at different levels including the individual, interpersonal, organisational and Governmental level (British Medical Association, 2005), which will require multi-layered interventions in order to sustain efforts and effect change. Educational psychologists are well placed to make contributions at all of these levels; undertaking work to ensure that children’s views are elicited and included (Department for Education and Employment, 2000) and also working in more systemic and organisational ways to effect change (Farrell et al., 2006).

Research including young people as informants is limited (Curtin, 2001) and children’s involvement in obesity research has largely been limited to rating pictures of children of varying sizes and offering self-judgements on the same scales (Hill & Silver, 1995; Richardson et al., 1961; Staffieri, 1967), asking children if they would like to be friends with obese children (Penny & Haddock, 2007) or through a story-telling method and adjective attribution task to elicit attitudes towards obese children (Cramer & Steinwert, 1998). Wills et al. (2006) call for more research ‘with’ as opposed to ‘on’ children and young people. Pupil participation was integral to the development of Every Child Matters and this has been a benchmark not only for educational psychologists but for all professionals involved in children’s services. A systematic review of children’s views about obesity, body size, shape and weight concluded that ‘research has so far failed to engage children properly in the debate about obesity and public health’ with no studies asking children directly what they think can be done to support them in maintaining a healthy body size (Rees et al., 2009, p.6).

The prevention of childhood obesity requires an understanding of how it is perceived in order to plan appropriate interventions. Gaining greater access to children’s views is, therefore, crucial. This study, therefore, sets out to ascertain and understand children’s views and attitudes towards healthy lifestyles and obesity, identifying influences and solutions in order to provide information that will inform multi-agency interventions contributing to Every Child Matters outcomes.

**Method**

The aim of the study was to explore children’s views, beliefs and understanding of childhood obesity, and for this purpose a qualitative research methodology in the form of semi-structured interviews was chosen. This enabled us to gather information on what participants thought and why they thought as they did.

The British Psychological Society Code of Ethics and Conduct (2009) was adhered to at all stages of this research. Ethical approval was obtained from the Norah Fry Research Centre Ethics Committee. Parents/carers received an information letter outlining what was involved in the research and children received child-friendly information letters. Informed consent was sought from participants and their parents/carers prior to the interviews. In addition, in order to protect the identity of the participants their details were anonymised in the transcripts and the children chose pseudonyms for the interview process. Participants were made aware that they could withdraw from the study at any time and that they could decline to answer any or all questions. Participants
were signposted to the head teacher for support or to discuss anything else related to the study once the researchers had left.

Participants
As low socio-economic status has been associated with increased obesity (Parsons, 2006), primary schools in areas of high socio-economic disadvantage were approached to ascertain their interest in taking part in the study. Following identification of a suitable school (the fourth highest in terms of socio-economic disadvantage in the area, as indicated by percentage of free school meals), a meeting was arranged with the headteacher to discuss the nature of the research and provide the opportunity for questions. Subsequently, parent information letters and consent forms were given to all children in the Year 5 class (age 9 to 10 years).

Of the 30 letters sent out to parents, only nine responses were received. This notably low response rate could be due to a number of factors including parental apathy or reluctance for their children to discuss this sensitive topic, or the method of recruitment may not have been best suited to this population. This has clear implications for the representative nature of the sample. It is recognised that participants who took part in the study may have different views and experiences from those who did not respond. However, the school reported general difficulties in engaging parents. Most children in the class were keen to participate, but were unable to owing to lack of parental consent. From those whose parents consented to them taking part, three girls and five boys were selected to take part in the study.

Design and procedure
Participants took part in an introductory session, which aimed to build rapport and included icebreaker games, discussions around their understanding of research and the procedure for this study. The children then completed their own consent forms and were given the opportunity to ask questions. Permission to digitally record the interviews was obtained from each participant and confidentiality was assured. It was emphasised that there were no right or wrong answers to the questions and that the researchers were only interested in hearing their views.

The semi-structured interview consisted of 10 questions (Appendix 1), which explored children’s views, perceptions and understanding of obesity. Participants were given the following working definition of obesity, in order to ensure uniformity of understanding:

“It's when someone has too much body fat, and they're well above their ideal weight. So your ideal weight is based on your age, your height, your build and whether you're a boy or a girl.”

A simple illustration of seven same-gender body figures, which ranged from very thin to obese was used to facilitate the discussion (Collins, 1991). At the end of the interview participants were asked what they might do to try to be healthy and what they might do as a result of the discussion. The interviews lasted no longer than 30 minutes. At the end of the interviews the children were given a ‘Change 4 Life’ poster and activity sheets1.

Data analysis
Thematic Analysis was used to interpret data in order to report ‘experiences, meanings and the reality of participants’ (Braun & Clarke, 2006, p.81). The researchers jointly collated and analysed the transcripts and field notes from the interviews. For each question an initial content analysis of all the responses was carried out to ascertain the main themes. Each participant’s responses were manually coded independently and then reviewed jointly. The entire data set was coded and emerging themes were data driven. The codes were sorted into themes and organised into ‘theme piles’. Different coloured post-it notes were used for each participant, in order to gain an overview of

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1 ‘Change 4 Life’ is a health programme organised by the UK Department of Health in January 2009.
the number of participants contributing to each theme. This process was carried out independently by both researchers and then reviewed jointly to ensure agreement. There was over 90 per cent agreement between the two raters on the coding of responses into themes and organising them into theme piles. Themes were then defined and refined using the coded data extracts.

Results

The following section describes the findings from the semi-structured interviews following a thematic analysis of the responses. Described below are the themes that emerged related to psychological aspects of childhood obesity, as well as the views of participants about being healthy or unhealthy. The numbers in brackets represent the number of participants sharing this view.

Participants’ views about being healthy or unhealthy

In terms of being healthy all of the participants placed importance on a healthy diet and exercise, with particular reference to ‘5 a day’\(^2\), eating less junk food and eating more fruit. Some of the boys related speed and being able to run fast to being healthy. Over half of the participants also made reference to appearance and weight, in terms of looking normal, being weight conscious, being thin and having a healthy appearance. Participants made reference to a healthy state of mind (7), and suggested that being healthy meant being happy (4). They also talked about confidence, a ‘can do’ attitude and being emotionally strong.

All participants associated a poor diet with being unhealthy, with reference made to junk food and excessive eating. Participants described an unhealthy person as someone who was passive, did not exercise and spent time on sedentary activities such as staying inside and watching TV (7). Some participants mentioned negative emotions associated with being unhealthy, such as feeling worthless, unhappy and not as good (5). One participant described an unhealthy person as being mean and a perpetrator of bullying.

No data were gathered on the weight status of the participants. The majority identified their weight status from a scale as ‘normal’ or ‘just right’ and indicated that they were happy as they were (6). A couple of participants, however, said they felt unhealthy or fat and would like to change (2). The general consensus was that it is good to be ‘normal’ and ‘blend in’.

How participants relate to obese children

- Accepting attitudes and empathy towards obese children.

Participants’ general stance regarding obesity appeared to be one of acceptance (7):

‘Fat ain’t a big deal, just coz you’re fat it ain’t the end of the world.’

Some participants felt that an obese child should not need to change unless they wanted to (3), and were able to find something good about obesity (7). The boys mentioned weight advantages relating to strength and power, protection against attack and a useful avoidance strategy (3). Girls linked obesity to indulgence in unhealthy eating (2). Participants demonstrated empathy and understanding of the difficulties that obese children faced (5), sometimes expressing this through sensitively worded language.

How obese children are seen

- Choice and limited self control over their own destiny.

Lack of self-control in terms of temptation, instant gratification and excessive eating, was largely seen as a reason for childhood obesity. Responsibility was located within the obese child (8) and partially parents (2). Participants placed high importance on

\(^2\) ‘5 a day’ is the name given to a number of programmes in the UK, the US and some other countries based on the idea of eating five portions of fruit and vegetables daily.
choice in terms of what obese children ate or whether they needed to change, but referred to psychological battles in which the craving for food won over the mind:

‘It tastes so good they just convince themselves to eat it, but inside they just like don’t actually want to eat it, they just feel like they do so they just eat it and they just get bigger.’

Negative consequences associated with obesity

Our analysis revealed that participants perceived obesity to be a problem in a number of ways.

● Bullying

Participants discussed the prominence of weight-related bullying which involved name calling, ‘taking the mick’ and excluding children from friendship groups and activities. They reported that bullying leads to negative emotions for obese children (4):

‘Coz you might be a bit humiliated, coz everyone would laugh at you … they would say that you are fat, you are chubby they would just hurt your feelings.’

Some participants thought that a fear of bullying led obese children to sedentary activities to avoid bullies, or compelled them to change (3).

● Emotional consequences

All of the participants reported negative feelings associated with being obese that were related to weight-specific issues rather than bullying. Boys associated negative feelings such as worry and unhappiness with functional issues such as poor health:

‘Happy as he is but he’s really unhappy coz he’s ill.’

Girls linked negative feelings such as body dissatisfaction, depression, annoyance, anger and regret with body image and size:

‘Annoyed at their overweight and they might think … I wish I lost weight coz I don’t like my body … why did I do this in the first place?’

● Obese barriers to quality of life

Participants saw obesity as a barrier that prohibited quality of life in different ways: limiting friendship opportunities (5) because they may not be able to participate in common physical activities and play-ground games, and limiting sporting success because it slows you down and inhibits performance (5):

‘Well the sad part is that you won’t win a lot of races, coz the weight will be pulling you down.’

Participants described social barriers such as weight-related embarrassment and health barriers such as weight-related incapacity preventing children from having access to educational and social opportunities (7). Obesity was linked to ill health, affecting school attendance and ability to undertake physical activities like exercise. Obese children were seen as engaging mainly in sedentary activities because their weight increasingly disabled them (6):

‘You might not be able to walk that well … coz you might fall over and everything.’

Boys also identified other inconveniences related to breaking ‘priceless’ things, not being able to fit into clothes, problems with access to transport (cars, boats, bikes) and being unable to work and earn money (4).

● Health consequences

Participants mentioned health-related consequences such as diabetes, asthma, heart attacks and general sickness (6) and injuries from weight-related accidents (2). They noted that these can be serious and result in hospitalisation. Participants described how being obese could contribute to death as a result of illness and disease (5):

‘You’re that fat, it means you’re in serious danger of dying.’

Influencing factors contributing to children’s perceptions of childhood obesity

Most of the knowledge participants had of obesity was through the media; Internet, TV and film (6). Participants also said that they either knew or had contact with an obese child (5):

‘I knew someone who was very fat, she was on the news, she had to have loads of people to get her out of bed.’

Participants felt that parents generally had negative influences on obese children, through ignorance, buying the wrong food,
Table 1: Children’s views of supportive mechanisms for obesity.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School</strong></td>
<td>'They don’t have much control at home an stuff and um but at school they have um healthy meals if um they have school dinners.'</td>
</tr>
<tr>
<td>- Education and teaching</td>
<td></td>
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<tr>
<td>- Communicate healthy messages to family</td>
<td></td>
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<tr>
<td>- Providing healthy food</td>
<td></td>
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<tr>
<td>- Regular exercise</td>
<td></td>
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<tr>
<td>- Stop bullying</td>
<td></td>
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<tr>
<td><strong>Family</strong></td>
<td>'If they’re still living with their parents their parents might say it’s time for you to stop lounging around and you got to do more exercise now and stop eating snacks and, er, eat more fruit and veg.'</td>
</tr>
<tr>
<td>- Parental discipline</td>
<td></td>
</tr>
<tr>
<td>- Parental encouragement</td>
<td></td>
</tr>
<tr>
<td><strong>Advice from professionals/ experienced others</strong></td>
<td>'They’d just go on a diet and someone might take all that stuff that wasn’t on the diet away so they don’t, not tempted ... like someone who’s been on a diet and knows what to do.'</td>
</tr>
<tr>
<td><strong>Social inclusion</strong></td>
<td>'Her friends would come and help her and be nice and come and help.'</td>
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<tr>
<td>- Loyal friends</td>
<td></td>
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<tr>
<td>- Attend clubs</td>
<td></td>
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<tr>
<td>- Invitations to participate in games</td>
<td></td>
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<tr>
<td><strong>Building emotional resilience</strong></td>
<td>'It wouldn’t be easy at first but it would get easier as he goes along.'</td>
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<tr>
<td>- Persistence</td>
<td></td>
</tr>
<tr>
<td><strong>Media</strong></td>
<td>'You could also use the dial that I have ('Change 4 Life'), switch different all the time, go out on your bike ... coz then you will be able to get less obesing.'</td>
</tr>
<tr>
<td>- Health promotion campaigns</td>
<td></td>
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<tr>
<td>- Reduce temptations</td>
<td></td>
</tr>
<tr>
<td><strong>Coping strategies</strong></td>
<td>'It’s not anybody else’s life to choose who you want to be ... being skinny is all right, so is fat but it’s not their choice, it’s what you want to be.'</td>
</tr>
<tr>
<td>- Ignore it</td>
<td></td>
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<tr>
<td>- Personal choice</td>
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<tr>
<td>- Avoidance</td>
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</tbody>
</table>

**Solutions**

All participants suggested that obesity could be addressed through individual behaviours related to modifying diet and exercise and made reference to at least one of the following: portion sizes, eating ‘5 a day’, healthy alternatives, sport, dieting, more fruit and being more active. Table 1 summarises supportive mechanisms that participants identified in assisting obese children to modify their behaviour.
**Discussion**

This small-scale, qualitative study clearly had a number of limitations which make it difficult to generalise its findings. Of these, the most obvious was the size and nature of the sample. It was conducted on one age group in a single primary school. From the small potential sample of 30 children eligible to participate, parental responses were received for only nine children, with a final total of eight participants. It is not known how representative these children were of the views of the whole group, or of other groups of children of the same age. In addition, school factors may have played a part in shaping the views expressed by the children.

It should also be noted that no independent weight data were gathered on the participants, and, therefore, their weight status is unknown. It has been noted that six of the participants felt that their weight was normal while two believed themselves to be overweight. However, without further information nothing definite is known about the status of the sample in this respect.

The study may also have been affected by social desirability factors, which restricted participants from articulating socially unacceptable views and increased the probability of them giving the ‘right answers’. It was noted, for example, that they demonstrated empathy and understanding of the difficulties that obese children faced and that they were sensitive in the wording they used. This may have reflected discretion towards the researchers and a wish to please them in the answers given.

Furthermore, some questions such as, ‘How far do you think being obese is a problem for children on this scale of 1 to 10?’, may have biased responses. Indeed, the whole context of the study should be noted. The interview script set the scene by stating at the start, ‘We are trying to find out what children think about being healthy’. This was the context in which the issue of obesity was raised, and it may not therefore be surprising that children in this study seemed to raise more health issues to do with obesity than in other studies involving children’s views.

Health issues were raised by all of the participants, whereas in the small number of existing studies involving children’s views about obesity they featured rarely (Rees et al., 2009). However, in general other studies have had a much larger sample size. Wills et al. (2006), with an older sample of 36 teenagers in the age range 13 to 14 years, noted that participants rarely spontaneously raised any health-related consequences of their own and others’ fatness. They did however note that half of their sample stated that being fat was unhealthy. It may, therefore, be that responses relating to health are more common when there is a context relating to health or questions that lend themselves to comments about health.

Overall, however, the perceptions of these participants say something about how some children perceive obesity, and this is an area in which many aspects of children’s viewpoints require further research. The results are congruent with previous findings suggesting that children reflect the way in which obesity is socially represented. Although what was unclear in this research was what influenced the way in which these participants related to obese children and if their views were consistent with their actions; this could be a further area for research.

Participants appeared able to see beyond weight status in that they recognised that obese children were the same as themselves even though they looked different. However, they displayed distancing effects in relation to obesity, stating that it is reasonable for others to be obese although they would not want this for themselves. Participants accepted and understood that it was hard for obese children to lose weight and that they might choose not to, as long as they were happy with themselves. This extends Wills et al.’s (2006) findings of general acceptance of body size in an obese group and lack of motivation to change when weight is not perceived as a problem. Our findings tentatively suggest that children have co-existing feelings of empathy due to the negative consequences that obese children experi-
ence, in contrast with an acceptance and respect for personal choice over their destiny. Influences over participants’ thinking in this respect could be explained by a number of factors. It may have been a reflection of the school ethos, or parental attitudes of this particular group of children versus wider cultural influences. Furthermore, it is difficult to ascertain the extent to which participants’ empathy was genuine or due to social desirability effects. Further research would need to triangulate findings to assess whether participants were providing socially acceptable responses or whether they really were being honest about how they respond to obese children. This research highlights a tension between the participants’ stated acceptance of obese children and their blaming discourse which places the responsibility for obesity largely on the child.

Participants recognised the stigmatisation and victimisation experienced by obese children through bullying, leading to negative feelings. This is consistent with previous research linking childhood obesity with bullying (Gray et al., 2009; Puhl & Latner, 2007; Strauss & Pollack, 2003), resulting in emotional consequences such as low self-esteem, negative body image and depressive symptoms (Eisenberg et al., 2006; Hayden-Wade, et al., 2005). Participants in this study hypothesised that fear of weight-related bullying could lead obese children to sedentary activities, which was also found in previous research (Gray et al., 2008; Hebebrand & Herpertz-Dahlmann, 2009; Storch et al., 2007). Participants’ views support historical and cross-cultural observations regarding the place of sedentary lifestyles and diet as major contributory factors to the development of obesity (Prentice & Jebb, 1995). However, these primary causes of obesity in terms of energy imbalance should not serve to obscure the complexity of wider factors that may be involved in the aetiology of childhood obesity. Previous research has identified conflicting evidence amongst an overweight population who either felt that their weight and diet were their own responsibility (Wills et al., 2006) or were influenced by factors outside of their control (Rees et al., 2009). Participants attributed sedentary lifestyles and over-eating to poor self-control and essentially saw obese children as responsible for their own weight, supporting the former of these positions and placing blame and responsibility on those who are overweight, as reported elsewhere (Rees et al., 2009). Consequently the trend in personal responsibility led participants in this study to target solutions towards individual behaviours such as modifying diet and physical activity.

The theme of obesity-related barriers was also consistent with previous research indicating that obesity can restrict opportunities, leading to reduced health-related quality of life (Schwimmer et al., 2003), with social and economical consequences being greater than many other chronic physical conditions (Gortmaker et al., 1993). In common with Wills et al. (2006), a prominent perception for participants in this study was the physical barrier related to being slowed down and not succeeding in sport. In addition, friendship success was thought to be affected by restricted participation in common activities, supporting previous findings that obese children were less likely to ‘hang out with friends’ and were socially marginalised (Falkner et al., 2001; Strauss & Pollack, 2003). In contrast, Phillips and Hill (1998) found that ‘fat’ did not mean ‘friendless’. The present study, although only based on the views of a small group of children, supports both findings in that obese children were said to be accepted but often thought of as peripheral in socialisation due to weight restrictions preventing them from ‘keeping up’. It is possible that this marginalisation may in fact be due to attitudinal barriers rather than physical barriers, since this research was not able to triangulate and verify participants’ stance of acceptance. Therefore, the extent to which social desirability factors might have influenced participants’ views about obese children being excluded or included is unclear. Further,
participants did not discuss socialising in inactive contexts.

Other emotional consequences particularly prominent for girls were feelings of regret regarding their weight. This could illustrate girls’ vulnerability to the effects of societal and cultural messages such as ‘Thin is good, fat is bad’ (Cramer & Steinwert, 1998) and stigmatisation of being outside acceptable norms.

Several studies have indicated that negative attitudes towards obesity originate in childhood (Hill & Silver, 1995; Latner & Stunkard, 2003; Stefferi, 1967). It is important, therefore, to understand influences that underly children’s thinking. Participants attributed parents’ roles in childhood obesity in terms of ignorance, neglect, denial or poor role modelling. This reinforces guidelines that parents of children under 12 should be encouraged to take greater responsibility for their children’s lifestyle (NHS, 2008; Spear et al., 2007). However, it is also a reminder that it can be hard to help parents provide positive messages regarding their children’s health and lifestyle. Most participants indicated that their main source of knowledge on obesity was the TV or Internet. This information, however, was often misinterpreted or regarded as humorous. School was thought to have a positive influence on healthy eating with the provision of food, but unsuccessful in helping children to learn about ‘healthy stuff’. Schools were, however, identified as supportive mechanisms foundational to behaviour change, for example in providing objective information that is not restricted by emotional tensions in families.

Conclusions
It is important to support children in making positive choices with regard to healthy lifestyles. Schools can promote enabling environments, providing opportunities to educate, model and inspire children to take up balanced lifestyles through provision of suitable food and regular exercise. School settings can engage children in physical activities with social elements by creating safe places for them to be active where they are uninhibited about their bodies and free from fear of bullying. Through consultation and training, educational psychologists can assist school settings with effective inclusion policies and social and emotional curriculum to address bullying associated with barriers to having access to active lifestyles. In addition, schools can teach children how to challenge negative behaviour and perceptions towards obese children, replacing these with supportive relationships. To facilitate a supportive environment, it would be useful for interventions to emphasise healthy lifestyles for all, rather than tackling obesity itself in order to reduce stigma (Ells & Cavill, 2009).

In the context of conflicting messages, schools can teach children critical thinking skills to analyse and assess sources of information to weigh up their credibility. In addition schools can act as a mediator to ensure that children are receiving the right messages using up-to-date knowledge and evidence-based interventions. Educational psychologists and multi-agency colleagues could act as reliable resources for schools to access this information. In essence multiple-level interventions are needed for all children that are culturally relevant and sensitive to the target population. Successful interventions are likely to involve a network of family, friends, professionals and organisations in long-term maintenance of healthy lifestyles.
Acknowledgements
The authors wish to thank the children who took part in this study, the participating school, and the staff on the Doctorate in Educational Psychology programme based at the Norah Fry Research Centre for facilitating this work and for their support and advice throughout the process.

References


Appendix 1: Interview script

Rapport building, then…

‘Thank you for coming to meet me today. Can you remember what we are here to talk about? If yes (tell me and then clarify) if no … We are trying to find out what children think about being healthy and have a few questions to ask you about this and also some questions about the concept of being obese. We are interested in what you think. You do not have to take part or answer any questions you don’t want to. There are no right or wrong answers. We will not use your name when we talk about the answers. However, if you say anything that affects your safety or the safety of another child then we will need to talk to another adult about this. Is that ok?’

General rapport building questions about school. For example: ‘Tell me about what school is like for you?’ ‘What do you enjoy about school?’ (Scaling activity using visual aid: ‘On this scale of 1 to 10, 1 being not good at all and 10 being excellent, how would you rate school?’).

‘What does healthy mean to you?’ (Further prompts might include, ‘What else?’, ‘What would a healthy child be doing?’, ‘What would they look like?’, ‘What would they eat?’, ‘How would they feel?’).

‘What does unhealthy mean?’ (Further prompts might include, ‘What else?’, ‘What would an unhealthy child be doing?’, ‘What would they look like?’, ‘What would they eat?’, ‘How would they feel?’).

‘Have there been times when you felt unhealthy?’ ‘What were they like?’

References:


‘Do you know what obesity is?’
If yes… ‘Can you tell me more?’
If no… (standardised explanation).

‘People talk a lot about some children being obese (like in the newspaper, at school, TV, etc.). Who has talked to you about this? What have they said?’

‘How much would the thought of being obese worry you on this scale of 1-10, 1 being not worried at all and 10 being very worried – where would you be?’

‘How far do you think being obese is a problem for children on this scale of 1 to 10, 1 being it is not a problem at all and 10 being a big problem – what do you think? Tell me a bit more about that? Why?’

‘What are the good or bad things about being obese?’

‘People have different views about why children are healthy or obese. What do you think? (Is it due to the child themselves, family, friends, school, TV, books, how come?)’

‘What do you do to try to be healthy? What else might help you to be healthy? (Is there anything that stops you from exercising and eating healthily?)’

Summarise discussion: ‘We have talked about … and you said … ‘ (Confirm their answers.) ‘Is there anything that we have talked about that has made you think differently or that you think you will do differently for yourself or to help anyone else?’

‘Thank you for taking part in our discussion and research, which will help us to understand more about what children think about being healthy and obese. If you are interested in finding out more about being healthy you can talk to … (name).’ (Give general health leaflet). ‘Or if there is anything that you want to talk about afterwards please tell … name).’