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**How do obese young women seeking treatment for weight loss experience being  
overweight?**

**A qualitative exploratory study.**

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## **Abstract**

This thesis aimed to explore how obese young women seeking treatment for weight loss experienced being obese. Semi-structured interviews were conducted with six obese females, aged 14-17 years. The interviews were led by an interview schedule that focused on body image concern, emotional distress and disordered eating behaviour. The focus was to encourage the participants to talk freely of their experience of being obese. Thematic analysis (Boyatzis, 1998) was used to analyse the transcribed interviews and to identify the central themes used to answer the following research questions:

- 1) How do obese young women seeking treatment for weight loss describe their body image concerns, and what is the nature of these concerns?
- 2) How do obese young women seeking treatment for weight loss talk about their emotional experiences?
- 3) How do obese young women seeking treatment for weight loss talk about their disordered eating behaviours?

There is a detailed description offered outlining the analysis process and the qualitative approach adopted that adhered to methodological rigour regarding trustworthiness and offering transparency in how the data were analysed.

The following themes were generated in relation to the above research questions:

- 1) Obesity and self-perception (including negative body image concerns relating to body parts dissatisfaction and negative cognitions regarding body shape)
- 2) The role of food and emotions (including emotionally driven eating and disordered eating behaviours)
- 3) Obesity and others perception (including wider society and negative perceptions and social isolation).

A dominant feature associated with these themes was the way in which the participants were self-critical regarding their weight and shape and fearful of others criticisms. The findings are discussed in relation to existing research on youth obesity and related psychosocial factors.

There are also considerations of the clinical implications of the findings and recommendations for future research.

## 1. Introduction

The purpose of this thesis is to explore, using qualitative methodology, how obese young women seeking treatment for weight loss experience being obese. More specifically, the aim is to determine whether obese young women experience body image concerns and psychological difficulties. This chapter will appraise the literature on youth obesity, psychopathology and body image and bring together current research in these areas.

Section one will briefly present the following: 1) definitions of obesity, 2) obesity classification and measurement and 3) prevalence of obesity.

The second section will focus on obesity and related factors and will explore 1) biological causes of obesity briefly, 2) psychosocial factors that have been found to be related to obesity, focusing on stigma, victimisation and emotional difficulties and 3) how obesity is treated in the UK.

Section three will be devoted to youth obesity, focusing on female populations, and its relationship with eating disorder psychopathology, emphasising similarities with binge eating disorder and emotional eating in particular.

The final section will focus on the concept of body image and will outline 1) what body image is, 2) body image measurement and 3) a review of literature on body image and its relationship with youth and young women's obesity, as much of the research on youth obesity and how it is experienced is focused on body image. Based on research presented so far, there will also be a section on psychological models that have been put forward to understand obesity. This will be used to provide a rationale for this thesis and the research questions that guided this exploratory qualitative study.

**1.1. Definitions of obesity.** The term 'obesity' is a medical description defined by Body Mass Index (BMI) that is commonly used in our everyday language. Obesity is defined as an excess accumulation of body fat which has more severe health implications than being

‘overweight’ (McCarthy, Ellis & Cole, 2003) and is a health problem. Classification of weight exists on a continuum, from underweight to obese, the greater ones BMI the greater the risk of associated health problems. According to the World Health Organisation (WHO, 2013, p.8), ‘overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health’. According to the NHS Choices website, obesity is when ‘a person is carrying too much body fat for their height and gender’. Nammi, Kokal, Chinnala and Boini (2004, p. 3) described obesity as ‘a state of imbalance between calories ingested versus calories expended which would lead to excessive or abnormal fat accumulation’. This description however is simplistic and there are multiple factors that may contribute to an increase in weight, which is not expressed in the definition of obesity.

**1.2. Obesity measurement.** The way in which obesity is measured is via body mass index (BMI,  $(\text{Weight in Pounds} / (\text{Height in inches} \times \text{Height in inches}) \times 703)$  for adults, and using centile charts that display height and age for children. There is a BMI calculation for children stratified by age and gender. BMI is a guide and commonly used to estimate what constitutes a healthy body weight. It is the predominant measure of weight in the UK and the USA. In adult populations a BMI of 25–29.9 is considered overweight. A BMI greater than 30 is classified as obese (National Institute for Health and Clinical Excellence Guidelines, NICE, 2006). Table 1 shows BMI classification from healthy to obese in adults (World Health Organisation, WHO, 2011).

**Table 1. Classification of healthy weight to obesity in adults**

<b>Classification</b>	<b>BMI (kg/m<sup>2</sup>)</b>
Healthy Weight	18.5–24.9
Overweight	25–29.9
Obesity I (Moderate)	30–34.9
Obesity II (Severe)	35–39.9
Obesity III (Morbidly obese)	40 or more

Children's and young people's BMI is determined by measuring weight and height and then referring to the UK 1990 BMI charts to give age and gender specific information. BMI measurement in this group can be problematic as there is variation between genders (Eisenmann, Heelan & Welk, 2004). Therefore there are no fixed cut-offs as in adult populations (as displayed in Table 1); however, according to NICE guidelines (2006) youth obesity is defined as having a BMI adjusted for age and gender at or above the 95<sup>th</sup> centile. Young people who have a BMI adjusted for age and gender at or above the 85<sup>th</sup> centile are considered to be 'overweight' and at risk of becoming obese.

An additional problem is that different countries use different population references and obesity rates vary from country to country and over time (Smith, et al., 2010). Therefore classification for adults is more straightforward than for children and adolescents.

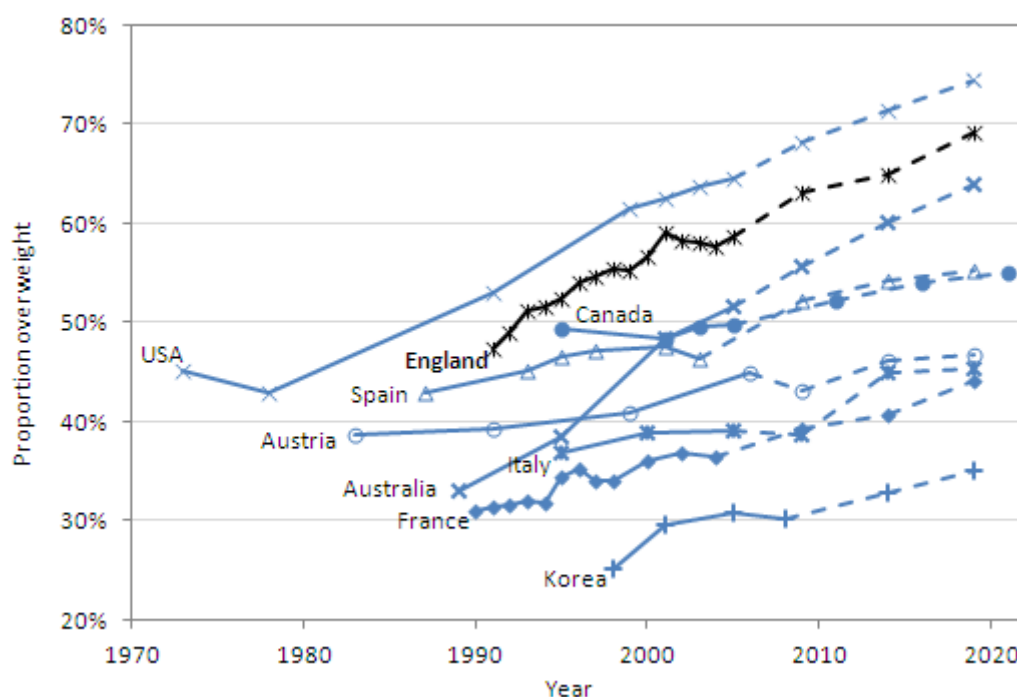
**1.3. Prevalence.** Obesity is a growing health problem across the world. Many factors have been associated with the rise in obesity, including increased accessibility to foods that are high in sugars, fats and salts (Department of Health, 2011). Childhood obesity is associated with type II diabetes (Maggio & Pi-Sunyer, 2003) and psychosocial and psychological difficulties (Dehghan, Akhtar-Danesh & Merchant, 2005).

In the UK there has been a drive towards becoming healthier and to finding ways in which obesity can be tackled. This has resulted in the publication of expert reports and

government guidelines (Gibson, Edmonds, Haslam, Poskitt, 2002; NICE, 2006) being created to help address the problems that obesity causes the healthcare system. More recently, the ‘Reducing obesity and improving diet’ policy was published (Department of Health, 2013), which considers how physical activity and education regarding nutrition should be the focus for obesity prevention.

England has the highest rate of obese adults in Europe (Organisation for Economic Co-operation and Development, OECD, 2010); see Figure 1 displaying a graph representing obesity rates in Europe from 1970 and future projections. Overall, one in four adults are obese in England.

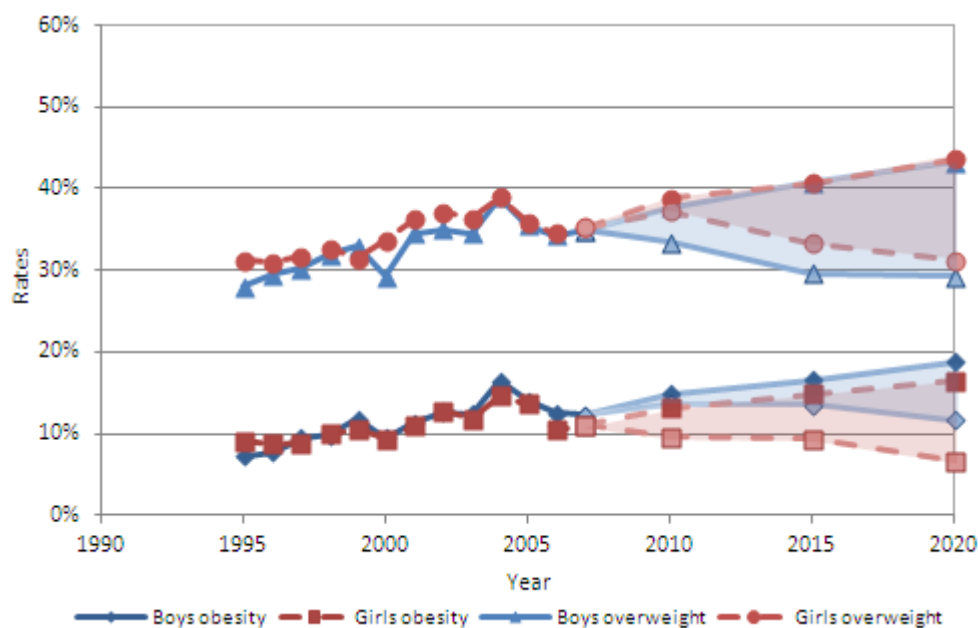
*Figure 1. Obesity rates in Europe from 1970 and future projections*



The rates of childhood obesity are also highest in the UK compared to the rest of Europe. The OECD (2010) reported that one in three children in the UK are overweight. The rates have continued to rise since 1990 and reached particularly high levels (40%) in 2005; see Figure 2. Since 2005, rates appear to have stabilised and have not increased as rapidly as

they had between 1990 and 2005. The future projections for youth obesity by the OECD for the next 10 years suggest that rates may increase by 7–8%.

*Figure 2. Obesity and overweight rates for children aged 3–17 years in the UK*



There are also differences identified in obesity rates in the UK for children from different ethnic and socioeconomic status (SES) backgrounds. Figure 3 displays data collected in 2010 from the OCED and shows that black and ethnic minority children have greater obesity rates than their white counterparts (almost 50% higher rates). Figure 4 displays the differences in socioeconomic status (SES) amongst children in the UK in 2010. Children from more deprived backgrounds are 1.7 times more likely to be obese than children from higher income families. This is measured by using the indices of social deprivation. Females with lower SES were found to be more likely to be obese and rates of obesity were greater for females than for males in this group.

Figure 3. Black and minority ethnic children obesity rates in the UK, 2010

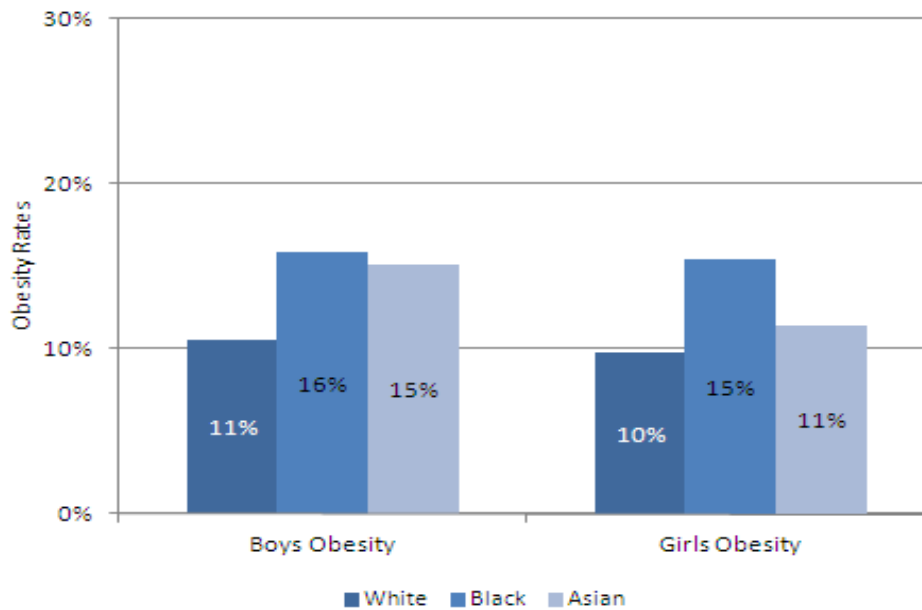
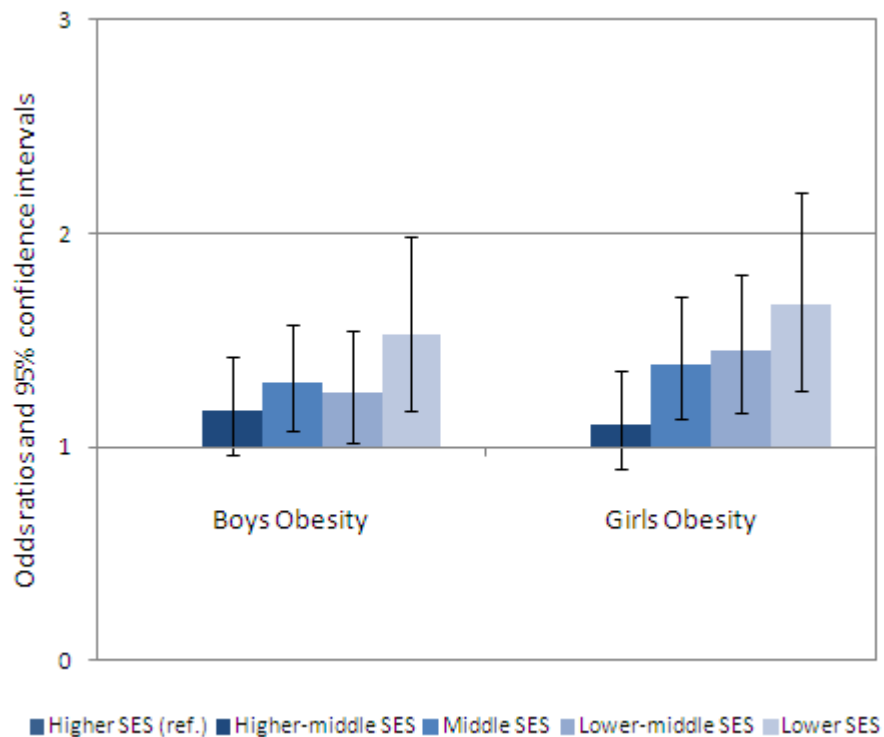


Figure 4. SES and gender differences for obese children in the UK, 2010



Source for all figures:

<http://www.oecd.org/els/healthpoliciesanddata/obesityandtheeconomicsofpreventionfitnotfat-unitedkingdomenglandkeyfacts.htm>, from the Organisation for Economic Co-operation and Development (OECD; Sassi, 2010).



In summary, so far this chapter has identified that obesity is a medical condition defined as an accumulation of excess body fat and a health problem. It is associated with Type II diabetes and cardiovascular disease. The way in which obesity is measured in the UK is by BMI for adults and weight for height and gender centiles for children and adolescents. Rates of obesity have increased around the world over the last 10 years, with rapid increases from 1990 to 2005. However, rates appear to be stabilising in Europe but not in the US where rates are on the increase. The UK has the highest rates of obesity in Europe and there are ethnic and SES differences amongst obese youths in the UK.

The following section will focus on obesity and related factors. There will be a brief outline of the biological and genetic factors that have been found to predispose people to obesity. This will be followed by an overview of research on obese youth populations as there is much less known about this group compared to adult populations. It is also well documented and recognised the majority of young people seeking treatment for weight loss are female (approximately 65%) and that obese young women are more likely to report additional psychological problems associated with their obesity (National Obesity Observatory, 2011). There is also the added pressure on women in all societies to have a specific body shape and be a certain weight (Counihan & Van Esterik, 2013), therefore it could be argued that women may experience further difficulties regarding their body image and additional psychological problems as a result of being obese (Caprio et al., 2008). Although this thesis will present information related to youth obesity in general, the main focus will be on young obese women and how they experience obesity. Research pertaining to psychosocial factors found to be related to obesity, including; social stigma and victimisation, depression and self-esteem, will be presented as the majority of research that has been conducted on obese young women explores these associated factors. The two other large areas of research on obese young women and related factors focus on obesity and its

relationship to eating disorders and body image concerns. There will be two separate sections devoted to these areas of research. This will also lead to the research questions that guided this thesis and a summary of all the information presented in chapter one will be provided.

#### **1.4. Obesity and Related Factors**

Obesity is considered to be a multi-factorial disorder which can be related to numerous health problems (Dehgham, Akhtar-Danesh & Merchant, 2005). It has been recognised that body weight is determined by biological factors, for example endocrine and hypothalamic disorders and genetics, as well as environmental factors, for example reduced levels of physical activity. There is also growing research on obesity and related psychosocial factors in order to try to uncover the causes of obesity and related mediating factors such as gender, ethnicity and SES.

This section will first briefly outline the biological factors associated with obesity and then explore the psychosocial factors identified as being related to obesity, drawing particularly on the recent review by the National Obesity Observatory (NOO, 2011). This presents the relationship between obesity and psychosocial factors.

**1.4.1. Endocrine and hypothalamic disorders.** There are many endocrinological disorders that contribute to obesity; however, it is important to note that this represents a very small proportion of the total cases (Jebb, 1997). Hypothyroidism is the disorder in this group that contributes most commonly to obesity, as weight gain is a primary consequence of decreased energy expenditure associated with this disorder. Polycystic Ovarian Syndrome (POS) is also related to weight gain due to the hormonal imbalances it causes (Jebb, 1997), although this is an extremely rare consequence of POS (Marsh & Brand-Miller, 2005).

**1.4.2. Genetic factors.** It is well documented that obesity develops due to dietary and lifestyle factors. However, recent developments in genetic research have also highlighted the influence of genetics as genes have been found to affect metabolism, appetite and the

deposition of fat by the body (the National Genetics Education and Development Centre, 2008). This suggests that some individuals are more at risk of becoming obese compared to others, due to genes influence.

Recent research has found that genetic factors are involved in the regulation of body weight (Barsh, Farooqi & O'Rahilly, 2000; Sabin, Werther & Kiess, 2011). There have been genetic associations found between obese parents and their children. These have been referred to as monogenic and polygenic factors, which explains the complex inherited aspects of obesity and who are more at risk of becoming obese (Hinney, Vogel & Hebebrand, 2010).

There are also genetic disorders associated with obesity, such as Prader-Willi Syndrome, which is associated with a strong desire to eat and over eating due to a lack of hunger regulation. This inevitably leads to obesity from a young age (Butler, 2006).

What has been a matter of debate is how much genes determine whether some individuals become obese or whether it is determined by environment. In a study by Wardle, Carnell, Haworth & Polmin (2008), looking at the influence of genes and environmental factors on BMI and waist circumference amongst 5092 twin pairs (aged 8 – 11 years) in the UK, they found that 77% of the variation for BMI and waist circumference was due to genes. The remaining 23% was attributed to environmental factors. There is also a growing area of research looking at the gene and environment interaction (Hetherington & Cecil, 2010; Marti, Martinez-González & Martinez, 2008; Qi & Cho, 2008), which suggest that risk of obesity is based on the interaction of these two factors. For example, genetic variants and exposure to environmental risks, including limited physical activity and poor diet. This may explain why some people who may be genetically predisposed to becoming obese do not. These findings have implications for how obesity is understood as well as how it is treated. Currently the NICE (2006) guidelines for obesity treatment state that intervention should focus on health and nutrition education, reducing food intake and increasing physical activity, and targeting

the environmental factors. There has been little attention placed on the genetic factors that put some more at risk of becoming obese. Environmental factors that influence obesity are related to the lifestyle choices people make and whether they have access to sporting facilities and have an understanding of food nutrition, to help them make more informed decisions about diet and exercise. See Lopez (2007) and Ball and Crawford (2006) for a detailed description of environmental factors that have been found to influence obesity.

More recently, the term ‘obesogenic’ environment has also been put forward as a way of understanding how environmental factors may influence and affect individuals understanding of nutrition and their ability to engage in physical activity. The obesogenic environment refers to how the individual interacts with their social environment and whether there are environmental factors that enable different foodstuff to be consumed and physical activity to be undertaken (Jones, Bentham, Foster, Hilsdon & Panter, 2007). It has been suggested that the way in which our environment is organised (for example, living in smaller accommodation with limited outdoor access to go for walks or to partake in exercise) does not support our ability to access sporting facilities and therefore reduces the amount of physical activity undertaken (French, Story & Jeffery, 2001). Also, changes in our home lives and the number of hours people work, coupled with the increase in affordable convenience foods that are high in salt and fat have become more popular (Cummins & Macintyre, 2002). Therefore numerous factors have been described as impacting on levels of physical activity that individuals engage in as well as the increase in convenience foods that take less time to prepare becoming popular. Much research in this field has looked at how food is accessed and the types of food available in more recent years and how this affects our diet and nutritional intake (Andreyeva, Blumenthal, Schwartz, Long & Brownell, 2008; Crawford et al., 2008). It is beyond the scope of this thesis to further explore the obesogenic environment. The important point that is being presented is that there are genetic and environmental factors

that put some individuals at a greater risk of being obese. What has also been identified is that there are psychosocial factors associated with obesity. This will be the focus of the next section.

**1.4.3. Obesity and psychosocial factors.** Over the last 10 years there has been a growing interest in the relationship between obesity and social factors, such as social stigma (Puhl & Brownell, 2003) and victimisation (Smith, 2010) as well as psychological factors, such as depression and self-esteem (Atlantis & Baker, 2008; Carpiniello et al., 2009). Much of the research in this area has focused on adult obese populations; however there is growing research on these areas for obese youth populations (Adams & Bukowski, 2008; Puhl & Latner, 2007; Wardle & Cooke, 2005). The following section will focus on youth obesity, particularly obese young women and psychosocial factors. The psychological and social aspects associated with obesity have been of interest as these two aspects have been found to be related. For example, if an obese young person is bullied regarding their weight, it is proposed that this will affect their mood and their self-esteem (Adams & Bukowski, 2008; Russell-Mayhew, McVey, Bardick & Ireland, 2012). Therefore psychosocial factors have been the main area that has been researched regarding obese young women.

**1.4.3.1. Youth obesity, social stigma and victimisation.** The view that obesity causes depression in obese young people has been put forward due to the common assumption that obese young people experience social stigma, victimisation and bullying due to their weight (Adams & Bukowski, 2008). There have been numerous reviews written on obesity and associated stigmatisation (Kraig & Keel, 2001; Strauss & Pollack, 2003). For example, Puhl and Brownell (2001) identified that both youth and adult obese populations are unfairly treated compared to their non-obese counterparts regarding education, healthcare and employment. There have been studies looking at how young children view overweight and obese individuals (Brylinsky & Moore, 1994; Latner & Stunkard, 2003; Puhl & Latner, 2007)

all of which identified that young children, (aged 3 – 5 years) had negative perceptions of overweight individuals. For example, Brylinsky & More (1994) found that young children perceived overweight people as being stupid, ugly, mean and lazy. In another study it was found that children would choose to be friends with those who were in a wheel chair or had facial disfigurement over an obese child (Latner & Stunkard, 2003). These studies suggest that overall, obese individuals are viewed negatively and are stigmatized against on the basis of their weight compared to their non-obese counterparts.

In obese children it has been found that in a sample of 11 year olds (n=2234) in West Scotland, those who were overweight or obese were twice as likely to experience teasing or bullying (Sweeting & West, 2001). It has also been found that victimisation of obese youths is most commonly reported from other family members, peers and teachers (Hayden-Wade et al., 2005; Wardle & Cooke, 2005). Compared to their healthy-weight counterparts, obese young women have reported increased levels of teasing and bullying and research to date has identified a strong relationship between youth obesity and victimisation (Eisenberg, Neumark-Sztainer & Story, 2003; Griffiths et al., 2006). Obese young women's experiences of victimisation have also been found to be associated with depression, low self-esteem and body image concerns (Eisenberg et al., 2003; Jackson, Grilo & Masheb, 2000; Young-Hyman, Schlundt, Herman-Wenderoth & Bozylinski, 2003). For example, Adams and Bukowski (2008) explored the prevalence of peer victimisation and also wanted to identify if this was a predictor of depressive symptoms and changes in BMI in a sample of obese and non-obese youths (n=1287, aged 12-13 years). It was found that for obese adolescents, over a four year period, peer victimisation predicted changes in depression and BMI, but not for non-obese adolescents. Those that were obese and experienced peer victimisation reported higher levels of depressive symptoms. This suggests that peer victimisation has greater long term effects on BMI and depressive symptoms for obese youths.

Studies to date that have explored social stigma, victimisation and youth obesity have found that obese youths, regardless of gender, are at an increased risk of being teased or bullied and this has been found to be associated with depression, low self-esteem and body image concerns. However, it is important to note that any children who experience victimisation regardless of their weight, who are teased or bullied about weight related issues also report greater levels of depression, low self-esteem and body image concerns (Eisenberg et al., 2003).

**1.4.3.2. Youth obesity and psychological factors.** It has been proposed that obesity causes psychological problems (World Federation for Mental Health, 2010), and the reverse has also been suggested, that psychological problems may cause obesity (Luppino, et al., 2010; Kivimaki et al., 2009). What is clear is that there are associations found between obesity and psychological problems, however whether one causes the other is still a matter of debate. This section will present current research that has identified relationships between obesity and psychological factors (focusing on depression and self-esteem).

**1.4.3.3. Depression.** Recent systematic reviews exploring the links between youth obesity and psychopathology have found that some obese youths, particularly young women, are at an increased risk of developing psychological disorders such as depression (Luppino et al., 2010). In a literature review compiled by Cornette (2008) focusing on the emotional impact of youth obesity, it was concluded that all participants reported some level of psychosocial impact, particularly depression, as a result of being overweight or obese. This association was more prominent in the younger obese females compared with their non-obese counterparts. The sample consisted of ten studies; two included a clinical sample and eight recruited participants from non-clinical school samples.

In a different review by Wardle and Cooke (2005) on the psychosocial impact of obesity in youth obese populations, depression was assessed. It was found that in treatment-

seeking samples, obese youths reported higher scores on depression measures compared to obese non-treatment seeking youths (Britz et al., 2000) and their non-obese counterparts (Eremis et al., 2004). In non-clinical cross-sectional samples, the findings were mixed. For example, in both Eisenberg et al. (2003) and Lamertz, Jacobi, Yassouridis, Arnold and Henkel (2002) studies no differences were found in obese and non-obese youths regarding depression. However, Sjöberg, Nilsson and Leppert (2005) found significant associations in their non-clinical large school sample study (n=4703) between obesity and reported depressive symptoms. Those who were obese scored higher on depressive symptoms compared to their healthy weight counterparts.

Anderson, Cohen, Naumova, Jacques and Must (2007) examined whether adolescent obesity is associated with the risk of developing depression or an anxiety disorder. This study was an analysis of a prospective community-based cohort, assessed four times over 20 years. In this sample (n=776, aged 9–18 years), 4% of females and 9% of males were obese. It was found that youth obesity in females predicted an increased risk of developing depression and anxiety disorder; however, this was not found for males. This may be due the stigma that is attached to weight and shape that is more prominent for females in Western society (Major, Eliezer & Rieck, 2012; Schafer & Farraro, 2011).

Wardle, Williamson, Johnson and Edwards (2006) investigated an association between youth obesity and depression and whether moderators such as socioeconomic status (SES), gender and ethnicity impacted on the findings. Their sample consisted of two large school samples (from London and the north of England). BMI was used to determine weight status and self-report measures were used to identify depressive symptoms and SES, gender and ethnicity. They found that there was a weak association between obesity and depressive symptoms in both samples. They concluded that in a community sample of youths, those who were obese did not report depressive symptoms significantly higher than non-obese youths,



and gender, socioeconomic status and ethnicity were not associated with depressive symptoms or obesity. These findings support those identified by Hill (2005) who also found that obese youths do not differ from their non-obese counterparts regarding reported depressive symptoms. Other studies, however, have found that childhood depression (Wardle & Cooke, 2005) and anxiety (Garipey, Nitka & Schmitz, 2010) can predict obesity in adolescence. Liem, Sauer, Oldehinkel and Stolk (2008) conducted a review of literature on childhood obesity and later onset depression and concluded that obesity in adolescence could result in depression in adulthood.

The conflicting evidence for the association between depression and youth obesity may be due to the different measures used to assess depression, as well as factors such as gender, SES and ethnicity, which are not accounted for in many of the studies (Wardle & Cooke, 2005). Also, the majority of the studies used non-clinical samples, therefore there is little known regarding clinical samples and whether treatment seeking obese youths have greater reported levels of depression. Therefore, whether depression is associated with youth obesity remains unclear.

**1.4.3.4. Self-esteem.** Low self-esteem has been found to be associated with youth obesity (Griffiths, Parsons & Hill, 2010; Zeller, Roehrig, Modi, Daniels & Inge, 2006). In a clinical study focusing on self-esteem in morbidly obese youths (n=107), Nowicka et al. (2009), found that the only factors that influenced self-esteem were gender and age. It was found that self-esteem was significantly lower in higher age groups (14 years and above) and that girls had significantly lower self-esteem, compared to boys.

McCullough, Muldoon and Dempster (2009) conducted a cross sectional survey of 8–9 year olds (n=211) in Belfast, from a total of 12 schools. They investigated whether obese and non-obese youths differed in their reported levels of self-esteem, social acceptance and self-image and whether SES had any impact. Those who were obese (27% of the sample)

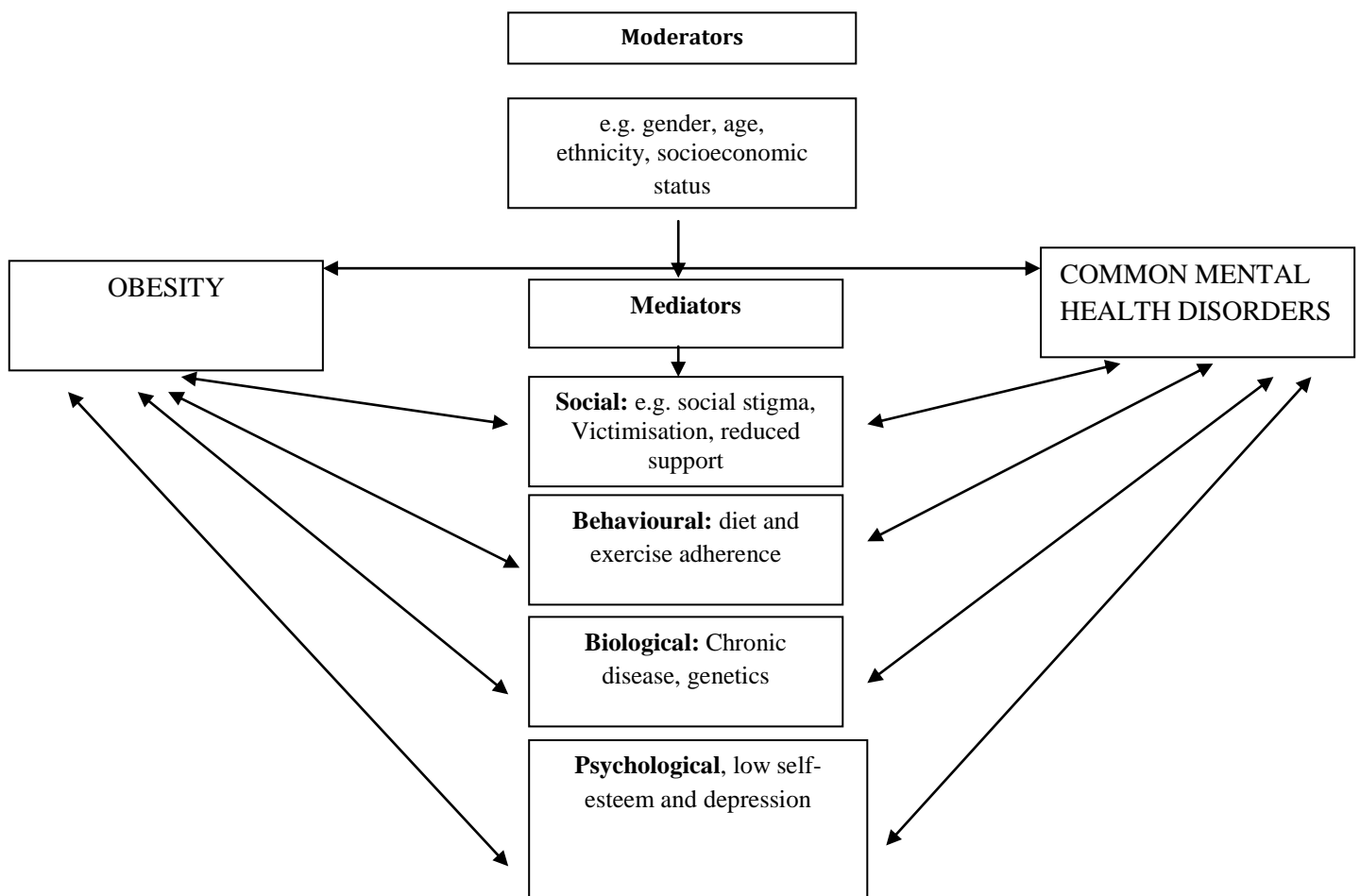
reported greater levels of low self-esteem, a more negative self-image and reduced social acceptance and were from more impoverished backgrounds.

In a review of literature focusing on self-esteem and obesity in children and adolescents (French, Story & Perry, 1995), a total of 35 papers were reviewed. The following was found; thirteen of the twenty-five cross-sectional studies identified that obese youths reported decreased levels of low self-esteem; within this group five studies compared obese and healthy-weight young people and found that obese youths reported lower levels of self-esteem. However, the authors highlighted that the majority of the studies were methodologically weak and had small sample sizes.

In summary, the research on the relationship between young obese women and obese youths in general and psychopathology has highlighted that there are multiple factors that affect and influence this relationship. There has been a strong link identified between young obese women and symptoms associated with depression and anxiety as well as low self-esteem in some studies (Cornette, 2008; Wardle & Cooke, 2005), but not others (Hill, 2005; Wardle et al. 2006). This could be due to differences in clinical and non clinical samples and different measures being used to assess specific aspects of psychopathology. Research to date has found associations between obesity and psychopathology for a specific group of obese individuals. In youth populations these were found to be treatment-seeking, clinical, adolescent females, but there is still little research in this field. What is clear is that the nature of the relationship between obesity and psychosocial factors is complex, and further research on the impact of these factors is required to aid our understanding of obesity and what might influence it. This is highlighted in the National Obesity Observatory (NOO; 2011) report on obesity. NOO (2011) have analysed research to date and based on these findings propose moderating and mediating factors that influence the relationship between

youth obesity and psychosocial factors (see figure 5). Details of the studies pertaining to further research identified in the NOO (2011) report are presented in Appendix 1.A.

The following section of chapter one will focus on treatment of youth obesity in the UK and will outline the NICE (2006) guidelines for obesity weight management.



*Figure 5.* Moderators and Mediators that are linked to obesity and psychopathology (NOO, 2011).

**1.4.4. Treatment of youth obesity in the UK.** This section will focus on treatment for obesity in the UK and will outline what is available for the younger obese population. It will be followed by a brief section on psychological treatments that have been used to treat obesity and research findings on this topic. Psychological treatments are not offered as standard practice currently however, this is a relatively new area of research and health professionals are investigating psychological interventions that may be applicable to specific groups of obese young people who do not respond well to the current treatments (Bogle & Sykes, 2011).

The way in which obesity is classified, as a health problem, affects the way in which it is assessed, treated and managed by professionals. The NICE guidelines (2006) on obesity for adults and children offer clear guidance on assessment, diagnosis and treatment of obesity. The focus is on person-centred care and the guidelines primarily advocate healthy lifestyle choices and concentrate on healthy eating and increasing activity levels. For the more extreme cases, drug treatment or bariatric surgical treatments are recommended. Psychological intervention as a primary treatment option is not recommended. It is suggested that if there appears to be underlying psychological problems that are contributing to weight gain then referrals to the appropriate psychological services should be made. However, there are no best practice guidelines on psychological interventions for treating obesity. The following sections will describe healthy eating and physical activity programmes for weight loss for obese youths offered in the UK.

**1.4.4.1. Obesity treatment: healthy eating and physical activity.** In 2006 the House of Commons Committee of Public Accounts produced a report dedicated to ‘Tackling Child Obesity – The First Steps’. The focus was on developing strategies and implementing assessment and treatment of childhood obesity (based on the NICE guidelines, 2006). This

involved three departments: Health, Education and Skills, and Culture, Media and Sport. All departments were to focus on diet and lifestyle changes for children by promoting healthy schools programmes and working with the food industry to help create better labelling and marketing of specific products high in fats and sugar. Based on these recommendations the government invested £1 billion a year in promoting healthy lifestyles and reducing obesity in children. It is also funding and developing 11 key weight management programmes across the UK. They began in 2009 and are intended to do the following:

- 1) Set out a twelve-week programme involving a weekly one-hour individual session followed by a weekly physical activity session
- 2) Encourage family involvement, e.g. education sessions, physical activity sessions and behavioural change workshops, all of which are aimed at changing lifestyle and improving self-esteem
- 3) Offer one-to-one sessions and conduct formal and informal assessments of willingness to change, psychosocial distress, teasing and bullying, nutrition and attitudes to food.

All of the above are in line with the NICE (2006) guidelines for obesity treatment for children.

As a result, across the country there are many 12 week physical activity and nutrition programmes that have been created to address childhood obesity. Of these, the most common are the MEND programme (<http://www.mendcentral.org>) and the Alive N Kicking programme ([www.ank-uk.com](http://www.ank-uk.com)). For those young people who do not wish to attend a group or who have additional psychological problems that may be maintaining or underlying their obesity, there is much less available. However there has been an increase in research on psychological factors associated with obesity as well as developments in psychological interventions to address these factors. This will be briefly presented below.

**1.4.4.2. Obesity treatment: psychological input.** Shaw, O'Rourke, Del Mar and Kenardy (2005) produced a Cochrane review on psychological interventions for overweight and obese adults. They concluded that the findings from previous studies looking at psychopathology are mixed; however, what is clear is that 'obese people in general do not find their state desirable' (Shaw et al., 2005, p. 4). Shaw et al. (2005) found that the most common form of psychological therapy offered for obese adults was cognitive behavioural therapy (CBT) and behavioural interventions that specifically target overeating and eating in response to emotional distress. The overall findings from this review suggested that treatment as usual (e.g. involving weight management programmes focusing on healthy eating and physical activity) coupled with CBT, targeting the over eating and eating in response to feeling low in mood, resulted in greater weight loss and greater maintenance of weight loss at three-month follow up compared with treatment as usual. What is difficult to determine is the longer term impact of CBT, as the majority of the studies identified for the review did not follow up on their participants over a three-month period.

There are also behavioural approaches to weight loss that have been used to modify and change eating habits (Brownell, 1994), which has been used in a number of studies and has been found to be successful at achieving weight loss (Aggarwal et al., 2012; Burnette & Finkel, 2012; Palmeria et al., 2010).

There is limited research on obese young women and obese youth populations in general and psychological interventions focusing on over eating behaviours and associated depression and self-esteem issues that some obese young people experience. This may in part be due to the way guidelines for treatment focus on increasing activity levels, promoting healthy eating and healthy lifestyle. A review on interventions and programmes for obese youths (Luttikhuis et al., 2009) found that the most successful interventions were the ones that targeted reductions in television viewing, targeted direct physical activity and

incorporated education on healthy eating. Family-based interventions which involved educating the family and addressing family conflict around mealtimes, which was identified as a difficulty in relation to sustaining weight loss long term (Bogle & Sykes, 2011), were found to be lacking. This view has also been taken by Tershakovec (2004) in a commentary on psychological considerations in paediatric weight management. Tershakovec (2004) proposed that interventions for children should also offer a more systemic framework that incorporated interventions that addressed why young people were over eating and adopted interventions that the whole family adhered to and not just the young person who is obese.

In summary, this chapter has presented the prevalence of obesity around the world and factors that are associated with obesity including biological and psychosocial factors. The relationship between youth obesity and psychosocial factors has been outlined and the mixed findings regarding this relationship have been presented. Research suggests that some, but not all obese youths experience social stigma, victimisation, depression and/or low self-esteem. Therefore how obesity affects those who are overweight and how they experience this is still unclear.

The focus for the treatment of obesity in the UK is physical activity and diet, rather than psychological intervention. Psychological approaches to treat obesity and additional underlying psychological problems are less well understood and there are no best practice guidelines. The following section will draw on literature pertaining to obesity and its relationship with eating disorders, as recent research has identified similarities between the two. Much of this research has involved female obese populations.

### **1.5. Obesity and its Relationship to Eating Disorders**

There is a growing amount of research on obesity and its relationship with eating disorders (Dingemans & van Furth, 2012; Wardle, 2009). Obesity is not considered to be an

eating disorder; however, it shares many similarities with eating disorder psychopathology (Day, Ternouth & Collier, 2009).

In order to understand this relationship, it is important to consider the diagnostic criteria that define eating disorders. According to the Diagnostic Statistical Manual (DSM-IV, 1994) anorexia nervosa is defined as;

‘refusal to maintain body weight at or above a minimally normal weight for age and height and having an intense fear of gaining weight as well as having a disturbance in the way ones weight or body shape is experienced’ ( DSM-IV, 1994, p. 539 ).

Bulimia nervosa is defined as;

‘engaging in recurrent episodes of binge eating, characterised by eating in a discrete period of time, and amount of food that is definitely larger than most people would eat in a similar amount of time and having a sense of lack of control over eating during the episode’ (DSM-IV, 1994, p. 545).

This is coupled with recurrent inappropriate compensatory behaviour to prevent weight gain.

Binge eating disorder (BED) is also classified as an eating disorder and is defined as

‘recurrent episodes of binge eating characterised by eating a larger amount of food than normal during a short period of time (within a two hour period), and having a lack of control over eating during the binge’ (DSM-IV, 1994, p.550). The term binge eating is used to describe those that engage in eating a large amount of food but do not meet the full criteria for BED, as these binges may be infrequent, and such behaviour is classified in terms of disordered eating behaviours. The term disordered eating is also in the DSM-IV (1994) and is used to describe a wide range of eating behaviours that do not warrant a diagnosis of a specific eating disorder, but a combination of symptoms related to different eating disorders. Those affected may be diagnosed as suffering from Eating Disorders Not Otherwise Specified (EDNOS).



The reason for exploring this proposed relationship between youth obesity and eating disorders is that obese populations have been found to engage in disordered eating behaviours such as binge eating and have also been found to have shape and weight concerns (Croll, Neumark-Sztainer, Story & Ireland, 2002; Neumark-Sztainer & Hannan, 2000). It has also been suggested that obesity may perpetuate eating disorders and vice versa (Goldschmidt, Aspen, Sinton, Tanofsky-Kraff & Wilfley, 2008, p. 257).

Youth obesity has been associated with an increased risk of developing disordered eating, and some types of disordered eating increases the risk of weight gain (Field et al., 2003; Shisslak et al., 1998; Stice, Presnell, Shaw & Rohde, 2005). It has also been found that youth obesity coupled with disordered eating is a risk factor for developing an eating disorder (Fairburn et al., 1998; Fairburn, Welch, Doll, Davies & O'Connor, 1997; Kotler, Cohen, Davies, Pine & Walsh, 2001). These findings suggest obese youths who display disordered eating behaviours are at an increased risk of developing an eating disorder, especially binge eating disorder (Decaluwé, Braet, & Fairburn, 2003). This is particularly the case for obese young women (Wadden et al., 2000). The relationship between obesity, binge eating and BED will be discussed in the next section.

**1.5.1. Obesity and binge eating behaviour.** The prevalence of binge eating behaviour and BED in obese young women has received much attention in recent years (Ackard, Fulkerson, Neumark-Sztainer, 2011; Decaluwé et al., 2003; Engel et al., 2007). The NICE (2004) guidelines on eating disorders highlight that many adults who have BED are obese and that a history of premorbid obesity has been found in 7–20% of women who suffer from anorexia nervosa and in 18–40% of women suffering from bulimia nervosa.

It is important to distinguish between binge eating behaviour and BED. When examining research on youth obesity and eating disorders, some articles differentiate between

binge eating behaviour and BED and others do not, therefore it is difficult to determine whether binge eating behaviour or BED is prevalent amongst obese youths.

The majority of research examining binge eating behaviour has focused on obese youth treatment-seeking female samples. It has been identified that 20–36.5% of obese youths seeking treatment for weight loss engage in binge eating behaviour (Berkowitz, Stunkard & Stallings, 1993; Britz et al., 2000; Decaluwé & Braet, 2003; Goossens, Braet & Decaluwé, 2007; Isnard et al., 2003). For example, Decaluwé, Braet and Fairburn (2003) examined the extent to which 10-16 year old (n=126) obese youths, who were seeking treatment for weight loss, reported binge eating problems. They established variables that distinguished between obese binge eaters and obese non-binge eaters and found that binge eating behaviour was reported in 36.5% of the youths and those obese binge eaters had increased levels of low self-esteem. Males and females reported similar occurrences of binge eating (35.3% of males and 37.3% of females). Both males and females who reported experiencing binge eating episodes were significantly younger than the males and females that did not. In a different study, Van Vlierberghe, Braet and Goossens (2009) explored whether youths referred for obesity treatment differed from non-referred obese youths on the prevalence of psychological symptom. The authors concluded that obese youths referred for weight loss treatment reported more psychological symptoms and binge eating behaviours compared to those who were not referred. There were no significant differences identified between males and females.

There have also been a small number of studies that have identified the prevalence of BED within an obese youth populations. For example, Glasofer et al., (2007) examined the frequency of binge eating in relation to psychopathology in obese treatment seeking adolescents (n=160). They measured binge eating and associated loss of control eating using the Eating Disorders Examination (EDE: Fairburn & Cooper, 1993) a semi structured

interview, and additional questions to record history of loss of control eating (for list of questions see Tanofsky-Kraff, Faden, Yanovski, Wilfley, Yanovski, 2006), to categorise participants into four groups; BED, recent but infrequent binge eating episodes, remote and infrequent loss of control eating and no history of loss of control eating. The BED group made up 6.3% of the sample (n=10). They found that the BED group reported higher negative mood and anxiety symptoms compared to all other groups and that the recent but infrequent binge eating episodes group also reported more anxiety. There were no gender differences identified. In a further study, Decaluwé and Braet (2003) examined the extent to which obese youths develop BED from a sample of 136 (10 – 16 year old) obese youths seeking weight loss treatment using the EDE-Q (Fairburn & Beglin, 1994) and the Eating Disorders Examination semi-structured interview adapted for children (EDE: Fairburn & Cooper, 1993). Only 1% met the criteria for BED and 9% were found to have bulimic episodes and episodic overeating was more common than binge eating. They concluded that it is important to assess the characteristics of binge eating behaviour and how they manifest in obese youths who are seeking treatment.

Research to date suggests that between 20 – 36.5 % of obese youths seeking treatment for weight loss engage in binge eating behaviour and a smaller proportion, between 1% and 6.3 % meet the full criteria for BED. As a result of these findings, there is a growing interest in the clinical significance of youth obesity and associated eating disorder psychopathology, as this may have implications for treatment (Eddy, Tanofsky-Kra, Thompson-Brenner, Herzog, Brown & Ludwig, 2007).

In addition, it is important to note that not all those who meet the criteria for BED are obese (Boutelle, Neumark-Sztainer, Story, Resnic, 2002). Binge eating behaviour in adolescence has been found to be associated with weight gain over time (Stice, Presnell &

Spangler, 2002; Tanofsky-Kraff et al., 2006), which may increase the risk of developing obesity in adulthood.

Other factors such as emotionally driven eating have also been found to be associated with binge eating behaviour and BED. Researchers have looked at the triggers of binge eating behaviour and have found that negative affect is a common cause of overeating. This will be presented in the next section. Theoretical models used to explain overeating in response to negative affect will be briefly outlined as it has been proposed that may be used to explain overeating amongst obese populations (Czaja, Rief & Hilbert, 2009; Goldfield et al., 2010).

**1.5.2. Obesity, emotional eating and binge eating.** One way that individuals cope with negative emotions or an experience is by eating, which is regarded as emotional eating, ‘the tendency to overeat in response to negative emotions such as anxiety or irritability’ (Van Strien et al., 2007, p. 106). There has been an increase in research looking at the relationship between emotional eating and binge eating; as well the prevalence of BED amongst emotional eaters (Pollert et al., 2013). Recent research has also found an association between emotional eating and BED (Pollert et al., 2013). It has been found that adults with BED eat in response to negative affect associated with stress and low mood and suffering from BED increases the risk of obesity (Sims et al., 2008). There is also a small body of research on adolescents with BED and emotional eating (Eisenberg et al., 2003; Goldfield et al., 2010; Nguyen-Rodriguez, Unger & Spruijt-Metz, 2009).

The negative affect model has been put forward to explain the relationship between negative emotions and overeating. This model argues that binge eating episodes are triggered by negative affect (Chua, Touyz & Hill, 2004; Meyer, Waller & Waters, 1998; Raman, Smith & Hay, 2013; Spence & Courbasson, 2012) and also suggests that a decrease in negative affect results in a reduction of binge eating behaviour (Deaver et al., 2003; Haedt-Matt &

Keel, 2011). This model states that binge eating functions as a negative reinforcement, which reduces negative affect, albeit a temporary solution to reducing negative affect. It is proposed that binge eating decreases or numbs negative emotions, or acts as a distraction from negative emotional affect (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Arnow et al., 1995; Wedig & Nock, 2010). It is also suggested that binge eaters may lack particular coping strategies/skills required to manage negative emotions, therefore they are more prone to binge eat (Geliebter & Aversa, 2003; Ricca et al., 2009; Wiser & Telch, 1999). This is also related to research situated in the psychosomatic theory of obesity (Kaplan & Kaplan, 1957) which has also been used to understand the role and function of emotional eating for obese individuals. Much like the negative affect model, it also proposes that food is used to regulate negative emotional states, which results in weight gain (Goossens, Braet, Van Vlierberghe & Mels, 2009; Grilo & Shiffman, 1994). However, it highlights the role of stress and anxiety as being the predominant emotion that causes this behaviour rather than negative affect in general, which applies to numerous negative emotional states (for example, depression, anxiety, loneliness etc). It has also been suggested that stress is a risk factor for emotional eating and binge eating in adult obese non-clinical population (Sims et al., 2008). This has resulted in a consensus that for some obese individuals, food is used as a form a self medication and to regulate negative emotional states in both child and adult obese populations (Czaja et al., 2009; Nguyen-Rodriguez, et al., 2009).

More recent research has investigated the relationship between over eating and loss of control eating, and related this to the affect regulation model (Burton, Stice, Bearman & Rohde, 2007). This model suggests that those who lose control of their eating and binge do so as it is offers comfort and a form of distraction from negative emotions (Goossens et al., 2009, p. 68).

There has also been a body of research conducted based on the assumption that bingeing is used by individuals as a form of escapism from 'aversive high self focus by achieving a cognitively restricted state that has the effect of dis-inhibition' (Heatherton, Polivy, Herman & Baumeister, 1993, p.50). A review by Heatherton and Baumeister (1991) further explored the notion that binge eaters maintain high standards and expectations and when they fail to achieve these, they develop a pattern of high self awareness which results in concerns over how they are perceived by others and how they perceive themselves. An additional consequence of high self awareness is experiencing high levels of emotional distress, and it is proposed that binge eating offers an escape from such feelings (for a more detailed account see Dixon & Baumeister, 1991). More recent studies by Stein, Kenardy, Wiseman, Douchis, Arnow, Wilfley, (2007) and Lillis, Hayes and Levin (2011) have also explored this hypothesis and looked at what was driving the binge eating. They argue that binge eating is used as a form of experiential avoidance which is described as a way of avoiding or changing negative distress even if the means of doing so causes harm to one's self.

In summary, there appears to be similarities between eating disorder psychopathology and obesity, especially for those who are obese and report binge eating behaviour. Research on binge eating behaviour and BED and its relationship with obesity is gaining interest. Studies conducted so far suggest that between 20 – 36.5 % of obese youths seeking treatment for weight loss engage in binge eating behaviour and a smaller proportion, between 1 and 6.3 % meet the full criteria for BED. There have also been attempts made to understand binge eating behaviour and the negative affect model (Chua et al., 2004; Haedt-Matt & Keel, 2011) and the affect regulation model (Burton, et al., 2007) and using binge eating as a form of escapism (Dixon & Baumeister, 1991) have been used to explain the function of overeating for those who suffer from binge eating behaviour.

Research exploring binge eating behaviour in obese youth populations has been presented in this section. Other factors, such as weight and shape concerns and body dissatisfaction, which have been found to be associated with eating disorder psychopathology, have been identified in obese treatment-seeking youths, particularly female obese young people (Decaluwé & Braet, 2003; Dingemans & van Furth, 2012; Knatz, Maginot, Story, Neumark-Sztainer & Boutelle, 2011). This has prompted further examination of obese populations and body image concerns (Dingemans & van Furth, 2012; Neumark-Sztainer & Hannan, 2000). How obese young people, particularly women, experience body image concerns will be explored in the next section.

## **1.6. Obesity and Body Image**

This section will focus on body image and how it is related to obesity. Definitions of body image and how it is measured will be described briefly. A summary of relevant literature on body image and youth obesity will be presented, focusing on obese females. There will also be an overview of all the information presented in this chapter followed by the study aims and questions that guided this thesis.

**1.6.1. Body image definition.** The term ‘body image’ can broadly be defined as ‘an attitude we have towards our body and our physical perception of it’ (Waller et al., 2007, p. 225) and ‘the picture of our body which we form in our mind, that is to say the way in which our body appears to ourselves’ (Schilder, 1978, p. 74). It is built of both positive and negative attitudes, which have been developed throughout life and are influenced by family, culture, peers, environment, education and wider societal attitudes and the media (Cafri, van den Berg & Thompson, 2006; Waller et al., 2007). The Waller et al. (2007) definition of body image will be used in this thesis.

There has been an increase in research on body image over the past 15 years, and particularly on the impact of negative body image, that is, having a negative perception of

one's own body (Cash, 2011). Much of this research has focused on the relationship between body image and eating disorders, especially anorexia nervosa and bulimia nervosa. Research on negative body image has also found that the term body image has taken on a variety of meanings (for example, body image concerns, dissatisfaction, disturbance, distortion and misperception and weight and shape concerns) which has resulted in confusion over not only what body image is but also what research on this area is measuring and reporting (Cash, 2011). Those who have a negative body image have been described as suffering from body image dissatisfaction, which is generally identified as the perception (among women) of not having an ideal thin body size (Cash & Smolak, 2011).

Body image disturbance or body image distortions are terms commonly used to describe body image dissatisfaction and over-estimation of body size in both eating disordered and non-eating disordered women (Cash, 2004). It has been suggested that body image may be better understood if it were referred to as *body images*, in order to take into account the multifaceted nature of the construct (Cash, 2004). There is growing agreement that body image is a multidimensional construct involving cognitive (attitudinal), affective, behavioural and perceptual characteristics (Cash, 2011). Much of the research on body image as a construct has been divided into these four broad areas. This has resulted in different methods being developed to measure these four components, which will be outlined below.

**1.6.1.1. Body image measurement.** The most common methods for measuring body image are the following:

- 1) Figure rating scales (FRS) to rate self-body image and body image of others (assessing perceptual aspects of body image),
- 2) Questionnaire assessments of the body image (assessing attitudinal aspects of body image, including cognitions related to dissatisfaction regarding body weight and shape, and affective aspects of body image relating to how emotions are associated with body image),



3) Questionnaires regarding avoidance behaviours (assessing the behavioural aspects of body image such as body checking and avoiding situations where the body will be exposed, such as swimming).

The following section will offer a summary of the literature on body image and its relationship to obesity. It will then go on to explore body image and its prevalence in youth obese populations, as there is much less known about this relationship.

**1.6.2. Body image research.** The relevance of body image research and research on its relationship with eating disorders is well established (Cash & Smolak, 2011; Chisuwa & O'Dell, 2010; Levine & Murnen, 2009; Stice & Shaw, 2002). It is recognised that it is important to examine negative body image in its own right and the effects it has on different populations other than eating disorder populations (Cash & Pruzinsky, 2002). Overall it has been found that women predominantly have a negative body image (Hotelling, 2001; Iannantuono & Tylka, 2012) and experience more problems with body image than men (Cash, 2004). Research on non-clinical populations has identified that a negative body image affects levels of self-esteem (Mellor, Fuller-Tyszkiewicz, McCabe, & Ricciardelli, 2010). It is associated with dieting behaviours and can affect individuals' ability to develop healthy eating behaviours (Cash & Pruzinsky, 2002). There has also been an increase in research on the experience of body image amongst obese populations, predominantly in adults. What is emerging is that in non-clinical samples obese female adults are found to have more body image concerns than their non-obese counterparts (Brodie & Slade, 1998; Meyer, McPartlan, Rawlinson, Bunting & Waller, 2011; Sarwer, Thompson & Cash, 2005). There is much less research in this area that focuses on obese youths and that uses clinical samples. The reason for exploring body image and its relationship with obesity is that, based on the findings from eating disorder literature, there are many similarities between obesity and eating disorders, obesity being a problem associated with weight, shape, and eating-related behaviours

(Fairburn, 2008). Stunkard and Mendelson (1967) were the first to put forward the idea that negative body image is related to obesity. They found that a proportion of, but not all, obese individuals in their non-clinical sample of obese adults reported experiencing body image concerns.

Since Stunkard and Mendelson's (1967) work on obesity and body image, there has been a number of studies conducted looking at this relationship, particularly for adult obese individuals. A comprehensive summary of the types of studies conducted on adult obese individuals and body image is provided by Sarwer, et al. (2005). They found that many obese adults have body image concerns (Cash & Henry, 1995; Heatherton, Nichols, Mahamedi & Keel, 1995), but these concerns are not universal and there does not appear to be a relationship between degree of obesity (BMI/weight status) and the intensity of the concerns (Wadden et al., 2000). The other interesting findings were related to the clinical significance of body image concerns. They found that for some obese women body image concerns were related to symptoms associated with depression and low self-esteem (Cash, 2004). Furthermore they identified that a small proportion reported body image concerns that are commonly associated with body dysmorphic disorder (Rosen, 2001). Thus, there is emerging research in this field exploring adult obesity, but there is very little known about the relationship between youth obesity and body image. The following provides a summary of relevant literature regarding body image and youth obese populations, highlighting research pertaining to female obese populations.

**1.6.3. Youth obesity and body image concerns:** A review of literature that assessed body image concerns directly (either through validated measures or asking directly using qualitative interviews) amongst obese youth populations (aged 10-17 years) was conducted (see Appendix 1.B. for details of the search procedure). Four bibliographic databases, PubMed, Medline, PsychInfo and EMBASE, were searched to identify studies published

from 1995 to April 2013. The International Journal of Obesity was also thoroughly searched manually, as this journal was particularly relevant to the search topic. Titles and abstracts of papers were identified that potentially fulfilled the inclusion criteria. The following eight groups of search terms were used: 1) obes\*, 2) body image\*, 3) body image disturbance\*, 4) body image distortion\*, 5) body image concerns, 6) body image dissatisfaction, 7) child\* and 8) adolescent\*. Each term in a group was searched in combination with every other term from the other groups. Searches were adapted for each database and performed independently. Full papers or abstracts were assessed and all potentially relevant papers were considered against the inclusion criteria. Quantitative studies that did not use validated questionnaires to assess body image in youth populations were excluded. Studies that involved children below the age of 10 years were also excluded as the majority of validated measures used to assess body image have been designed for those who are 10 years and above (Cash & Smolak, 2011). The eight relevant studies identified will be presented.

***1.6.3.1. Quantitative studies identifying body image concerns in large non-clinical samples.*** The majority of studies that explore body image concerns in youth obese populations focus on large non-clinical school samples and were found to assess the perceptual and attitudinal aspects of body image. Most of these studies used the figure rating method (Stunkard, Sorensen & Schulsinger, 1983) and questionnaires to assess body image concerns.

Fonseca and Gaspar de Matos (2005) collected data on 5697 Portuguese school students aged 11–16 years, 89 of which were classified as obese (1.6%). They aimed to identify psychosocial indicators that distinguish obese youths from their peers. They used the Figure Rating Scale (Collins, 1991) to assess perceptual aspects of body image.

In addition to measuring body image concerns, Fonseca et al. (2005) used validated self-report questionnaires from the WHO (1998) survey of adolescent health. These focused on psychosocial factors, physical activity, and dieting behaviour.

They found that obese teens were significantly more likely to report a negative attitude towards their appearance than their healthy-weight counterparts. Younger obese teens identified the largest image from the FRS to represent their own body shape, whereas older obese teens identified the thinner images to represent their own body shape. They also found a significant number of obese youths reported difficulties making friends compared to non-obese youths.

Goldfield et al. (2010) investigated body image concerns, dietary restraint and depression and weight status in a non-clinical sample of obese adolescents. The total sample size was 1460, of these 146 were classified as obese (age range 13–16 years). Participants completed three self-report questionnaires, the Body Esteem Scale for Adolescents and Adults (BESAA: Mendelson, Mendelson & White, 2001), the Dutch Eating Behaviour Questionnaire (DEBQ: Van Strien, Frijters, Bergers & Defares, 1986) and the Child Depression Inventory (CDI: Kovacs, 1992). Weight status was obtained using digital scales and height measures were taken in schools by trained nurses.

Goldfield et al. (2010) found that obese youths reported greater body image concerns and also reported higher scores for depressive symptoms than normal-weight youths. Interestingly, obese youths did not report a greater number of incidences of emotional or external eating than their non-obese counterparts, suggesting that those who are of a healthy weight also engage in emotional or external eating and it is not isolated to those who are obese.

Cinelli and O'Dea (2009) conducted a study on the differences between indigenous (N=333) and Anglo-European (N=4367) Australian youths regarding obesity and body image. They used the Body Appearance Rating (BAR: Van Hoorn, Kefford, O'Dea, Pettigrew, Richardson & Abraham 1999) to assess physical appearance, a self-report questionnaire, with scores ranging from 0 to 10 (10 being perfect). Cinelli and O'Dea (2009) found that indigenous males and females overall were more likely to desire weight gain than their Anglo-European counterparts and less likely to desire weight loss. There were no significant differences identified in the male obese indigenous groups (7.2% of the 163 males) compared to the Anglo-European obese group (6.9% of the 2166 males) or amongst the indigenous obese females (9.1% of the 170 females) compared to the Anglo-European obese females (4.8% of the 2201 females) in terms of their scores on the BAR. All of the obese participants reported significant body image concerns and indigenous Australians were more likely to desire weight gain, which might be related to the different cultural perceptions concerning what is desirable and healthy regarding weight and shape (Burns & Thomson, 2006).

Similar findings were identified in a study by Ceballos and Czyzewska's (2010) focusing on the differences between obese Hispanic/Latino and European American adolescents regarding body image concerns. Their sample consisted of 228 Hispanic/Latino youths, of which 27.2% were obese, and 91 European American youths, of which 17.6% were obese. They used a computerised survey which displayed gender specific adolescent silhouette drawings based on the Figure Rating Scale (Stunkard, Sorenson & Schlusinger, 1983). There were also two additional questions added from the Children's Eating Attitudes Test (ChEAT-26; Smolak & Levine, 1994) which assessed body thinness preoccupation. An

assessment of body stereotypes was also administered based on the Siperstein Adjective Checklist (ACL: Siperstein, 1980).

The study found that females were more dissatisfied with their body shape compared to males and had a stronger desire to be thinner. Overall, all those who were obese reported significantly more body image concerns than healthy-weight participants. In the silhouette figure exercise, all of the obese participants overestimated their body size. Male and female Hispanic/Latino participants identified larger body sizes as the ideal unlike European Americans. European American male participants reported significantly more negative attitudes towards the obese male body silhouette than did Hispanic/Latino males. This was not found for the females in this study. The findings from this study are similar to those in a study by Cinelli and O'Dea (2009), who also identified cultural differences in what is considered to be the ideal weight. In both studies, participants from minority ethnic groups found larger weight and shape figures to be more desirable.

There have been only a small number of clinical sample studies investigating body image concerns in obese youth populations. Huang et al. (2007) conducted a randomised controlled trial (RCT) to explore the effects of a one year intervention for obesity called the PACE+ study (N=336). It was designed to raise awareness of health risk and dieting behaviour for obese individuals by exploring the impact the intervention had on participants' self-esteem and body image concerns. Data were collected at baseline, 6 months and 12 months. The Body Dissatisfaction subscale of the Eating Disorder Inventory (EDI-BD: Garner, Olmstead & Polivy, 1983) was used to measure body image concerns at all three time points. At baseline they identified differences between reported body image concerns for gender and weight. Overweight and obese female adolescents reported more body image dissatisfaction and lower self-esteem than males and those who were of a healthy weight.

There were no intervention effects for body image dissatisfaction or impact on self-esteem for either boys or girls. The intervention did not target body image or self-esteem directly. However, females who experienced weight reduction at 6 months and maintained this at 12 months reported a greater improvement in body image dissatisfaction than did those who had gained weight at 12 months. This suggests that body image concerns improve with weight loss.

Decaluwé et al. (2003) explored the prevalence of binge eating behaviour amongst obese youths seeking treatment for weight loss (N=126, age range 12–16 years). They used the Eating Disorders Examination Questionnaire (EDE-Q: Fairburn & Beglin, 1994) not only to assess the frequency of specific eating behaviours but also to explore body image using the Eating, Weight, and Shape Concern subscales. In addition, the self-report questionnaires assessing self-esteem and depression were also used.

It was found that 36.5% of their sample reported binge eating episodes. The sample was split and comparisons were made between the obese non-binge eaters and obese binge eaters. It was found that obese binge eaters reported greater levels of body image concerns than non-obese binge eaters. The obese binge eating group was also found to be slightly younger (10–12 years old) and reported lower levels of self-esteem than the non-obese binge eating group. There were no differences regarding reported depressive symptoms. This study highlights that binge eating is a problem for some obese treatment-seeking youths and it is also associated with greater body image concerns and lower self-esteem.

**1.6.3.2. Exploring body image concerns using qualitative methods.** To date there have only been two qualitative studies identified that directly focused on body image concerns amongst young obese females and both used treatment seeking American samples. Therefore research in this area is limited. In adult populations the same was found. There

were only a small number of papers identified that directly examined how obese individuals experience being obese and explored body image concerns. There were three qualitative studies identified that focused on the experience of services for obesity treatment (Byrne, Cooper & Fairburn, 2003; Edmunds, 2005; Turner, Salisbury & Shield, 2012). There was also one Australian study identified focusing on how obese individuals experience being obese in adulthood (Thomas, Hyde, Karunaratne, Herbert & Komesaroff, 2008). The main findings from Thomas et al. (2008) were that experiences of obesity were diverse, but the most common theme identified were that participants reported feeling victimised from an early age and that they experienced social stigma associated with their weight. This also impacted on their self-perception and many of the participants expressed having negative body image concerns.

Boyington et al. (2008) explored cultural attitudes towards weight and shape, body image, diet and physical activity amongst obese African American females (N=12, age range 12–18 years) from a hospital weight management program. They used qualitative methodology which involved five semi-structured one hour group interviews which explored the following areas guided by an interview schedule: definition of personal health, dietary and physical activity habits, perceptions of personal health, body perception and attitudes, important figures and role models, social support and cultural and environmental factors. The interviews were audio recorded and transcribed and thematic analysis was used to identify themes electronically.

It was found that body weight and size preference were predominantly determined by the individual and influenced by those around them, their social circle, and not the media or wider society. Celebrities were not perceived as role models for body weight and shape or diet and physical activity. A third of the participants experienced negative comments from



their peers regarding their weight and shape from early childhood; however, they did not find this problematic and it did not motivate them to lose weight. They perceived being 'skinny' as not important. What was important for them was to be satisfied with the size they were. The participants were able to highlight some positive aspects associated with being overweight, and the ideal and preferred body shape was of a large size, especially in the breast and buttock area. A limitation of this study is that the sample had a varied age range, 12 to 18 years, which may have impacted on the type of information gathered.

Neumark-Sztainer, Story, Faibisch, Ohlson and Adamiak (1999) gathered in-depth descriptions of the experiences of being overweight from a non-clinical sample of African American (N=24, age range 14–18 years) and Caucasian (N=26, age range 14–18 years) female adolescents, aiming to understand how they perceived themselves and their social context in the USA. They were also interested in differences regarding body image and self-image.

Qualitative semi-structured individual interviews were used to collect data, with each interview lasting between 30 and 45 minutes. Interviews were guided by an interview schedule designed by the authors, which was directly related to body image and self-perception. There were specific questions regarding how participants felt about their weight and shape, whether they had a desire to be a different weight and shape, how they felt when they looked in the mirror and whether others treated them differently. The interviews were audio recorded and transcribed. Data were analysed using content analysis (Berg, 1998), and the following themes were identified: weight-specific self-perceptions; non-weight related self-perceptions; situations in which one feels self-conscious; perceptions of ideal self; perceived ability to become ideal self; and weight as an issue. Both African American and Caucasian obese females expressed dissatisfaction with their body shape and weight and were

concerned about their weight status. Some described high levels of body dissatisfaction and described wanting to ‘cut the fat off’ whilst others avoided social situations for fear of being criticised about their weight. The main difference identified between the two groups was that African American females were able to describe positive as well as negative aspects associated with their body weight and shape, as they described larger women as being attractive and desirable, unlike Caucasians.

Similar findings were reported by Boyington et al. (2008), who also identified that African American obese females were able to describe positive aspects of their body weight and shape and identified larger women as attractive. These findings relate to previous research that has found that African Americans have commonly reported larger women as being more desirable (Meshreki & Hansen, 2004).

A limitation of both studies is that they used a female sample therefore gender differences were not assessed. This further limits the generalisability of the findings. By using qualitative methodology, however, both studies identified rich, useful information relating to body image and the experience of being obese.

In summary, research on body image concerns and obese youth populations is limited. To date, studies indicate that: all obese youths reported more body image concerns compared to their healthy-weight counterparts; younger obese youths (aged 12–14 years) reported greater body image concerns; obese youths from ethnic minority backgrounds and those from Caucasian backgrounds all reported body image concerns; however, those from minority backgrounds found fuller body shapes more desirable than did Caucasians. The two clinical quantitative studies found that body image concerns were associated with low self-esteem and that 36.5% of the obese participants reported symptoms associated with binge eating behaviour (Decaluwé et al., 2003). Furthermore, participants who engaged in binge eating

behaviour also reported greater body image concerns compared to participants who did not engage in binge eating behaviour.

In both qualitative studies all the participants were female and described having body image concerns; however, African American obese females were able to describe positive and negative aspects of being obese. This was not the case for Caucasian obese females (Neumark-Sztainer et al., 1999). African American obese females also described how they considered fuller figured women to be more attractive and desirable and how they did not want to be 'skinny'. These studies found marked cultural differences amongst ethnic minority obese young women regarding what is considered attractive and desirable. A major limitation of these studies is that they used American female samples; therefore their generalisability is limited.

One major flaw identified in all the studies was the lack of theoretical grounding for the reasoning behind exploring body image concerns; however, they all discussed how the findings could be applied to diagnosis and/or treatment of obese youths.

The following section will outline a new model that has been put forward to explain childhood obesity (Russell-Mayhew, McVey, Bardick & Ireland, 2012) and associated psychosocial factors, eating disorder psychopathology and body image concerns that have been presented so far in this chapter.

### **1.7. Mental Health, Wellness and Childhood Obesity Model**

In a recent systematic review of literature focusing on psychosocial factors and associated youth obesity, Russell-Mayhew et al. (2012) have proposed a mental health and wellness theoretical model based on the findings. They argue that there is a lack of theoretical understanding and models that combine relevant research on youth obesity and all the

findings from literature on the associated factors. Figure 6 presents their proposed model that includes psychological factors, mediating variables and wellness factors. This theoretical model is the first of its kind as it is based on a systematic review that examined all of the aforementioned factors altogether.

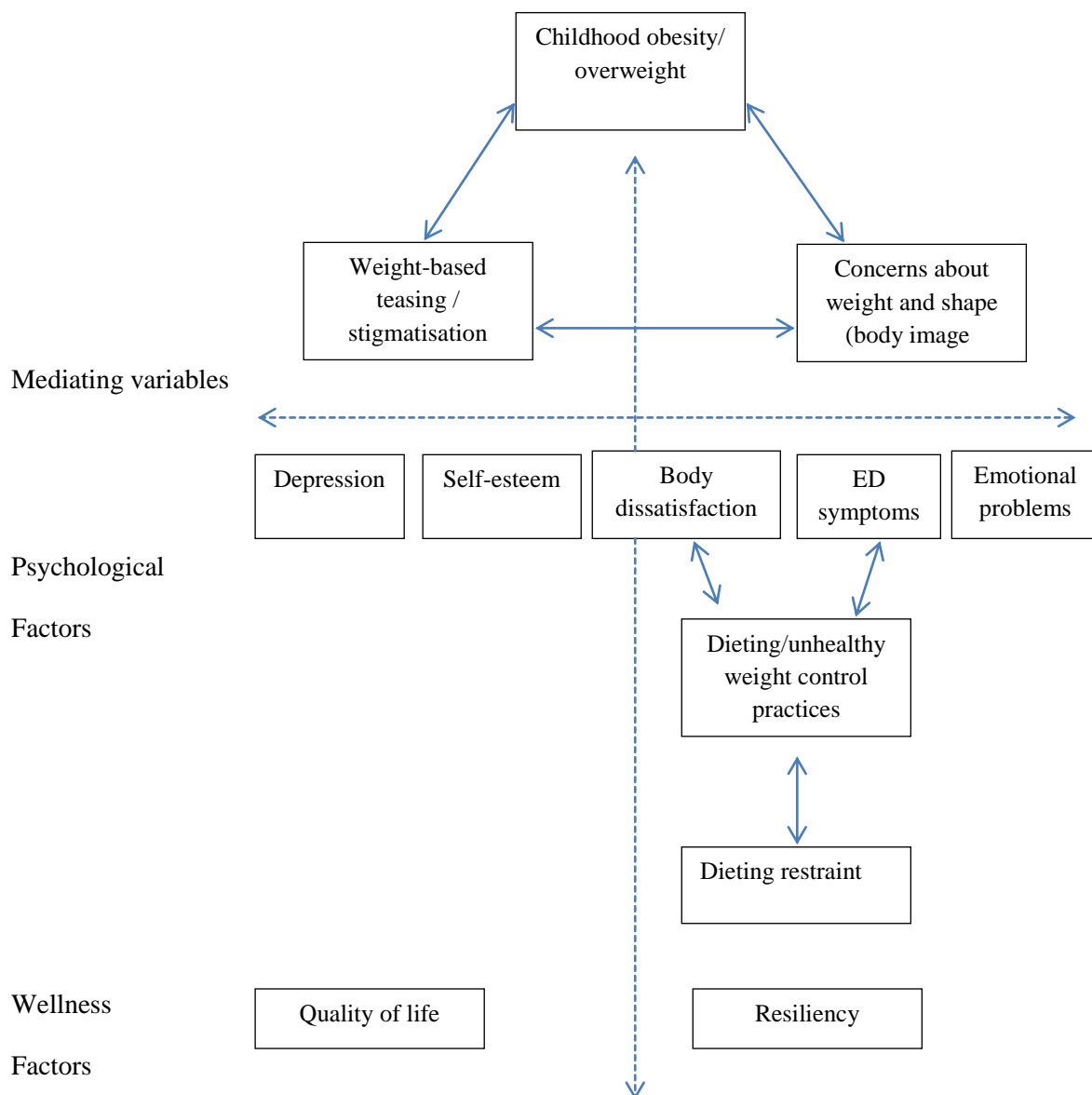


Figure 6. Proposed mental health and wellness model of youth obesity (Russell-Mayhew, McVey, Bardick & Ireland, 2012, p. 3).

Much of chapter one has been devoted to three central areas of research that include the psychosocial impact of youth obesity and its relationship to eating disorder

psychopathology as well as body image concerns, all of which the mental health and wellness model of obesity highlights. Research pertaining to these three central areas has already been extensively presented in chapter one. The other areas of research Russell-Mayhew et al. (2012) explore are quality of life (QOL) and resilience models associated with obesity. They draw on two small areas of research focusing on quality of life and youth obesity and dieting behaviour and the impact this has on some obese young people. They argue that research on QOL and youth obesity is limited due to the focus being on the psychopathological impact (highlighting depression and self-esteem), which fails to assess or explore the impact on young people's QOL (Russell-Mayhew, 2012, p.5). In large non-clinical samples, obese youth's quality of life has been found to be lower than to their healthy-weight counterparts (Friedlander, Larkin, Rosen, Palermo & Redline, 2003; Janicke et al., 2007). In clinical samples obese youths reported even lower levels of QOL compared to non-treatment seeking obese samples (Swallen, Reither, Haas & Meier, 2005).

The other area of research identified is related to Restraint Theory (Stice, Presnell, Groesz & Shaw, 2005). Although research in this field is limited, they argue that the risk of obesity amongst young people is increased when they engage in unhealthy dieting behaviours. For example, they present research on restrictive dieting, which has been linked to disordered eating/eating disorders (Tanofsky-Kraff, Yanovski, Schvey, Olsen, Gustafson & Yanovski, 2009) and weight gain/obesity (Russell-Mayhew et al, 2012, p. 3). This is further supported by Restraint theory (Stice, et al., 2005) which suggests that restriction of food intake will result in disinhibited eating, and behaviours such as binge eating and emotional eating. Although research is limited in this field, it has been found in cross-sectional data that dietary restraint is associated with obesity (Claus, Braet & Decaluwé,

2006) and is a predictor of weight gain in young people (Johnson & Wardle, 2005; Stice & Shaw, 2002).

Therefore this proposed model of understanding youth obesity offers a new way of pulling together existing literature on the mediating variables, psychosocial factors as well as wellness factors that have been found to be associated with youth obesity. What it also highlights is that current treatment of youth obesity in the UK does not take into account the impact of the aforementioned factors, which inevitably will have an impact on treatment outcome (Russell-Mayhew et al., 2012).

**1.8. Summary and rationale for research.** To summarise, obesity is a growing health problem across the world (WHO, 2011). Suggestions for how to tackle the issue have focused on healthy eating, nutrition and diet education, as obesity is considered to be a health rather than a mental health problem (NICE, 2006). The three central areas of research regarding youth obesity have been presented; youth obesity and associated psychosocial factors, eating disorder psychopathology and body image concerns. The focus of this thesis is on obese young women's experiences, however due to the limited research focusing on young women, research pertaining to general youth populations have also been summarised.

Findings from research regarding psychosocial factors are inconsistent; findings suggest that some obese youths experience stigmatisation, victimisation, depression and low self-esteem, whereas others do not. There appears to be a difference between youths seeking treatment for weight loss and those from non-clinical samples, especially as those who are seeking treatment generally have a greater BMI. It is these individuals who report greater symptoms associated with psychopathology. Thus the impact obesity has on mental well-being has been a matter of much debate. The NOO (2011) report identified moderators and mediators that place some at higher risk of developing obesity and associated

psychopathology, but there is still much debate on obesity and its relationship with psychological distress, particularly depressive symptoms.

This chapter has also considered the relationship between youth obesity and eating disorder psychopathology. There is evidence to suggest that some obese young people do engage in disordered eating behaviours, such as binge eating behaviour and that between 1% and 6.3% of obese youths from clinical samples meet the criteria for BED. However, research in this area is limited and the majority of the studies focus on clinical populations, therefore there is little known about non-clinical populations and associated eating disorder psychopathology. What research in this area has highlighted is relevance of emotional eating associated with obesity and binge eating behaviour. In addition, psychological models such as the affect regulation model have been used to explain disordered eating behaviours, by drawing on research on eating disorder populations. It is also proposed that such models could be used to understand some obese individuals who engage in binge eating behaviours.

Finally, the last area that has been explored is body image and how it affects obese populations. There has been much debate around the definition of body image, as it is considered to be a multifaceted construct that has cognitive, perceptual and attitudinal characteristics (Cash, 2011). Research on obesity and body image has gained more interest recently as body image has been found to impact on those with an eating disorder and as some obese youths report symptoms associated with eating disorder psychopathology, this has also been of interest in obese populations. From the review of literature conducted in section 1.3, the findings suggest that all obese youths report body image concerns. However the nature of these concerns are difficult to determine as the majority of the studies are quantitative, using questionnaires focusing on the perceptual aspects of body image therefore there is little known about other aspects associated with body image (such as behavioural).

Both qualitative studies identified had female treatment seeking populations and all identified that there were marked differences between different ethnic obese female populations regarding what is considered to be attractive and the ideal body shape.

In summary, inconsistent findings, coupled with individual variation in what obese youths report as affecting them suggests that obesity is more complex than a physical health problem that can be treated by offering nutritional advice and attending physical activity groups. These complexities and individual differences are not recognised by the current guidelines on how to treat obesity. Therefore, associated psychosocial factors, eating disorder symptoms or body image concerns are not assessed or targeted in treatment, even though it has been found that some obese youths report the aforementioned symptoms. To date, there has not been a framework offered to understand these three areas of research and the relationship between these factors and youth obesity. The first attempt to conceptualise these factors has been offered by Russell-Mayhew et al. (2012) and the model of mental wellness and childhood obesity.

There appears to be a gap in our understanding of youth obesity and associated psychosocial factors. This is in part due to the focus of much of the research on quantitative studies that focus on prevalence of psychosocial factors, eating disorder psychopathology and body image concerns and how obese youths differ from their healthy weight counterparts. There has been little qualitative studies that seek to explore the experience of youth obesity and understand what actually affects young people by open exploration of what young people report as being relevant to them, and how they experience being obese. Interestingly, the two studies that were identified focused on female populations, which may reflect on the fact that those seeking treatment for weight loss are predominantly female (NOO, 2011). Thus this thesis is concerned with exploring youth obesity, focusing on a female population, by



adopting a qualitative approach, using semi-structured interviews, as a way of gaining an insight into how obesity is experienced, rather than using predetermined questionnaires that assess specific and general psychopathology.

### **1.9. Aims of thesis**

This thesis is concerned with exploring young obese women's experiences of being obese, body image concerns and whether this is a source of psychological distress. Therefore the following questions guide this study:

- 4) How do obese young women seeking treatment for weight loss describe their body image concerns, and what is the nature of these concerns?
- 5) How do obese young women seeking treatment for weight loss talk about their emotional experiences?
- 6) How do obese young women seeking treatment for weight loss talk about their disordered eating behaviours?

Qualitative interviews and thematic analysis were conducted to address the research questions. The methodology and approaches adopted for data collection are presented in Chapter Two.

## **2. Method**

### **2.1. Introduction**

This chapter will describe the qualitative methodological approach adopted and the recruitment procedure to collect data for this thesis. In line with qualitative methodological approaches there is a detailed discussion regarding the researcher's ontological and epistemological positions. There is also a description of thematic analysis and how trustworthiness and rigour have been maintained throughout the design and analysis process. Lastly, there will be a description of the ethical issues that this study raises and what procedures were put in place to minimise any potential participant distress.

### **2.2. Methodology Adopted**

This study used qualitative methods to collect data from a clinical population of obese young females seeking treatment for weight loss. Qualitative methods were used to address the research question by using semi-structured interviews and thematic analysis. Questionnaire data were also obtained to help contextualise the sample and to further add to the interview information obtained. The information gathered from the questionnaires was used to describe the sample and no quantitative analysis was conducted due to the small sample size. Nevertheless, it was hoped that the questionnaire data might add to the information gathered from the qualitative interviews on obese young peoples' experiences of being obese. In addition, since very few studies have been designed focusing on young women's experiences of obesity, it was decided that an exploratory qualitative study would be a good starting point.

### **2.3. Qualitative Framework Adopted to Address the Research Questions**

The qualitative approach adopted for this study was influenced by Schutz's Theory of Social Phenomenology (Schutz, 1973) and its application as not only a philosophical framework but also as a form of methodology in its own right. Schutz's social

phenomenology has been described by Fereday and Muir-Cochrane (2006) as ‘...a descriptive and interpretive theory of social action that explores subjective experience within the taken-for-granted, commonsense world of daily life of individuals’ (Fereday & Muir-Cochrane, 2006, p. 2). In this context, social phenomenology adopts the perspective that individuals living out their daily lives in the world are able to apply meanings to situations and then make judgements about these. For the purpose of this study, it was the subjective experience of being an obese youth that was the focus and the participants’ interpretations of this. Schutz (1967) also felt protective of this information and devised ways of ensuring that the data remained pure and was not changed or tainted by the researchers own view point and interpretation. Schutz (1967) called this method interpretive understanding. He identified three essential processes that were required when analysing and making sense of individuals’ experiences and the subjective meaning placed on these experiences or descriptions of social action;

- 1) Logical consistency. The researcher must be clear with the conceptual and methodological framework adopted. These must be consistent with formal logic.
- 2) Subjective interpretation must be grounded in the meaning the action had for those (participants) describing and experiencing it.
- 3) The interpretation must be adequate and fit. In other words, the researchers’ interpretations must be familiar to the participants and must be described in such a way that adequately fits the original version of that description.

(Fereday & Muir-Cochrane, 2006, p. 83)

The present study aims to adhere to the above three processes involved in interpreting qualitative data as well as developing trustworthiness and rigour, as defined below.

**2.3.1. Developing trustworthiness and rigour.** The three processes described in the previous section have evolved and changed through the years; however, these principals have

been applied to many qualitative studies. More recent qualitative researchers still apply the notions that interpretive research requires trustworthiness and a process that ensures that this has been achieved in order to produce interpretations that are credible (Horsfall, Bryne-Armstrong & Higgs, 2001; Koch, 1994; Shenton, 2004). The notion of rigour is commonly described as a process, which demonstrates integrity in an interpretive study (Aroni, et al., 1999; Shenton, 2004).

Like Schutz (1967), Horsfall et al. (2001) also prioritises the notion of consistency and rigour and state that good qualitative research involves detailed and in-depth planning, attention to the phenomena under investigation, producing interpretations that are true to the participants' descriptions, analysing and describing the analysis process with clarity and producing useful findings. This also includes providing detailed description of how themes were created and defined and offering direct quotes to support interpretations (Horsfall et al., 2003; Rice & Ezzy, 1999; Silverman, 2010). This is also a way of demonstrating and strengthening the validity of such research (Patton, 2002; Silverman, 2010). The results section of this thesis describes briefly how the study adheres to these processes and offers direct quotations to support interpretations to ensure that interpretations were related to the participants' words and that the researcher did not change the meaning behind the experiences they reported (see Appendix 2.A. for a sample of transcript and the development of the coding frame).

Schutz's (1967) notion of adequacy is also present in current interpretive studies and is related to the checks that some researchers carry out involving checking and confirming the findings with the original participants, known as participant verification (Leininger, 1994). This process was not used in this study, due to the time restrictions associated with completing the thesis. However all the participants were given the option to receive a summary of the findings, and were asked to comment on what they thought of the findings.

This provided a way of disseminating the findings to those who wished to receive the information.

The following section will outline the method of collecting data adopted for this study and how rigor can be achieved using this method.

**2.3.2. Qualitative semi-structured interviews.** For the purpose of this study and in order to address the research questions semi-structured interviews were used. These provided a way of gaining an understanding of obese young peoples' experiences, in order to capture the complexities of such experiences. Semi-structured interviews have become a common data collection method in qualitative research (Aronson, 1994).

There are however limitations that are associated with this approach. The researcher acknowledges that the qualitative interviews will capture one snap shot in time and due to the small numbers (N=6 participants), the generalisability of the findings are limited as they are only applicable to those who took part in the study at that particular time point. However it was thought that this approach would be the first step in this exploratory study to understanding obese youths experiences, how they interpret their experiences how they feel about themselves and whether it influences how they live their lives.

Also, as this study was exploratory, it was also thought that having predetermined questions regarding what is already considered to be important regarding youth obesity may prevent any new information being collected or allowing different experiences to be voiced. The interviews were semi-structured and included a list of questions and topic areas that were used as ways of opening up discussions around specific topics but not limiting discussions. The interviews were audio recorded, transcribed and analysed using thematic analysis and ranged between 21 to 43 minutes in length.

**2.3.3. The interview schedule.** The interview schedule was created to address the proposed research questions and also as a way of opening up discussions around topics. It was developed by the researcher to help introduce the main topics that were of interest and to be flexible and allow for the unexpected (for example, participants raising different issues or topics). The researcher also used prompts and asked curious questions, in line with Lofland and Loflands (1995) and Kvale (1996) recommendations. This enabled the researcher to follow-up on what the participants were describing and also to clarify any misinterpretations. The researcher referred to Kvale's (1996) list of ten qualification questions that should be adopted to ensure interviews are conducted in a sensitive manner which allows the participant to tell their story and provide the researcher with tools to be able to follow up, prompt and clarify the information they are receiving. The list below displays Kvale (1996) list of qualification questions and how the interviewer should approach the participants when conducting the semi-structured interviews. Kvale (1996, p. 131-155) proposes that the interview should be:

- *Knowledgeable*: about the participant and the topic of discussion
- *Structuring*: gives purpose for interview, asks whether interviewee has questions
- *Clear*: asks simple, short questions
- *Gentle*: allows people to finish, gives them time to think
- *Sensitive*: listens attentively to what is said and how it is said, is empathetic in dealing with the interviewee
- *Open*: responds to what is important to interviewee and is flexible
- *Steering*: knows what he/she wants to find out.
- *Critical*: is prepared to challenge what is said, for example, dealing with inconsistencies in interviewees' replies.

- *Remembering*: relates what is said to what has previously been said, reverts back to and paraphrases
- *Interpreting*: clarifies and extends meanings of interviewees' statements

**2.3.4. Interview schedule topics.** Regarding the interview topics that were chosen, this was guided by previous research on this area drawing on literature from adult and youth obesity studies. For example, research findings identifying links with obesity and body image concerns (Boyington et al., 2008; Cash & Henry, 1995) binge eating/disordered eating behaviour (Glasofer et al., 2007) and psychopathology (Anderson et al., 2007; Norwicka et al., 2008). There were also discussions with the obesity weight management team that hosted the study and their views regarding what may be important to ask (see Appendix 2.B. for the interview schedule).

**2.3.5. Thematic analysis.** Thematic analysis shares many principles of content analysis, in that common themes are identified and documented. The aim of thematic analysis is to understand rather than count how many times a particular word was said or how many times a category was identified. It focuses on the themes that arise rather than how many themes arise. Essentially thematic analysis is concerned with identifiable themes and patterns of living and behaviour and tends to focus on narrative data and reflects directly on the main ideas and conclusion in the data, 'looking for what is prominent rather than higher order, new explanations for findings...' (Pope, Mays & Popay 2007, p. 96). This study is exploratory since there is limited research on youth obesity and how being obese is experienced. It was hoped that qualitative interviews would help inform and aid in understanding how obesity affects individuals and whether they experience associated psychopathology such as body image concerns, emotional distress or disordered eating behaviours. Also it would help in identifying how these symptoms may be similar or different to body image concerns and associated psychopathology that are commonly reported in eating disorder populations.

Participants that were currently undergoing treatment for obesity and attending a weight loss programme in Suffolk were invited to take part in the interviews. The data was collected cross sectionally from this clinical sample.

An alternative qualitative methodology that was considered was grounded theory. A grounded theory approach focuses on the 'day to day lives' of people in the social world. It considers how meaning is created through narrative descriptions and these descriptions are used to generate theory (Strauss & Corbin, 1998). However as this study was exploratory and due to the limited time available to carry out the data collection and analysis, thematic analysis was considered to be a more suitable method.

**2.3.6. Analysis process.** The process of interviewing and analysing data were conducted in line with Boyatzis (1998) indicative approach and with Kvale (1996) seven stages of qualitative interviewing and analysis which include; thematising, designing, interviewing, transcribing, analysing, verifying and reporting. The first step is to collect and transcribe data. The next step is to identify all data that relates to the already classified headings, e.g. weight concerns, binge eating etc. All of the talk that fits under these specific headings identified and placed with the corresponding heading. The next stage involved combining and cataloguing related headings and identifying the general themes and subthemes.

Themes are defined as units, created from patterns such as 'conversation topics, vocabulary, recurring vocabulary, recurring activities, meanings, feelings, or folk sayings' (Taylor & Bogdan, 1984, p. 131). Themes that emerged from the participants descriptions are pieced together to form a comprehensive picture of their experience collectively (Aronson, 1994). The coding process is difficult and requires attention to detail and decisions to be made regarding how the data fits into the assigned codes. This involves careful reading and re-reading of data (Rice & Ezzy, 1999, p. 258) and seeing something in the data that is



different or unique or ‘recognising and important moment prior to the process of interpretation’ (Feraday & Muir-Cochrane, 2006, p. 4). The last stage involved building a valid argument for choosing the themes. This was done by reading the related literature (Aronson, 1994). An outline of this process is presented below.

**2.3.7. Identifying Themes.** It is important to note that the description of how the themes emerged and were created is also briefly reported in the results section; however, this process was flexible and allowed for reassessment of the questions being asked. It was also reflective in that the data collection and analysis process was conducted concurrently and previous data collected was re-read and new emerging themes generated from new data was considered against all the data previously collected. The interview guide also included some new areas to explore as a result of data collected. All of this was done to ensure that the theme allocations placed on the new data were true to the original experiences described and themes assigned. This process has been described as the principal of ‘goodness’ in qualitative research (Tobin & Bagley, 2004).

This process involved the following steps to be adopted, as described by Ryan and Bernard (2003) and Guest, MacQueen and Namey (2012, p. 66). The first stage involved becoming familiar with the interviews. This was achieved by the researcher transcribing all six interviews and listening back over them in conjunction with the log book notes made after each interview. Secondly, all the transcripts were searched for the following; repetition, the use of metaphors or analogies, transition (naturally occurring shifts from one topic to another), constant comparisons or differences being identified, linguistic connectors such as ‘if’, ‘because’ ‘since’ as these are considered connecting words that are used to reveal participants systems of logic (Guest et al., 2012). Ultimately this involved searching across the transcripts and finding repeated patterns or differences of meaning in relation to the research questions.

Initially, codes were created to start to organise the text and offer a way of logging when something of note was identified in the transcript. Once initial codes were created, they were examined to see if there were any overlap or relationship between codes and this was also logged. By logging initial codes and thoughts (interpretation) of these codes, a map of the potential themes could be developed. It is important to note that the development of the themes involved the researchers interpretation of what was being expressed in the transcripts. This process is described as going beyond describing the text, as it offers an interpretation of what is being expressed (Boyatzis, 1998).

Once initial codes were developed, all of the transcripts were screened for similar occurrences and text relating to the codes were extracted and examined in relation to each other. This enabled firmer themes to be identified and comparisons, overlap and differences to be identified. This involved re-assessing the text and themes numerous times, to ensure that the extracts of talk selected truly represented the allocated themes. At this point a clear map of the themes and accompanying extracts of transcript were created that addressed the research questions. The themes were finalised once the researcher and a colleague who was also doing a qualitative thesis had a chance to review the thematic map and interpretations of the data and selected extracts from the transcripts. This enabled the researcher to reconsider any overlap or inconsistency and also offered the researcher a chance to test the interpretations made. Therefore, in summary, the following explicit steps were taken to collect and analyse the data collected for this thesis:

- 1) Semi-structured interviews were conducted and audio recorded
- 2) The researcher listened to and transcribed all of the interviews
- 3) The researcher first identified when there were topic shifts, for example;

*Talk about participants own weight (0.18 secs – 2.13 minutes)*

*Described feeling low and unhappy and related this to self value (2.14 – 3.56 minutes)*

The researcher used this to create a ‘map’ of all of the general topics that were raised in each interview as a way of providing an outline of each interview.

- 4) The researcher also went through each interview and looked for repetition, the use of metaphors or analogies, transition (naturally occurring shifts from one topic to another), constant comparisons or differences being identified, linguistic connectors such as ‘if’, ‘because’ ‘since’.
- 5) The researcher then went back and referred to the Log Book and cross referenced the ‘map’ of each interview with the Log Book this as well as listened through the interview alongside reading the Log Book.
- 6) After doing steps 1 -5, the researcher started to notice broad themes that were being raised in relation to the questions being asked and these were mapped and logged throughout each interview.
- 7) These broad themes were cross referenced starting with the first interview, and then looking for similarities, differences and overlap in the other interviews.
- 8) Data was constantly being read and re-read and re-listened to in order to check the themes were corresponding to each other. This then resulted in a thematic map being drawn outlining the themes that were emerging and where they were in the data and in the transcripts.
- 9) Once the map of themes was finalised, accompanying extracts from the

transcript were attached to the allocated themes in order to re-check the themes and whether the themes fit what was being expressed in the extracts. The themes were finalised once the researcher and a colleague who was also doing a qualitative thesis reviewed the thematic map and interpretations of the data and selected extracts from the transcripts.

**2.3.8. Researcher relationship.** This section will outline the researcher's position and role in this study. The researcher's ontological and epistemological positions are defined and described and the researcher's personal relationship to this study and its interpretation is discussed.

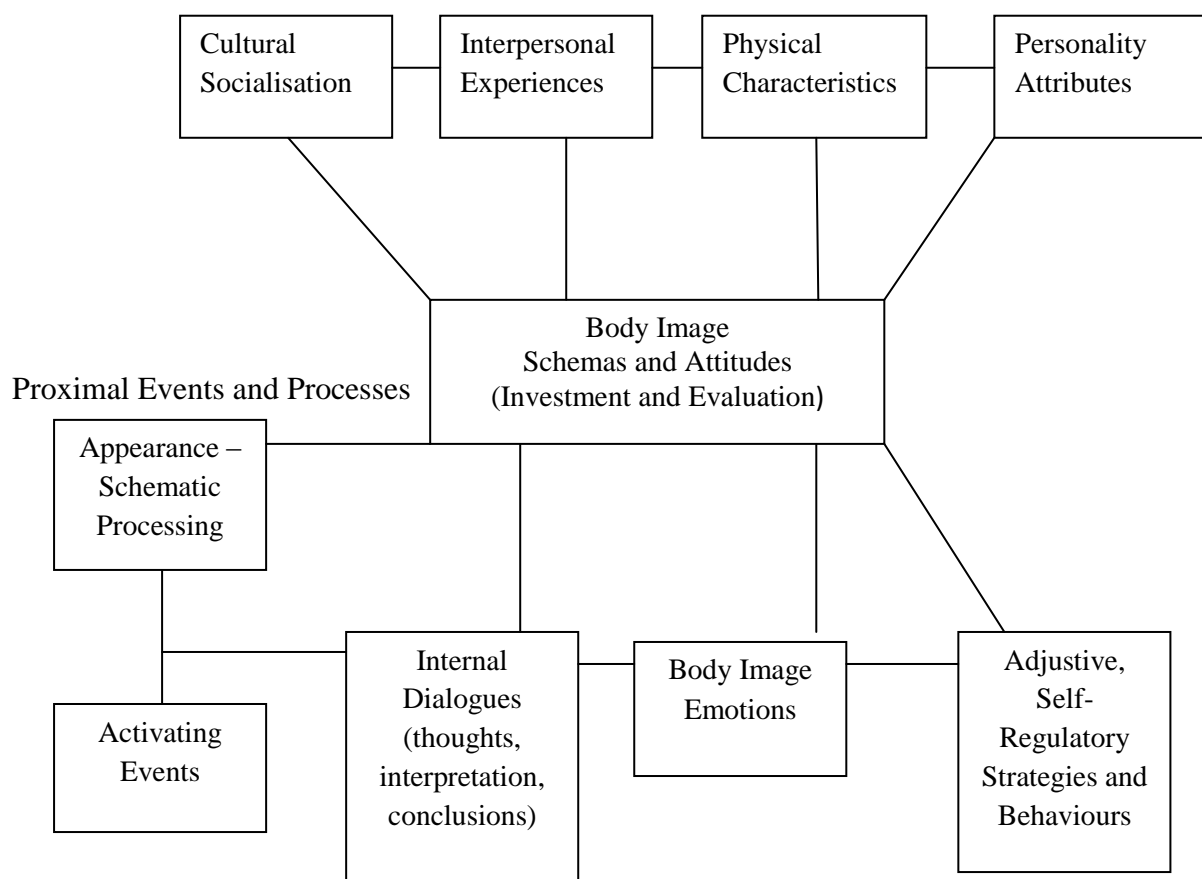
**2.3.9. Ontology and epistemology.** Ontology has been defined as a way of offering a language to describe concepts and relationships between them, within a specific area. It offers a way of developing a shared understanding and a way of communicating this. Epistemology is the 'study of knowledge – what it is and how it differs from opinion' (Shenton, 2004, p. 2). Epistemology attempts to understand and identify what is truly knowledge and how this accurately reflects reality, and seeks to identify facts to make assumptions about that knowledge. Qualitative research is guided by ontological and epistemological positions and these are used to guide the method for analysis and processes involved in interpreting the information collected. It is a vital part of any qualitative research that these two positions are clearly defined from the beginning of the study as they determine and define how the information will be collected and interpreted (Mason, 2002).

The ontological framework this study is based upon is a cognitive behavioural perspective on body image (Cash, 2004). It is a heuristic conceptual model, which incorporates the many different layers associated with body image and how it develops and affects individuals. It differentiates between historical events and current events that impact

on the experience of one's self and body. In this context, the experiences and interpretations that obese young people report are a result of external factors (media and cultural understandings of weight and shape), internal personal factors (cognitive, affective and physical processes) and behavioural factors. Figure 7 displays this model.

*Figure 7. A cognitive behavioural model of body image development and experiences (Cash, 2004).*

Historical, Developmental Influences



The epistemological framework this study follows is one that leans more towards realism, however also considers relativist perspectives and how this impacts on the research process and findings. In line with the traditional realism approach, the researcher remained

objective and provided a transparent methodological account of this study and the process carried out to conduct the research. However, there were also considerations of how the researcher's presence, position and role within the research (from design to carrying out the interviews) may have influenced the findings. Therefore in this sense the relativist perspective was considered. This approach towards analysis is much like Richardson (2000) who valued rigour and transparency and providing evidence for identified phenomena as well as placing importance on what they themselves bring into those interpretations and challenge the notion that there is one single truth. This study on youth obesity and how obese youths seeking treatment for obesity experience being overweight, was designed with the researchers own understanding of eating disorders and associated theoretical models which the researcher wanted to explore in this study. Therefore the researcher brings her understanding of food, weight and shape and eating disordered behavioural difficulties from eating disorders and how these relate to obesity, as well as allowing the participants voices to be heard and understood in their true form and how they were intended.

These ontological and epistemological positions view the participant's interpretations as experiences that are directly related to the context of their social world and their understandings of weight and shape, created through their environments. It also allows for differences in participants understanding and how they create meaning and make sense of their world (Guest, Bunce & Johnson, 2006). By adopting a more fluid approach, and not a rigid approach that only adopts a realism or relativist perspective, it was hoped that the multidimensional aspects that impact on the participants information they offer could be examined.

**2.3.10. Researcher's background and experience.** What the researcher brings and how this has influenced the topic of research and the methodology adopted is also an area that was considered (see Appendix 2.C. for a more detailed description). I am in my early thirties,

married and have a young child. I am Turkish Cypriot but born in the UK and have lived here all my life. My cultural understanding of weight, shape, attraction, eating disorders, and obesity is mixed as it has been influenced from my Turkish heritage as well as my British upbringing. I am also a new mother and have experienced my own body shape grow and change whilst being pregnant which has given me a new insight and perspective regarding my own weight and shape. I am also a clinical psychology trainee, in my final year. This has impacted on how I try and make sense of health and psychological disorders.

I have also been shadowing the dieticians at the weight management programme who agreed to take part in this study. This has provided a way of having firsthand experience of the assessment and treatment process that obese youths seeking treatment for weight loss undertake. This helped me fine-tune my line of enquiry and help mould my ideas further and offered an insight from other professionals' experiences of obesity weight management. This process is sometimes referred to as 'immersion in the setting' (Holloway & Wheeler, 2002). Relevant literature, documentaries, talking to other professionals in the field of enquiry are also other ways in which I immersed myself to try and gain a greater understanding of the obese youth treatment seeking culture. A culture does not just exist within an environment it also consists of different values and ideologies and ways of thinking and these change over time as a result of different experiences and interactions (Holloway & Wheeler, 2002). All of these different experiences offered a valuable insight and a different mode of access to the participants' world.

**2.3.11. Researchers reflexive commentary.** From the start of a study some qualitative researchers keep a log book describing all of their initial thoughts, beliefs, interactions and all the information that initially moulded the study. This is maintained throughout the study and is considered an important process as it allows the researcher to identify how key patterns emerged in the data as well as identifying how the researchers own

understandings developed (Guest et al., 2012). It offers a way for the researcher to monitor their own development and be critical of their work, which has been defined by Guba and Lincoln as ‘progressive subjectivity’ and is used to establish credibility (Guba & Lincoln, 1989).

Some of the notes kept in the log book will be used in the Results chapter to help express in more detail how interviews developed. The researcher also talks in the first person during some of the descriptions of the results as she reflects on her own background and her relationship with the data, in order to take a more critical view of how the data is being interpreted.

## **2.4. Methodology and Design**

**2.4.1. Study setting.** Clients who were receiving treatment for obesity from a weight management programme in Suffolk were invited to take part in the study. The programme was a new service across Suffolk to address the increasing prevalence of childhood obesity. The service comprises of a multidisciplinary team including a dietician and physical activity advisor who works with overweight young people and their families to achieve and maintain a healthy weight through positive lifestyle choices. The qualitative study targeted only those currently receiving treatment as information pertaining to previous clients could not be released due to the weight management services confidentiality concerns.

**2.4.2. Inclusion criteria/exclusion criteria.** In order to be eligible for the study, young people attending the weight management clinic the following inclusion/exclusion criteria were imposed:

- Aged between 14 – 18 years and female
- BMI at or above the 95<sup>th</sup> centile adjusted for age and gender
- Fluent in English

Exclusion criteria:



- Developmental impairment (e.g. autism)

Age 14 years and above was chosen for two reasons. Previous research has reported that this is when eating disorder symptoms become more prevalent in youth populations (Fairburn, Welch, Doll, Davies & O'Connor, 1997; Patton, Selzer, Coffey, Carlin & Wolfe, 1999) and the self report questionnaires used in the present study have all previously been used in this age range.

**2.4.3. Recruitment.** Families were offered information sheets on the study from the weight management service receptionist upon arrival at the clinic. There were opportunities to discuss the study with the researcher during one of the meeting groups (activity meetings for those currently undergoing treatment and their families) held at the clinic, or in an after school club (which the researcher attended). Care was taken when presenting the study to families during the meetings to ensure that it was delivered in a clear manner for both parents and children and that it was their choice on whether to take part or not to take part. A brief summary of the study was presented (10 minutes) and there were opportunities to ask questions. Information sheets were also available with the researchers contact details so that potential participants were free to contact the researcher to discuss participation further.

In total, 34 young people met the criteria for the study. All of the families and the young people were given information regarding the study and were present during the brief presentation of the study. Twenty-two were approached directly as they expressed interest, either by discussing the study after the summary presentation or contacted the researcher after receiving information from the service receptionist. Out of the twenty-two, six agreed to take part. The reasons for not taking part varied, the most common reason was time. Many families felt that their children were already committing to two evenings a week for the weight management classes as well as attending school and had additional commitments (clubs) after school which limited when they could be interviewed. A smaller proportion also

did not like the idea of their children being audio recorded and asked about their obesity as they felt it might make them feel worse about themselves by further highlighting the issue. An additional point regarding the small sample size was also related to issues regarding the change in the study design during the data collection period. This study was originally designed to collect postal questionnaire data as well as interview obese youths and was going to use both quantitative and qualitative methodology to address the research questions. However, the questionnaire component was unsuccessful due to the low response rate (a total of 162 questionnaires were posted, with stamped addressed envelopes provided for returning and four were returned). Therefore the study design was discussed and changed appropriately. The large scale quantitative aspect was excluded and the study became qualitative.

**2.4.4. Procedure.** If families were interested in the study they were given an information sheet, from the service staff. At the bottom of the sheet there was a slip that was detachable so that families could express their interest and provide their contact details by posting the slip in a specially designed posting box, in the weight management clinic. For those families providing contact details the researcher contacted them to fully explain the study and address any questions posed. They were given a consent form and an information sheet, for reference. The researcher arranged with the family a mutually convenient time to be interviewed. All the interviews took place in a clinic room in the weight management service (none were conducted outside the service, in accordance with the ethic committee's decision). Formal written consent was received when the families came to the weight management service for the interview. Before the interview was conducted the researcher greeted the families and any additional questions were addressed. It was at this point that consent was obtained. The interview was semi-structured based around a series of topics/ questions and audio recorded. The interview times ranged from 21 – 43 minutes. This was shorter than was

expected, however it may reflect on the populations' age or on the actual questions being asked, as many after the interview stated they had never been asked to talk how they experience their obesity. To acknowledge participation in the study a small incentive was offered, in the form of a raffle to win an iPod. (See Appendix 2.D. for consent forms, information sheets and questionnaires used in this study).

**2.4.5. Interview process.** By the time the participants attended the interview they were familiar with the researcher due to the discussions regarding the study and arrangement of interview time and date, prior to the interview. Prior to the interview starting, all participants were briefed once again about the study, what the interview would involve and their right to withdraw from the interview or the study at any point. Issues regarding confidentiality and any further questions they had were also discussed. This was designed to build some rapport with the participants and to ensure they were clear regarding the study and their involvement.

At the end of the interview the participants were asked if there was anything they wanted to add or if there was anything they thought was important to this area of research. Once the interview ended, there was a debriefing, which involved the participant being asked how they found the interview and how they were feeling about what they had shared. They were also asked whether they wanted anything omitted from the interview. All of the participants agreed to keep all the information in their interviews. In relation to two of the six participants where there were disclosures of self-harm, they were asked if the researcher could further discuss this with the team and with their parents. Permission was given for this to happen as both the team and parents were aware of these issues and it was not a new disclosure. Such disclosures were documented in the clients' files that were stored by the weight management service, which were all confidential.

**2.4.6. Measures.** The following measures were administered after the interviews as a way of finding out more about the participants and these were used to further help describe the participants and contextualise the interview findings.

I. The Eating Disorders Examination Questionnaire (EDEQ: Fairburn & Beglin, 1994). The EDEQ is a self report questionnaire that assesses the frequency of key eating disorder behaviours and is the only self report questionnaire that differentiates between the various forms of overeating. Luce and Crowther (1999) reported the EDEQ has good internal consistency (ranging from .78 to .93) and test-retest reliability (ranging from .81 to .94). It is validated for those aged 12 and above. The reason for using this measure was that research suggests that a proportion of those who are obese engage in eating behaviours found in eating disorder populations, for example binge eating and a proportion of this population also meet the criteria for binge eating disorder. Therefore the EDEQ was used, as it is a commonly used questionnaire to identify such features in eating disorder youth populations.

II. The Body Shape Questionnaire (BSQ: Cooper, Taylor, Cooper & Fairburn, 1986). The BSQ is a self-report measure of the body shape preoccupations typically found in eating disorders. It has been used in eating disorder and non-eating disorder community populations (Eldredge & Agras 1996; Hilbert & Tuschen-Caffier 2004, 2005; Pook, Tuschen-Caffier & Brähler 2008).

Internal consistency reported by Cronbach's alpha was 0.97 (Di Pietro & de Silveira, 2009) and reliability coefficient of 0.88 (Rosen, Jones, Rimerez & Waxman, 1996). It is validated for those aged 14 and above. This measure is commonly used to identify body shape concerns. There is very little known about body shape concerns in obese youth populations. This will also aid in addressing research Q2.

III. The Child Version of the Mood and Feelings Questionnaire, short form (SMFQC:

Angold, 1995). This is a 13 item self report questionnaire designed for 8-18 year olds to assess mood and depressive symptoms. The scale is reported to have high internal reliability, Cronbach's alpha 0.90 (Angold, 1995) and good test-retest reliability of intra-class correlations of 0.75 (Costello, Benjamin, Angold & Silver, 1991). This measure was included to give an indication of the individual's mood and add to the researchers understanding of the participant's level of distress.

#### IV. The Rosenberg self-esteem scale (RSE: Rosenberg, 1965).

The RSE is a ten item Likert scale. The scale has been widely used in previous research in youth obese populations. It has high reliability; with test retest correlations are typically in the range of .82 to .88 and Cronbach's alpha for various samples are in the range of .77 to .88 (Blascovich & Tomaka, 1991). It is validated for those aged ten and above. This measure was included on the basis that previous research has found low self-esteem to be commonly reported by treatment seeking obese youth populations (Simeon et al., 2003).

#### V. Demographic information

This questionnaire was created by the researcher. Data were collected on the following areas: age, gender, ethnicity, education or occupation, height, weight (last measured, to allow for BMI calculations), reason for referral, date first seen by weight management team, number of sessions attended, type of treatment received, and outcome of treatment.

**2.4.7. Ethical considerations.** Ethical approval was granted by the Norfolk and Waveney Ethics Committee in November 2011 (see Appendix 2.E).

**2.4.8. Consent and confidentiality.** Consent was sought from parents/main carers and young people. Information sheets and consent forms were created to be age appropriate (parents, 16+ years and 14-16years). Young people over 16 years did not require parental/main carer consent but they were asked to inform their parent/main carer of their

involvement in the study and were given an information sheet. If parents had consented to the study but the young person did not assent, the young person would not participate in the study, however this did not occur. The information sheets clearly outlined what the research was about, the choice to take part and the importance of confidentiality. All data/information on the participants were anonymised and kept in a safe locked office in the weight management premises. Information will be kept until the study is completed in accordance with the requirements of the Ethics Committee (for a minimum of five years).

The processes involved in audio recording and transcribing the semi-structured interviews were fully explained to participants and their families in order to make this process as transparent as possible.

**2.4.8.1. Potential distress.** This study aimed to interview obese youths about their weight, shape and body image concerns. It was possible that these may be sensitive issues for some individuals and they may have found discussing these issues difficult. There was a specific plan to be followed if the following should occur. If during the course of the interview any participant became distressed the interview would be stopped. The researcher would have ascertained the source of the distress and participants would have been counselled appropriately. They would have the option of discontinuing the interview and withdrawing from the study without indicating why. It would be made clear that this would not impact on their current or future treatment with the weight management team.

Furthermore, if participants became distressed they would have been advised to seek further help from their lead clinician from the team and may have also been advised to see their GP in the case of additional problems identified. They were also advised to contact the weight management team for further support or help after the interviews if they required it. No participants reported feeling distressed during the interview or contacted the clinic staff after the interviews for further assistance. On one occasion there were concerns regarding a

participant's well-being, which was discussed with her family and the service providing treatment. It was subsequently identified that social services were involved with the participant in question. On another occasion there were also concerns regarding a participant's restricted food intake and limited diet. The participant was over 16 years of age, however, she did inform the researcher and the team that her mother was aware of her difficulties related to food and that they were seeking help from a CAMHS Eating Disorders Service. This was documented in the participant's weight management file, which is stored by the weight management service.

### **3. Analysis and Results**

#### **3.1. Introduction**

This chapter will start by providing a description of the participants that took part in this study and will include a discussion of the scores they obtained from questionnaires assessing body shape concerns, disordered eating behaviour, mood and self-esteem. The next section will provide a summary of the themes identified in the narrative accounts of the six young females who agreed to take part in this study. The themes identified will be presented and the context in which the interviews took place. The researcher-participant relationship will also be discussed in relation to the findings.

#### **3.2. Description of the Participants**

All of the participants who agreed to take part in the study were female. Four were recruited from the after-school clubs run by the weight management service and two were recruited through information provided by the weight management team. Their ages ranged from 14 to 17 years. They had all attended the weight management programme and were still involved in treatment.

A brief summary of each participant's life history, how they became obese and an overview of what they shared in the interviews will follow. A summary of this kind provides an opportunity to introduce the participants and further describe the sample. All of the participants' names have been changed to ensure that confidentiality and anonymity was maintained. Following on from this there is a summary provided detailing each participants score obtained from the questionnaires they completed (see Table 6) on body shape concerns (BSQ: Cooper, Taylor, Cooper & Fairburn, 1986), eating disorder symptoms (EDEQ: Fairburn & Beglin, 1994), mood (SMFQC: Angold, 1995) and self-esteem (RSE: Rosenberg, 1965).



**3.2.1. Sally.** Sally was 14 years old at the time of interview. She was an only child and her parents had separated when she was 10 years old. Her mother left the family home at that time. She currently lived with her father, although her paternal grandmother looked after her most of the time. She described her weight gain as becoming a problem from the time her mother left and when she was experiencing difficulties at school, related to friendship conflicts and bullying. She described episodes of binge eating when she was unhappy and interpreted her overeating as providing an emotional function in that it offered her comfort. She described feeling guilty about overeating and how her social life was limited due to her obesity. She also referred to past self-harming behaviour she had engaged in, when she was feeling low. She described in detail her conflictual relationship with food, referring to it as a ‘drug’, and expressed her own perception of her body shape as ‘appalling’. She held many negative beliefs about her body. She was in the early stages of the weight management programme and had lost a few pounds at the time of interview. She was on the 95<sup>th</sup> centile weight for height at the time of the interview.

**3.2.2. Kim.** Kim was 14 years old at the time of interview. She lived with her parents and her older brother. She attributed the majority of her weight gain to a physical illness, ulcerative colitis (an inflammatory disease of the colon), and being put on steroids as part of the treatment. She reported being overweight before her illness; however she gained further weight following steroid treatment. She did not describe overeating and was the only participant who did not report weight and shape concerns. She did not express negative beliefs about her weight and shape was also the only participant who was confident displaying her body in public, for example wearing a bikini. She did not describe any bullying or low mood. She was on the 95<sup>th</sup> centile weight for height at the time of the interview and had lost two stone over the last eight months and had almost completed the activity program with the weight management team.

**3.2.3. Anna.** Anna was 15 years old at the time of the interview. She lived at home with her parents and was the oldest of four children. She was very close to her family, engaging in many family days out and spending a lot of time with her family members. She described her problems with her weight as starting in primary school, where she was overweight and bullied. She became emotional talking about her grandmother's death and stated following the loss of her grandmother she gained weight and used food as a form of emotional comfort. She has been on the weight management programme for some time but had been unsuccessful in losing weight. Anna discussed how being obese limited her school sporting activities and how she struggled to take part in activities that involve displaying her body in public (for example, swimming).

She had also engaged in self-harming behaviour in the past, burning her skin with aerosol sprays and taking an overdose at the age of 14. She reported no self-harming behaviour at the time of the interview and stated she was not suicidal. She was at the 96<sup>th</sup> centile weight for height at the time of the interview.

**3.2.4. Sarah.** Sarah was 17 years old at the time of the interview. She lived at home with her mother and younger sister; her parents were separated. She attributed her weight gain to a combination of factors, including a friendship break-up, the loss of a friend to leukaemia and a physical health problem (fractured spine, causing limited mobility). She described how she turned to food for comfort during these times. Her weight gain had caused her to become isolated and she did not leave her house due to her lack of confidence. She held very negative views of her weight and shape and avoided situations where her body would be on display. She reported having periods in the past where she felt depressed about her weight and previously had experienced suicidal thoughts.

Sarah lost three stone in weight during her time on the weight management programme and she was still involved in the programme's diet and activity clubs. However,

she had developed a different relationship with food since her weight loss. She described feeling guilty each time she ate and had begun to engage on a daily basis in self-induced vomiting following eating. Sarah's mother and the weight management service were aware of her difficulties with food and she was seeking additional help from a specialist eating disorders service. Sarah was at the 99<sup>th</sup> centile weight for height at the time of the interview.

**3.2.5. Becky.** Becky was 15 years old at the time of the interview. She lived at home with her parents and her younger sister. She was almost at the end of her treatment with the weight management team and had lost over two stone with their help and through following a famous diet brand. Becky explained how she had always been overweight as a young child, and she attributed the majority of her weight gain to her emotional state following her grandmother's death. She described how she used food as a way of blocking out bad feelings: 'I'll just eat and eat and I don't really think about it until I feel I'm stuffed'. She recognised that her emotions played a particular role in her over eating and that when she was happy she did not use food in this way. She did not report any bullying, although she had experienced some teasing regarding her weight. She had not engaged in any self-harming behaviour and had no suicidal thoughts. She was at the 95<sup>th</sup> centile weight for height at the time of the interview.

**3.2.6. Alice.** Alice was 15 years old at the time of the interview. She lived at home with her mother and stepfather. She was an only child. Alice attributed her weight gain to a medical condition, polycystic ovarian syndrome (POS), and frequently referred to her mother, who also has POS and was also currently overweight.

Alice was sad at times throughout the interview and cried towards the end. She had been bullied most of her life because of her weight and reported still being bullied. She had very negative thoughts regarding her weight and shape and had a strong desire to be thinner. She described how feeling low in mood made her want to binge and how, if she did not find

food in the house, she would steal money from her mother's purse to buy food to binge eat. She engaged in binge eating behaviour on a weekly basis. She felt guilty after the acts of stealing and binge eating and described going into a daydream state to escape her low mood and sadness. She was low in mood and did openly talk about suicidal thoughts, although she was not actively self-harming, nor had she ever self-harmed. Following discussions with Alice, she disclosed that her mother and the weight management team were aware of her difficulties. It was subsequently found that Social Services were involved and that the family were seeking additional help for Alice from the appropriate services. She was at the 98<sup>th</sup> centile weight for height at the time of the interview.

**3.2.7. Summary of the quantitative information obtained.** This sub-section will present the scoring guides for the questionnaires used in the present study to display what the scores mean regarding the participants' responses. Table 2 displays a summary of each participant's scores. For the RSES, scores between 15 and 25 are in the normal range, and those below 15 are in the low self-esteem range. Therefore all the participants except Kim fell into this range and Anna and Alice had the lowest scores, suggesting greater low self-esteem. For the EDEQ, a score of 4 or higher is considered to be in the clinical range for eating disorder psychopathology. Based on this, Anna, Sarah and Alice scored in the clinical range on the global scale, and all participants apart from Kim scored in the clinical range for shape concerns. For the weight concerns subscale, Anna, Becky and Alice scored in the clinical range. For the BSQ, a score of below 80 represents no body shape concerns, between 80 and 110 represents mild body shape concerns, between 111 and 140 represents moderate body shape concerns and over 140 represents marked body shape concerns. All participants except Kim reported some level of body shape concerns, and Alice scored particularly high compared to the other participants. For the SMFQ, scores above a sum of eight suggest

significant low mood. Kim was the only participant not to display any significant symptoms of low mood. Sally scored the highest and Becky scored just above the significant level.

**Table 2: Total scores for questionnaires on self-esteem, mood, body image concerns and disordered eating behaviours**

	Sally	Kim	Anna	Sarah	Becky	Alice
RSES	12	20	7	14	11	7
EDEQ Shape concern Subscale	5.63	0.125	6	5.12	5	5.62
Weight concern subscale	3.6	0	6	3.8	2.4	4.2
Global scale	3.65	2.72	4.25	4.03	3.65	4.41
BSQ	168	63	162	148	140	207
SMFQ	23	6	14	9	10	19

Key:

RSES: The Rosenberg Self-Esteem Scale (Rosenberg, 1965)

EDEQ: The Eating Disorders Examination Questionnaire (Fairburn & Beglin, 1994)

BSQ: The Body Shape Questionnaire (Cooper, Taylor, Cooper & Fairburn, 1986)

SMFQ: The Short Mood and Feelings Questionnaire (Angold, 1995)

### 3.3. Thematic Analysis Findings

The aim of the interviews was to explore the issues associated with being an obese youth and to identify features associated with this problem. The participants' narratives regarding their understanding of being obese were considered in relation to the following

questions:

- 1) How do obese young women seeking treatment for weight loss describe their body image concerns, and what is the nature of these concerns?
- 2) How do obese young women seeking treatment for weight loss talk about their emotional experiences?
- 3) How do obese young women seeking treatment for weight loss talk about their disordered eating behaviours?

It is important to note that the interview schedule was designed to prompt conversations on topics such as body image concerns, disordered eating behaviours and emotional difficulties, therefore the themes that have been created were guided by this.

Although the young people's descriptions of how they became obese, their experiences of being obese and how this affected their lives varied, common themes were identifiable. Five out of the six participants focused on the negative aspects of being obese whilst one reported not feeling unhappy about their weight and was in fact glad they were not 'skinny'. The aforementioned five participants had a strong desire to be thinner. Three of the six attributed their weight gain to health-related problems. There were also common emotional reactions to being overweight combined with negative perceptions and cognitions regarding their weight and shape, as well as negative beliefs regarding how others view them. Five of the participants were self-critical and also fearful of others' criticisms. The participants commonly identified themselves as being different to their peers and described how they felt this impacted on their relationship with the social world. The themes presented will be broadly grouped into three areas, each containing related subthemes:

1) Obesity and self-perception

- Negative perceptions regarding weight and shape

- Body parts perception
- Negative cognitions
- Self deprecation
- Behavioural consequences
- Desire to be different

2) The role of food and emotions:

- Emotional difficulties and emotionally driven eating
- Disordered eating behaviours

3) Obesity and others perception:

- Wider society and negative perception
- Social isolation

The themes were identified and developed in line with Boyatzis's (1998) inductive approach and with Kvale's (1996) seven stages of qualitative interviewing and analysis, described in Chapter Two.

The following extracts (quotations) have been selected from the interview transcripts to provide examples of the themes identified. All of the transcripts have been made anonymous and the participants will be referred to as Sally, Kim, and so forth to maintain anonymity. There is also some commentary extracted from the researcher's log book. The log book was compiled during the data collection and analysis phases. It was used to map the research process and includes information on recruitment, interactions with families and the weight management team, and post-interview thoughts and feelings. It also includes some reflective commentary on the process issues evident at particular points in the interviews and the researcher's interpretation of what was occurring. This is written in the first person.

The extracts taken from the transcripts are presented with a number of words underlined. This underlining indicates that the participants were upset or tearful, which was evident in their tone of voice. This is designed to display the emotional aspects of their narrative. Some extracts have ellipses between the sentences ('...'), which indicates that some of the transcription is missing, such as the researcher's responses to the participant's narrative, for example 'hmm hmm, okay', or a continuation question, for example 'Can you tell me a bit more: how, why?' There are points in the extracts where the researcher asked a question that is related to the theme that arose. This is displayed as 'INT:' followed by what the researcher said ('INT' refers to the interviewer). Brackets were also used when the participants cried, for example '(Kim started to cry)'. Square brackets were used to make it clear what the participant was referring to, for example '[referring to her father]'.

### **3.3.1. Obesity and Self-Perception**

This broad theme related to internal thoughts and attitudes regarding weight, shape and self-perception, and the consequences of these which included avoidance behaviour. At the core of these internal thoughts was self criticism. For example, a common theme identified for five of the six participants was negative thoughts and feelings they had regarding their body image (weight and shape concerns). All but one of the participants disliked specific parts of their body. Sally, Sarah, Alice and Anna's scores from the BSQ all indicated they had marked body image concerns and all participants but Kim scored in the significant range for shape concerns from the EDEQ questionnaire. The consequences of these thoughts and attitudes caused some to avoid activities where their bodies would be on display (for example, swimming and PE). There were three participants who described suicidal thoughts associated with their negative self-perceptions regarding their weight and



shape and two of these had made attempts on their lives in the past. The identified themes and subthemes will be presented below.

**3.3.2. Negative self-perceptions regarding weight and shape.** This theme was common amongst five of the six participants and related to two different aspects of body image concerns; perceptual (how participants perceived their physical weight and shape) and cognitive (participants thoughts and attitudes regarding their weight and shape). Some of their remarks indicated extreme negative body image concerns. There were many negative thoughts and attitudes the participants expressed in relation to their body shape. These discussions also evoked strong emotions regarding weight and shape which will be presented below.

**3.3.2.1. Body parts perception.** Sally stated that she liked only her height when asked if there was any part of her body she liked:

*“Well I like my height and that’s it.”* Sally

In contrast to Sally, Anna and Sarah were able to point out more parts of their body they liked:

*“My face body, my face bit ... yeah my hair.”* Anna

*“From my shoulders up ... I’m happy ... it’s going sound quite weird actually but my boobs ... my calves ... and my eyes.”* Sarah

Becky was unable to identify any parts she liked:

*“I’m still over weight I’m not happy with what I look like.”*

INT: *Okay so do you like your body shape?*

*No not at all.*" Becky

Anna, Sarah and Becky also identified similar areas which they disliked:

*"... Probably my stomach, and my tummy area ... and probably my thigh bits."* Anna

*"... My tummy I absolutely hate ..."* Sarah

INT: *If you could change anything about your body would you?*

*Yes ... my belly ... and my legs cos they're really fat (laughs) ... I don't really like very much.*" Becky

Alice expressed extreme negative feelings when she was asked what she disliked about her body:

*"Everything ... my stomach ... and my arms ... my arms are so baggy and they are so big and sometimes I just have to wear a jumper ... and I wear a lot of jackets ... my wrists and my arms ... I don't understand cos my mum's wrists and ankles are really small and ... sometimes I feel like just get like a scissors or a knife and just chop it all off."* Alice

Sally also stated extreme negative feelings regarding her body:

*"I've had days when I just want to get a knife and cut the fat off to make myself look perfect."* Sally

It seemed Sally was making a value judgement about herself at this point in the interview in relation to her body weight and shape. This notion of perfection is raised again and further explored in relation to Sally's cognitive aspects of body image in the following section.

Alice and Sally were unhappy with most of their body parts. Their suggestions of cutting or chopping off their 'fat' conveyed their extreme dislike of these body parts. Alice also compared herself to her family members, which the other participants did not do. She described how she was different from her mother in particular, further emphasising her sense of being different. Both participants also scored in the high range for low mood and body image concerns from the SMFQ and BSQ and body shape subscale score from the EDEQ. Further references to self-harm will be explored in a subsection exploring self-deprecation.

Kim was the only participant who stated she liked her body parts. She was more positive than all of the other participants:

*"I just like the fact that I'm not too small and I'm not too big."* Kim

Kim had lost over two stone in weight and was the only participant throughout the interviews found to be positive regarding her perception of her weight and shape.

In summary, five of the six participants described parts of their body they disliked and struggled to identify parts they liked. Their perception of their body parts related to the perceptual aspects of body image (e.g. how one rates one's body parts, as described in Chapter One). For two participants, their strong dislike of particular body parts evoked extreme negative feelings, and suggestions of 'cutting' and 'chopping off the fat' further conveyed their dislike. Kim was the only participant who did not have negative perceptions regarding her physical body parts.

**3.3.2.2. Negative cognitions.** The participants' negative cognitive perceptions (beliefs and attitudes) and how they interpreted these in relation to their self-worth was a dominant theme identified for five of the six participants. The participants were critical of their weight and shape and in some cases these discussions evoked strong emotions for the participants during the interview, which will be presented below.

Sally stated:

*"Well I'd like to change it [my weight] cos it's like, it puts me down it puts me all moody and I sometimes take it out on my friends and I don't want to take out on them.*

INT: *So do you like how you look? Do you like your body?*

*Well I like my height and that's it. I'm appalled at everything else."* Sally

Sally expressed that her weight affects her mood, which in turn affects how she treats her friends. She also stated that she was 'appalled' by her body, and at this stage during the interview she became upset.

Becky also held negative views regarding her body and stated that she viewed her weight and shape as 'bad' and that this was directly related to her confidence:

INT: *how do you view your weight and shape?*

*Bad ... I'm not happy with what I look like or how I feel as well cos I'm not very confident ... I think I act like I'm more confident than I am really cos it's just easier that way I think".* Becky

She stated that she acts as if she is confident externally, but is not internally, due to her weight. Acting confidently, she suggested, made things easier.

Only one participant, Kim, stated that she was not concerned about her weight and shape. She also had a more positive body image perception. This was strikingly different to the other participants. Kim had lost over a stone in weight and had originally gained weight as a result of ill health. When asked about how she viewed her weight and shape, she stated:

*“I’m not really fussed, I don’t really mind. I’m not unhappy with it ... but I’m not really happy with it ... kind of in the middle”.* Kim

*“I want to be smaller but I don’t want to be like too small, because I was ill I went like really skinny ... and if I go really skinny it makes me feel like I’m ill ... so I want to be smaller but not too small”.* Kim

For Kim, being ‘skinny’ had negative connotations and associations with illness. Kim’s weight gain had occurred as a result of her ill health and her taking prescribed steroids. The reason why Kim did not want to look ‘too small’ was that looking small had associations with her physical illness.

Alice and Sarah also described their weight gain as a response to a physical illness, but not as a response to medication. The opposite was the case for Sarah. She had a strong desire to be skinny and to continue to lose weight. Sarah, like Kim, had lost a substantial amount of weight, and she attributed her weight gain to her fracturing her spine, coupled with a friendship break-up and the loss of a friend to cancer. Sarah appeared to have reacted differently to Kim regarding the weight loss and had a strong desire to lose weight:

*“I personally ... feel I’m morbidly obese ... ever since I gained me weight ... all I see is the proper skinny, you can see the ribs and that’s the look I want”.* Sarah

Sarah was describing two contrasting extreme body shapes. She identified herself as the ‘morbidly obese’ person but desired to be the ‘skinny’ person. She also suggested that she

was more focused on ‘skinny’ people, as she was frequently noticing individuals with that body shape.

In summary, five of the six participants expressed strong negative thoughts and beliefs regarding their weight and shape, and this impacted on their self-worth and confidence. Only Kim viewed being skinny in a negative way, as this reminded her of when she was physically unwell and so held a negative connotation for her.

**3.3.2.3. Self-deprecation.** This subtheme was identified as it captured the more extreme negative thoughts and associated behaviours that three of the six participants described which were related to suicidal thoughts and self-harm.

Self-harming behaviour was not a topic to explore in the original interview schedule. However, after conducting the first interview, where suicidal thoughts were expressed by the participant, it seemed important to explore this further with the other participants. Some volunteered this information themselves by expressing that they felt like they could not go on, resulting from low mood, bullying, or being overweight.

The ways in which suicidal ideation and self-harm were talked about by the participants will be illustrated below. It is important to note that where relevant the researcher took the appropriate actions in all situations where any risk was identified.

Sarah did not express suicidal thoughts and was not self-harming, although she had experienced such thoughts in the past when she had been heavier:

*“... I’m not going to lie when about 2 years ago I did [have suicidal thoughts]... but that’s when I was at my biggest stage, but now I’m fine...”. Sarah*

Anna expressed how she had self-harmed in the past but would not do it again. She also took an overdose two years ago, following the death of her grandmother:

*“... I wouldn't say as much as for overeating but yes I have done it quite a lot of times actually [self- harmed].*

INT: *And is it something that's connected to food and to your weight and shape or not?*

*Sometimes ... I kind of self-harmed when I was depressed ... with spray cans [aerosol sprays] and burned my skin ... and then I got really depressed. It was right near my birthday in fact it was like 2 or 3 days before my birthday that I took an overdose last year.*

INT: *Okay and was that connected to just being sad?*

*Yeah, to food and being sad and ... being lonely I kind of think ...*

INT: *So what about now, do you still self harm?*

*No, I think about doing it but I don't". Anna*

Anna stated that it was not only her weight that caused her to self-harm, but also a combination of loneliness and depression, particularly at a time that was associated with her grandmother's death.

Sally also described times in the past when she had thoughts of harming herself:

*“ I've had days when I just want to get a knife and cut the fat off to make myself look perfect ... it was directly after my mum left and I started to gain this weight and I was like what have I done, my mum left and she's never coming back and I realise that now and I just looked down on myself I was just like, well I need to go, I'm going to get a knife and cut this fat off to make myself the perfect figure for everyone*

INT: *have you ever done anything?*

*I self-harmed a couple of times because of bullying ... just scratches...*

INT: *And have you done it since?*

*No". Sally*

Sally acknowledged that her weight gain and self-harming thoughts were directly associated with her mother leaving. She did not express anger or criticism towards her mother; rather she self-criticised ('what have I done'). There was also a suggestion of self-blame in her description of wanting to be the 'perfect figure for everyone', suggesting she was not perfect in her current state.

Alice described, in the context of comparing herself to her mother, how she wanted to take scissors and 'chop off' all her 'fat'. She was highlighting how she felt she was different to her family in terms of her appearance:

*"... sometimes I feel like just get like a scissors or a knife and just chop it all off.*

INT: *Have you ever self harmed?*

*Well sort of, I've sort of like tried it but it's not for me ... you can self-harm by eating so that's what I do ...".* Alice

Alice was the only participant who interpreted her obesity and overeating behaviour as a form of self-harm. This suggests that Alice was using food and overeating as a form of punishment or as a form of escapism and release from her emotions, as has been identified in literature on the function of self-harming behaviour (Horne & Csipke, 2009). She also expressed that she was unable to actually cut herself and self-harm as she had tried in the past and was unsuccessful:

*"Sort of tired to cut myself ... I couldn't do it cos it really hurt ... well sometime I feel I will ... there's always something stopping me but I don't know what ..."*(Crying) Alice



This comment came at the end of the interview, and I became worried about Alice and her well-being after. I informed the weight management service and her family, and it became apparent that social services were involved and the family were seeking appropriate additional help.

In summary, some of the participants reported suicidal thoughts in relation to their weight and others had a desire to ‘cut off the fat’. The motivation appeared to come from a form of self-criticism and could also be considered a form of punishment. However, it was not just the obesity that was causing these suicidal thoughts; it appeared to be a combination of low mood, low self-esteem and self-criticism, as well other difficulties they were encountering at that time in their lives

**3.3.2.4. Behavioural consequences.** Another theme that was identified was the behavioural consequences associated with the negative cognitions presented previously. For example, some participants avoided looking at their reflection in mirrors, and others avoided certain situations due to a fear of being criticised by others and so being made to feel self-conscious. Also, four of the six participants expressed how they struggled when their body was displayed in public, especially when taking part in activities such as swimming. Examples will be illustrated in the extracts below.

Sally was particularly emotional and started to cry when she was describing how she felt when seeing herself in mirrors:

*“If I stand and look into a shop mirror or into a reflection, I just like see, oh that’s not going to change, I just see a massive blob, and it makes me feel real worse about myself cos I know that it’s me. (Starts to cry)” Sally*

There was a suggestion of a defeated belief that her image was ‘not going to change’, followed by the realisation that she did look like a ‘massive blob’ in her words. Sally was very emotional at this point in the interview. When asked if she avoided mirrors she stated:

*“ I only have a tiny little one to do my makeup and that’s it,*

*INT: When you walk past a shop and you catch yourself, how does that make you feel when you see how you look?*

*Heart broken ... cos on Saturday I just looked at the mirror and I was just like, what have I become? Because I used to be so energetic and things and now I am just like this”. (Starts to cry) Sally*

Sally avoided mirrors, as this forced her to face her reflection and her weight gain.

*Sally said these things 11 minutes into the interview and I was struck by her negativity towards herself and her body. I had not anticipated that so early on in my first interview I would be uncovering such strong emotions (taken from log book).*

For Sarah and Becky also, seeing their own reflections was a cause of great distress, and they struggled to look at themselves in mirrors:

*“ So seeing myself in a reflection is just a nightmare unless its head up”. Sarah*

*“If I see myself in the mirror I’ll just like put clothes on quickly cos I don’t like what I look like ... I find it hard to just like look at myself in the mirror if that makes sense? ... I just don’t like what I look like without clothes on.” Becky*

Not only did some of the participant's struggle looking at their own reflection, they also struggled to different extents regarding their body being on display in public. Four expressed that they actively avoided going swimming or doing PE, as these activities involved being seen by others, which made them feel uncomfortable. For example, Sally and Anna described how it was difficult for them to display their body in public, as others might see them and judge them negatively. Sally went to great lengths not to let her body be seen by others, and Anna was fearful of others making comments:

*"Yeah I try to avoid it [swimming] because I don't like people seeing me even if they don't know me, I just don't want them to see me."*

INT: *So what about if you were to go on holiday and there was a beach or swimming pool?*

*Then I'd like quickly like dive into the swimming pool and that's where I'd stay. I went on holiday in July and I stayed in the pool for about 10hrs every day".* Sally

*"So I kind of don't do PE or don't get changed in front of everyone else ... cos I don't want them to see and so they don't take the piss".* Anna

Sarah was more concerned that she might see herself, which is the reason she gave for avoiding such activities. She echoed what Sally had mentioned before regarding her seeing her reflection, which forced her to face herself, in relation to her weight and shape. It is a possibility that Sarah was also reminded of her weight gain and her body shape when she saw her body without clothes on. This may be why she avoided such activities.

*"I can't go swimming because as soon as I take my trousers off and I see actual skin ... I can't, I hate it".* Sarah

Kim was the only participant who did not avoid PE or swimming and did not struggle to get changed in public:

*“No. I like that sort of thing”*. Kim

Kim did not appear to have any concerns regarding her weight, shape and body image. She did express that she did not enjoy PE; however, she did not avoid it and she did not attribute her lack of enjoyment to how she looked, as did the other participants:

*“I just don’t enjoy it ... cos most people are like smaller and they can do more ... I think it’s just a struggle because I get like out of breath quicker than everyone else does”*. Kim

Kim referred to how her size, in relation to height (Kim described herself as short for her age during a different stage of the interview) affected her ability to take part in sports, and it was this and not the negative views she held about her body that she gave as a reason for not liking PE.

In summary, four of the six participants struggled with looking at themselves in mirrors, as this reminded them of their weight and made them feel unhappy about their weight gain, causing some to be self-critical. They also avoided situations where their body would be on display in public, for fear of judgement by others or for fear of reminding themselves of their weight gain.

**3.3.2.5. *Desire to be different.*** This sub-theme related to how the participants wanted to look different, wanting to look like someone else or seeing others and wishing they had a similar appearance. This theme related not only to how they wanted to be different but also to

what they valued as being positive in terms of body weight and shape. Four of the six participants stated that they wished to look like others, illustrated below:

*“I wish that I was my mate sometimes ... she looks perfect ... she’s not overly skinny and she’s not overly fat, she’s just right which I think is the perfect ideal weight.*

INT: *So that’s something that you kind of aspire to, something you would like to be? Yeah”.* Sally

Sally used the word ‘perfect’ repeatedly in her narratives, especially when describing other people. She conveyed how she was different to others as she was not perfect, and how her friends were perfect, further emphasising how being overweight separated her from her peer group. Sarah also expressed a strong desire to be different from how she was at present. She had ideas about the ideal weight and what people should look like, in contrast to Sally.

*“ I want to be that skinny where you look like you could just break if someone pushes you.*

INT: *So do you feel like that’s what you want to look like?*

*That’s the look you should have”.* Sarah

Sarah expressed how she watched others and wished she had similar features. Comparing herself to others caused her to feel more negative about herself, and this, in turn, motivated her to lose weight.

*“I was sitting in the cafe earlier and all these people walked passed and I was like oh I wish I had her legs or I wish I had her bum ...*

INT: *How does that make you feel?*

*Really bad about myself but then it makes me more eager to lose it”.* Sarah

In a similar way Becky also looked at others and wished she looked like them:

*“I like looking at celebrities and ... some of my friends that are really pretty like when I see people in the street ... I think ‘oh they’re really pretty, I wish I looked like them’ ... I’m not saying all fat people are ugly ... but I think well I see it that like ... I’m more over weight so less people think I’m pretty”.* Becky

Becky linked the value of attractiveness to weight and expressed how she believed that she is overweight and therefore fewer people find her ‘pretty’. Becky’s own perceptions regarding others who are overweight were also negative. Her comment reflects the cultural and societal norms of attraction and how, in Western society, beauty and attractiveness are strongly associated with weight (Puhl & Brownell, 2003).

Alice also looked at others and wished she looked like them; however, she placed emphasis on one person:

*“Like there’s this girl ... at school and she’s like really pretty and like got a really nice body and like really nice clothes ... and she gets new Blackberry every time it comes out ... and she’s really popular and she’s like the dream girl to be and I’m like why can’t I be like her? And she’s never been bullied or anything”.* Alice

It was not only the girl at schools weight that Alice appeared to admire, but also her lifestyle.

*At this point in the interview I noticed how sad Alice had become, how her facial expressions had changed and how she had become tearful. I started to feel a great sense of sadness for Alice. I was interpreting her narrative as that of someone who*

*was struggling to find where they fit amongst their peers. This sense of being so different and unpopular was something that also reminded me of some of the clients I had worked with in a therapeutic manner during my clinical training on my adolescent eating disorders placement. I started to consider that there were certain similarities between the experiences of being obese and that of suffering from an eating disorder during adolescence (extracted from the log book).*

Kim was the only participant who stated she did not wish to be or look like anyone else.

In summary, all but one participant expressed a desire to look different. From the above extracts it could also be argued that the participants' desire to look different was linked with the desire to be accepted amongst their peers. Some stated they wanted to be popular, as they were different and somehow not accepted due to their weight. Others commented on how they placed a value on appearance and how this was influenced by being overweight.

**3.3.3. The Role of Food and Emotions.** The following broad theme of the role of food and emotions that has been identified relates to the second and third research questions: how do obese young women seeking treatment for weight loss talk about their emotional experiences? And, how do obese young women seeking treatment for weight loss talk about their disordered eating behaviours? Within this theme there were two sub-themes identified to capture the various ways in which food, emotions and disordered eating behaviour were significant and related for the participants:

- 1) Emotional distress and emotionally driven eating (referring to turning to food as a form of comfort in response to distress)
- 2) Disordered eating behaviours

Five of the six participants described food as serving a function that was emotionally driven. This was expressed in terms of food providing a source of comfort and/or fulfilment at times of emotional distress. Sally, Alice and Anna also scored high for low self esteem and low mood based on the SMFQ and RSE scores. Three of the six participants described how they struggled and turned to food when someone close to them had died. One participant expressed how she turned to food when her mother left the family. The other common reason for emotional distress that was identified was bullying. Three of the six participants reported that they had been bullied for their weight in the past during the interviews. Two of the same three also stated that they were still being bullied regarding their weight at the time of the interview. Being bullied about their weight evoked negative thoughts and feelings in the participants which, on occasion, resulted in them eating to make themselves feel better. These themes will be discussed in the following sections.

**3.3.3. 1. Emotionally distress and emotionally driven eating.** Turning to food as a source of comfort or fulfilment in the context of unhappiness or using food as a way to escape the causes of unhappiness were common themes expressed by five of the six participants. For example, Becky expressed the following:

*“I turn to eating a lot like with anything but I don’t normally eat when I’m happy ... if that makes sense ... I don’t think I need the food but... when I’m sad ... it’s like something is there [food] that’s like making you feel more fuller but when I’m happy ... I don’t need the food”. Becky*

Here, Becky expressed how food was directly related to her mood and that feeling unhappy resulted in her needing the food to improve her mood, to make her feel fuller and thus content. This could suggest that when she is unhappy she feels empty and eating fills this void.



Sally also described how food was related to low mood, but eating for her served a different function. She used food to avoid talking about the difficulties and sadness she was experiencing at the time of her mother leaving:

*“cos my dad was upset about it or he wouldn’t show it and he’d buy food so it would make me eat more, so we would both comfort eat ourselves because we didn’t want to talk about it [her mother leaving]”.* Sally

Sarah also confirmed that in response to her weight increasing she became more depressed, and how weight gain and low mood were associated:

*“It got to a point where I was so depressed that I couldn’t actually get to school I was so sad that I didn’t have the energy to get out of bed or ... I just cried ...”* Sarah

Kim was the only participant who did not comment on food being related to her mood. The reference she made regarding the role of food and its function was in the context of her weight gain. Specifically, she noticed she ate more when she was alone or bored:

*“... I think it’s just cos I used to eat when I came home from school cos my mum’s never there ... it was either because I was bored or cos I was hungry.”* Kim

Of those participants who identified using food as a form of comfort/fulfilment, three attributed their unhappiness to someone dying and one related it to her mother leaving home. For example Anna and Becky both lost their grandmothers and Sarah lost a close her friend to leukaemia. All three participants identified these times in their lives as periods when they gained a lot of weight.

*“... I found it really hard [pause] round feb ... half term of 2009 ... cos I went to go and see my nan up in hospital ... she had septicaemia ... I just couldn't see her cos I was like really upset and everything and I kind of find it ... hard round February January time and around my birthday as well because I was born on the same day as my nan passed ... I must admit I do eat more [during that time of year] ... but I have a feeling that I control it [control the eating] ...” Anna*

The extract above suggests that Anna was struggling emotionally with the loss of her grandmother and was eating more due to the distress it caused. However, she stated she was in control of her eating. Like Anna, Becky found comfort in food also:

*“INT: So do you find when you are generally upset you turn to food?”*

*Yeah a lot.*

*INT: Has it always been like that?*

*I think so like when I lost my nanny I ate a lot ... it's weird like if you talk to someone they talk back ... when you eat food there's nothing like there like bad coming from it. You're just eating and eating and eating”. Becky*

In contrast, Sarah's experience of loss not only evoked sadness but also made her feel that she was wasting her own life by not leaving her house due to her weight. Sarah had described at a different stage in the interview that she avoided leaving the house as she did not want others to see her as she feared they would criticise her for her size. This made her feel depressed and this triggered her to eat in response to her low:

*“... He had leukaemia [a close friend at school] ... and then he died and I went quite sad because I thought I'm wasting my life sitting at home because of my size where he had a really good life ... and died from something like that and (pause) which then got me depressed and I ate a bit more, you know?” Sarah*

Sarah also described how she used food as a form of comfort due to a friendship break-up when she was younger. This resulted in her feeling lost, which she identified as a main reason for her turning to food:

*“I was never big when I was little ... it sounds really silly but I got into a big fight with my best friend ... and I then went into comfort eating and I gained I don’t know a stone or two”. Sarah*

*“... so once I lost her, [best friend] I was lost myself ... ” Sarah*

Sally described how her weight problems started and attributed them to her mother leaving her family:

*“Since my mum left ... I was comfort eating because I was only 10 and I didn’t realise what was going on ...”. Sally*

*I wondered whether Sally was also feeling lost as a result of her mother leaving, and whether this was similar to what Sarah was expressing (taken from the log book).*

In summary, for these four participants food became something that they turned to when they were feeling emotionally distressed (due to a loss) and something that related to a sense of the ‘need to feel fuller’ (described by Becky). The participants used the term ‘comfort eating’ and some suggested they turned to food because they did not know what else to do with the difficult feelings they were experiencing. It could be argued that eating provided these participants with one way of coping with loss or managing difficult feelings, as food did not talk back and offered a sense of fulfilment.

Additionally, some participants described how food provided comfort and fulfilment in the context of bullying and the distress this caused. For example, Sally, Alice and Anna were bullied in the past for their weight at school. Becky and Sarah described how they were teased due to their weight. The bullying and teasing resulted in some participants comfort eating. Sally stated, for example:

*“People pick on me for my size which makes me eat more.”* Sally

Sally also described how the bullying made her feel:

*“Upset ... I go home and I just find something to eat that ... will comfort myself, like sweets or like a fizzy drink or something”.* Sally

Sally made the link between the bullying and her comfort eating. Alice also stated how she had experienced bullying in relation to her weight and how she was being bullied on the Internet through social networking sites, such as Facebook and BBM, regarding her weight. Alice was very emotional at this point in the interview and cried when she talked about the bullying:

*“I’ll eat, like if I’m upset I’ll eat ... there was this girl XXX, when I was on BBM ... and she sort of said something about me, I said like ‘go away’ ... then it got onto weight ... then she said ‘I’m ...skinny and you’re like a size extra extra large’ ... and then she put it on Facebook and everyone else was liking it and everything ... and I was just really upset and I just felt like eating lots of chocolate”.* Alice

At this point in the interview a brief break was taken.

*I felt upset and angry with the bullies and felt a sense of sadness watching Alice cry. I asked if she wanted to stop the interview but she stated she was fine to continue. It was obvious that Alice's bullying was still ongoing and affecting her (taken from log book).*

Alice's first reaction when she was upset following the bullying was to eat chocolate, and not tell anyone or talk to anyone about her feelings. This was similar to Becky also, who stated that she turned to food to help her with difficult emotions, rather than talk to someone and seek help in that way.

In summary, two of the participants who were bullied recognised that they comfort ate as a result of the bullying. Bullying regarding their weight and appearance may have impacted on the participants' own perceptions of their bodies, adding to their negative body image concerns described in section 3.3. It was evident that the bullying caused negative emotional reactions in all participants who were bullied, especially Alice. Alice was still being bullied and was struggling to lose weight on the weight management programme (as noted by the weight management team).

*I wondered whether the negative emotions the bullying caused may be contributing to her weight maintenance, as she was not able to discuss any of these issues with the weight management team and was not receiving any support to overcome the negative thoughts and feelings she was experiencing (taken from log book).*

**3.3.3.2. Disordered eating behaviours.** Another theme that was associated with the role of food and emotions was the participants' descriptions of their eating behaviours. This was directly linked to their low mood and unhappiness as some described overeating or binge eating when they felt low in mood. One participant described limiting her food intake and engaging in self-induced vomiting.

It is important to note that, for the purposes of this thesis, binge eating was defined to the participants as eating a large quantity of food in a specific period of time that is larger than most people would eat in a similar period of time and having a sense of losing control over their eating (Diagnostic Statistical Manual of Mental Disorders, DSM-IV, 1994).

Binge eating behaviour was described as a way of managing low mood and distress. Four of the participants stated they engaged in binge eating episodes resulting from having 'bad days' or as a result of distressing events and in response to their negative feelings, illustrated in the following extracts:

*"Sometimes like say if I like had a really bad day at school and I get home ... and then I'll just eat and eat and eat and I don't really think about it until I feel I'm stuffed and then I've already ate it before I can think about it ... yeah it's just there and I'll just eat it".* Becky

*"... last week I was so wound up ... my mate, she like, burst out crying and everything had just gone wrong for me at school I literally had my tea then I had an ice cream then had like a snack bar, then I had like some caramel short bread all after each other just because I was so mad at what had happened at school"* Sally

Becky described eating in response to a bad day in an almost mechanical manner, with no thought regarding what she was doing – it was simply an action that she did when she became upset. In contrast, Sally described her binge eating as a way of managing her anger.

Sally went on to explain further why she binge ate and the function and role that food played in her life:

*“If it’s been a really bad day then I go and just sit and eat to make the pain go away ... it does for about a couple of minutes then it comes all rushing back”.*

INT: *So what’s the feeling that it creates in you?*

*That I feel better about myself ... like, I’ve eaten something then I go well, it’s taken the stress away, it’s like a drug to me and it’s like really bad but it’s like I will sit there and I’ll eat it and I feel bad, I feel good about myself after for about 10 minutes then all this like emotional side just comes rushing back ... like I have visions of the bullies just running in circles, going and calling me all these names, and like my mum leaving and bringing back the emotional side of me ... and I eat some more”. Sally*

Sally described her eating as something that helped ‘hide the pain’. She also referred to food as a drug. She described her relationship with food as being of an addictive nature and conveyed the power that food had in her life. Her descriptions of food providing both positive and negative feelings as well as of the thoughts and images of the bullies exemplified how she was struggling to cope emotionally. She acknowledged that food did not always provide a positive feeling in the long term; nevertheless, the binge eating offered immediate relief from distress to ‘hide the pain’. The idea of food being a drug was referenced by one other participant, Alice:

*“Well it’s like that small chemical that makes you feel good ... like the taste makes you feel a little bit good ... then you feel worse ... it’s sort of like ... if someone’s on drugs, they are like that ... it’s sort of like a high, then it’s gone, then you want more and you’re hooked on it ...”. Alice*

Alice expressed a direct comparison to drugs and addiction when describing her relationship with food. She also described an additional problem she had developed in relation to this. She had started to steal money from her mother's purse in order to buy food to binge eat:

*"I used to steal money out of my mum's purse to get something ... like a big bar of chocolate ... as much as I could buy with the money ... then I'd go and eat it ... in my room and like close the door and eat it ... and then like cry ... the next morning I'd be like I'm so fat ... then that makes me do the whole thing again, it's like a vicious cycle".* Alice

Alice, like Sally, was aware of the 'vicious cycle' that she was engaging in.

*When describing this, her tone lowered and she stared blankly at me* (taken from the log book).

Alice also explained how she had run away from home as she started feeling guilty for stealing and the problems it was causing the family:

*"I run away ages ago ... cos I didn't feel (pause) good enough (pause) for my mum or anyone ... there's no trust between us so I'd rather run away and she'd be better off without me..."*. Alice

Alice expressed a sense of letting people down, and being self-critical of her actions. In addition, Alice was the only participant to describe how she daydreamed when she felt low in mood as a result of either the bullying or the binge eating:



*“Well I sort of like go into day dream and think that I am skinnier ... I dream a lot like about me doing dancing and everything and being really skinny ... it’s really hard to explain ... I’m somewhere else like in a dream ... I’d be in like a trance ... it’s really hard to control ... it’s like someone else takes over me ”. Alice*

It appeared that Alice used daydreaming to disengage with her reality, as it was too painful or difficult to think about her real life. It could be also be a possibility that she engaged in binge eating to also disengage and distract herself from her negative feelings.

In contrast to the other participants, Sarah had developed a different relationship with food due to her weight loss (Sarah had lost over three stone) and was determined to continue to lose weight quickly. She was the only participant who induced vomiting and who limited her food intake to the extent that she stopped eating regular meals, as evidenced by the extract below:

*“... I’ve been stuck at this certain stone[she was stuck at a certain weight and was struggling to lose additional weight] ... and I’ve been stuck for like 2 months and nothing was changing it so I thought if I just cut my eating ... and then it got to a point where I would miss my breakfast, my lunch ... and I would have to eat my tea because my mum was there ... but as soon as I’ve eaten my tea I’d then have to go swallow it and then throw it up ... because I thought oh my god I’m now about to gain all this weight again which I’ve just lost ... ”. Sarah*

*There was desperation and sadness in her voice whilst she was describing her eating behaviour and she was crying and trying very hard to express herself clearly (taken from the log book).*

Sarah’s descriptions and the fact that she was struggling and using a compensatory method (self-induced vomiting) to help control her weight suggested she was engaging in

disordered eating behaviours that are associated with someone who has bulimia nervosa. This appeared to be triggered by her weight loss and her difficulties with continuing to lose weight. Sarah's relationship with food had changed from one that was comforting and providing a sense of fulfilment to one that could be interpreted as punishing and evoking a negative reaction. She was starting to have negative thoughts regarding what the food was doing to her body each time she ate:

*"INT: How does it feel when you put food into your mouth now?"*

*... like a really obese person that's shovelling greasy fatty food in her mouth constantly even if it's like an apple I have to have it cut up into tiny pieces ... yeah just some really big person sitting there with grease down their clothes, with like all ketchup across their face shoving it in even if it's like a little apple". Sarah*

The vivid imagery that Sarah used conveyed how powerful her desire was to not gain weight. This extract offered an insight into her own negative cognitions regarding obese people and how she perceived them. She did not describe engaging in binge eating episodes or currently losing control over what she was eating.

*Sarah became emotional and upset at this stage. I was struck by her fear of weight gain and how her descriptions of her apparent fear of food were similar to those I had heard from young people suffering from anorexia nervosa (taken from the log book).*

Also embedded in this theme of eating behaviours was the experience of guilt for three of the six participants. These feelings were related to the binge eating cycle and going from feeling unhappy to relief (as a result of eating), and subsequent distress again as a result

of over eating and the risk of potential weight gain. This is illustrated in the comments from Becky below:

*“INT: What does it do to how you feel if you are just eating and eating any ideas?  
Well at the time ... you feel a sugar rush when you are just eating the chocolates ...but  
after I think it makes you feel worse cos then you feel bad about the eating and the weight  
you have put on”. Becky*

Sally also suggested that she felt guilty regarding how much she ate. In contrast to the other participants she had different reasons for her guilt:

*“... I’m eating all this food and yet there’s like people out there who don’t have  
enough food and they ration it and I’m just like well I have all this food and I’m  
eating it all ... some people would do anything to have the amount of food I have and I  
just sit there and I just take advantage of it ...” Sally*

In summary, some of the participants did engage in disordered eating behaviours, such as binge eating, restricted eating and self-induced vomiting. The most common of these were binge eating in the context of low mood and using binge eating as a form of escapism, as something to block out the distress. This resulted in three participants feeling guilty and becoming low in mood following overeating, causing them to eat again as a way of coping with their feelings. This was described as a vicious cycle by the participants. Alice also described stealing money from her mother in order to buy food to binge eat and used daydreaming to escape from painful feelings and reality. What was evident was the power food had and how emotions were driving the binge eating. For one participant the fear of weight gain resulted in restricting food intake and triggering compensatory behaviour (self-

induced vomiting). For this participant, the fear of gaining all the weight she had lost was driving her disordered eating behaviour.

### **3.3. 4. Obesity and Others' Perception**

The theme of obesity and others' perception is related to the negative body image concerns expressed by participants. There were two different aspects that were expressed in relation to body image concerns;

- 1) The participants' views on how others perceive them and on wider society and negative perceptions
- 2) The consequences of this and the resulting social isolation

Both themes were common across five of the six participants and highlighted a different aspect of how they viewed their bodies. Their concerns regarding others' views about their weight may be related to the stigma attached to being obese in society. The consequences of this were that some of the participants experienced a fear of others' judgement and being criticised. This theme was related to social situations and how being in those situations (as someone who was overweight) would make the participants feel. This was separate to the avoidance behaviours described in the previous section, as this theme was concerned with social interaction and avoidance of going out and engaging with the participants' peers.

In the case of four participants, this fear of others' judgements resulted in the participants isolating themselves and not socialising with their peers, as a selection of extracts will illustrate.

**3.3.4.1. Wider society and negative perceptions.** Five of the six participants expressed how they believed wider society perceived them in a negative manner. The following three extracts illustrate this:

*“...I feel like they [other people] see me and then judge me straight away ... but I think that I’m a nice person but they don’t, I don’t think they want to take the time to get to know me ... because I’m big and stuff ...” Sarah*

*“... I think if I see a really fat person on the street I think lazy, like not lazy but I think like, you’re not trying with your weight ... and I think that’s what people think about me when they see me in the street ... cos I think if you are pretty like more people want to speak to you ...” Becky*

*“Well, I think if they are more thinner [than you] then they think the world loves them and like treats them different...”. Sally*

Sarah, Becky and Sally highlighted how they are not noticed as much as those who are slimmer and are treated differently to them. They felt that people make judgements about those who are overweight and do not want to get to know them as individuals, suggesting their weight created a barrier. Becky also admitted that she herself makes negative judgements about others in relation to their weight.

In contrast, Anna described how she is judged due to her aggressive behaviour she displayed during times of bullying, and not solely for being obese:

*“... because I’ve been aggressive with my anger and they don’t see the real me and they don’t see that I’m really nice and like really talkative and everything.*

*INT: ... When have you been aggressive?*

*Like if people say anything about my weight I’ll probably hit them ... when I was younger but I have learnt not to do that now”. Anna*

Anna was the only participant who stated she responded in an aggressive manner to comments about her weight. She suggested that this aggression may prevent her peers from seeing the ‘real’ Anna.

Sally mentioned not being accepted at school because she was not ‘skinny’ and therefore not ‘perfect’:

*“There’s a thing at our school that if you’re not right, like a certain weight or something you’re not perfect ...*

*INT: What’s perfect then?*

*Well like tall and skinny and ... that’s like perfect.” Sally*

Sally’s own interpretation of perfection involved being tall and skinny, which is linked to the stereotypical ideal body size in Western culture (Cash & Pruzinsky, 2013). Sally also went on to describe how her family viewed her in relation to her weight and shape:

*“Well they try and like cover me up with like baggy clothes, like buy bigger clothes and because they’re hanging off me he goes [referring to her father] I need to fill them so I eat more to fill them”. Sally*

Anna also referred to how her family viewed her weight and shape, particularly her father:

*“My dad kind of bullies me but I bully him in some ways. So he calls me worms cos I’ve got stretch marks on my stomach”. Anna*

Sally and Anna referred to two different responses they received from their fathers regarding their weight. Sally claimed her father buys her bigger clothes and then encourages her to eat more to fill them. Anna’s father called her names in relation to her stretch marks. It is important to note that neither appeared distressed when making these remarks during the interview.

*It was difficult to know whether these incidents upset the participants. I wondered after reading through their transcripts whether these incidents further added to both*

*participants' negative body image and their lack of confidence regarding their weight and shape* (taken from the log book).

Kim was the only participant who did not perceive wider society as viewing her differently in relation to her weight.

**3.3.4.2. Social isolation.** This theme was common in the comments of four of the six participants and related to how their weight prevented them from engaging with the social world around them. The participants expressed how they isolated themselves from society as they felt they could not face going out where others could see them. The extent to which social isolation affected the participants varied from extreme (not leaving the house) to more limited (not feeling comfortable going out with peers to a party). It appeared that fear of being judged by others combined with the participants' own negative perceptions of their weight and shape had resulted in them isolating themselves, as illustrated in the extracts below:

*"There's like things I wanna do ... like go out with my mates and like be happy with myself but I can't because I think oh if I wear this, too tight people or whatever people will be looking at me and going oh look at her she's not right ..."* Sally

*"I'm like a hermit crab ... I literally just stay in my house ... that's what everyone calls me, a little hermit ... obviously in the last few months I've lost 3 stone and 2 dress sizes ... so before I lost that I literally lived in my house, I'd only go out if it was urgent ... because I had no confidence in case people judged me"*. Sarah

For Sally the fear of judgement by her peers acted to reduce her confidence to go out with her friends and to socialise, whereas for Sarah the effects of this fear were more extreme. Sarah did not leave her house and became very isolated from her peers and the

world outside when she was at her heaviest weight. However, since losing over three stone on the weight management programme she has gained more confidence and was going out more. Sarah went on to describe her present feelings about social interactions with her peers. She expressed mixed thoughts regarding her body image, although her weight loss had a positive impact on her feelings regarding social interaction with her peers. She still, however, held contradictory negative thoughts about her appearance, possibly stemming from her beliefs and thoughts at the time when she was at her heaviest weight:

*“Obviously from what I look like last time I feel better ... I’m not completely happy but then I feel better ... I still do have that little demon on my shoulder saying ‘oh fatty, you know, get back in the house sort of thing’”. Sarah*

There seemed to be a struggle within Sarah, as suggested in the above extract. Her description of having a ‘demon’ making negative comments on her shoulder was a vivid illustration of how she struggled with her negative body image. The way in which she referred to herself with the words ‘oh fatty’ was also interesting, as it demonstrated another form of self-criticism and suggested a sense of not being worthy as she still felt she was overweight. It is also important to note that although she had lost the greatest amount of weight amongst the participants she still had the highest BMI weight for height and was still classified as morbidly obese.

Anna and Kim did not make any references to social exclusion due to their weight or shape.

In summary, four of the participants avoided certain situations, as they felt they would not fit in with their peers and would be judged negatively. Sarah’s case was particularly extreme: her fear of being judged resulted in her not leaving her house before she had lost over three stone. Since her weight loss she was less isolated; however, she still experienced



negative thoughts that sometimes prevented her from going out. Unlike the other participants, Anna and Kim did not comment specifically on their weight negatively affecting their social lives.

### **3.5. Interview Context**

This section will focus on the interview context and in particular the following aspects: the setting, the participants' reasons for taking part, the researcher-participant relationship and the researcher's position. All of these aspects were considered when the interviews were taking place and may have affected the information gathered.

**3.5.1. Setting.** All of the interviews were conducted in the weight management building in a private office. Although the researcher's role was clearly outlined to the participants and was separate from the weight management service, all of the participants were complimentary about and grateful for the service. The participants were familiar with the offices where the interviews were conducted, and this may have made it easier for them to disclose information more freely. Although the interviews were conducted in a formal office setting, it was surprising at how easily a good rapport developed with the participants. This may have been a result of the weight management team's style of working and conducting itself, as it was a friendly open environment where everyone was welcome. This welcoming atmosphere may have helped participants feel at ease.

**3.5.2. Researcher-participant relationship.** The interviews were jointly constructed between myself and the participants and were guided by the interview schedule. Initially, in the first interview, I found that I was less at ease with the participant and was more rigid with the questions I was asking. However, as the interviews progressed I managed to relax more and build on the responses I was receiving. I found it easy to build rapport with the participants, and that the informal discussion with the families before the interview helped with this. In all the interviews I felt a sense of sadness when the participants were distressed,

when they were describing all the things they disliked about themselves, and when they were describing risky behaviours.

**3.5.3. Researcher's position.** As outlined in the method section, I primarily approached this research as a clinical doctorate trainee, and a researcher whose aim was to obtain the required information to fulfil my clinical psychology studies. However, I am also a new mother, female and come from an ethnic minority background, all of which impacted on my approach and interpretations of the data. I am also at an early stage in my career, and my specialist placements have been with adolescents with eating disorders. I noticed that I adopted a similar style and approach to question asking and assessment in the interviews with the obese youths as I did with clients who had eating disorders. As a result of my clinical psychology training I sometimes responded and reacted in a therapeutic manner, but I was mindful of this. I found this to be positive, as there were risk-related behaviours that were described by the participants which required thorough assessment and post-interview action to be taken.

The log book provided me with the opportunity to express how I experienced the interviews and the interactions involved in recruitment. It also enabled me to reflect and question myself as well as the narratives.

### **3.6. Summary of the Findings**

This chapter has presented the themes identified from the interview narratives of six obese young women's experiences of being obese. The themes were created and identified by adopting a thematic analysis approach in conjunction with the researcher's reflective commentary. In order to stay true to the data and to enable transparency and coherence regarding the themes and how they were defined, the researcher used extracts from the transcripts and also from the log book to display the context in which the themes were being

identified. This was also used to convey aspects of the participant-researcher relationship that the researcher was experiencing.

There were three broad themes identified: 1) obesity and self-perception, 2) the role of food and emotions and 3) obesity and others' perceptions. Associated subthemes were identified that related to the broad research question and additional three research questions that guided this thesis:

How do obese young women seeking treatment for weight loss experience being overweight?

- 1) How do obese young women seeking treatment for weight loss describe their body image concerns, and what is the nature of these concerns?
- 2) How do obese young women seeking treatment for weight loss talk about their emotional experiences?
- 3) How do obese young women seeking treatment for weight loss talk about their disordered eating behaviours?

All of the themes identified were jointly constructed in the research interview context, and considerations regarding the motivation to take part, the setting and the relationship between the researcher and participants were presented. It was identified within the narratives that five of the six participants did have a negative body image, related to disliking body parts, negative cognitions regarding their weight and shape, avoidance of social situations, self-criticism and fear of the criticisms of others. Four of the five also described their relationship with food as emotionally driven, as being directly related to low mood and food being used as a form of comfort/fulfilment in response to feeling low (due to bullying or experience of a loss). The same four participants described engaging in disordered eating behaviours. Three of the four described engaging in binge eating and overeating and one described using compensatory behaviours such as vomiting to control weight gain. One of the

participants who described binge eating behaviour also stated that she had stolen money from her mother to buy food to binge eat, as well as experiencing daydreaming as a way of escaping from the negative emotions she was experiencing.

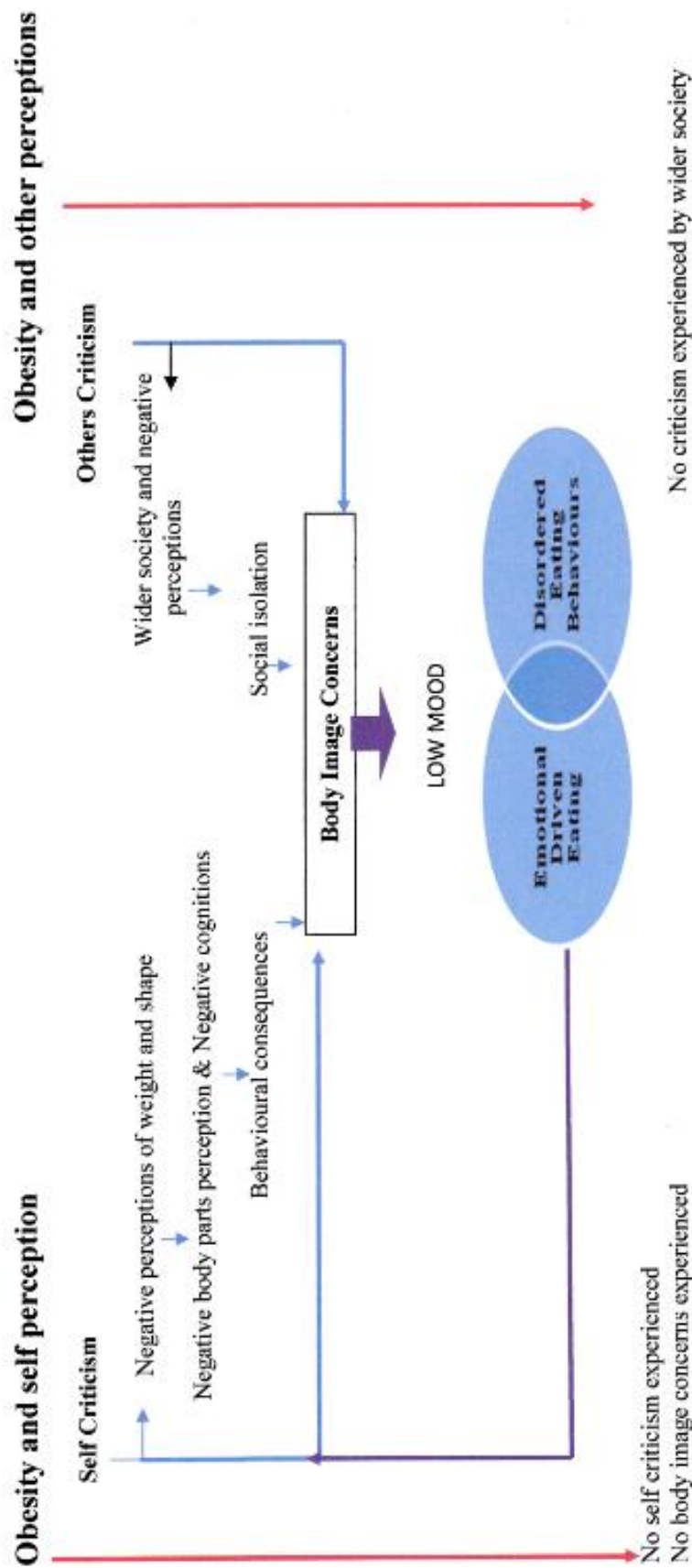
Embedded within their discourses were, for some of the participants, feelings of guilt, self-criticism and fear of criticism, which were further increased by bullying. Two participants also described food as a drug and something that they needed to combat negative feelings and a way offering a form of comfort in response to the emotional distress they were experiencing.

Also, the results obtained from the self-report questionnaires in relation to mood, self-esteem, body image concerns and eating disorder symptoms indicated that participants who scored above the normal range for body image concerns also scored high for low mood and low self-esteem. Interestingly, the participants who also reported engaging in binge eating behaviour were those who reported the greatest body image concerns and depressive symptoms. This additional information was used to contextualise the sample and further describe the sample. These findings were also in line with previous research pertaining obese women's experiences of obesity (Counihan & van Esterik, 2013), and may reflect the fact that all the participants were female and how females may experience additional psychological problems associated with their obesity due to cultural and societal influences that affect how weight and shape is perceived (Caprio et al., 2008).

Figure 8 offers a diagrammatic representation summarising the three broad themes identified. It demonstrates how the themes were linked in the context of how the six participants expressed their experiences of being obese young women. It also shows the cyclical nature and relationship between negative body image concerns, low mood and disordered eating behaviours. Consideration of the impact of the fear of others criticism are

also displayed. This diagram offers a way of presenting the themes identified and understanding how, for the participants in the present study, obesity was experienced.

Figure 8. The Experience of Obesity for Young Women



## **4. Discussion**

### **4.1. Introduction**

This chapter will commence with a summary of the study aims and findings. This will be followed by the findings being discussed in relation to existing research in the field of body image, psychological distress, disordered eating behaviours and obesity. Finally, the clinical significance of the findings and the study's strengths and limitations and future research considerations will be presented.

### **4.2. Aims of the thesis and study findings**

This thesis aimed to use qualitative methods to explore how obese young women experience being obese, and whether they express body image concerns, emotionally difficulties or describe disordered eating behaviours. This study was explorative as the aim was to understand what obese young women experience by providing them with the opportunity to 'tell their story' and to gain an understanding from their unique perspective.

Qualitative methodology was used and semi-structured interviews were conducted with six obese females seeking treatment for weight loss. The interviews were co-constructed with the researcher, within an interview setting and guided by the following research questions;

- 1) How do obese young women seeking treatment for weight loss describe their body image concerns, and what is the nature of these concerns?
- 2) How do obese young women seeking treatment for weight loss talk about their emotional experiences?
- 3) How do obese young women seeking treatment for weight loss talk about their disordered eating behaviours?

Thematic analysis was used to analyse the narratives and address the research questions by identifying relevant themes. There were three broad themes identified: 1) obesity and self perception, 2) role of food and emotions and 3) others perception of obesity. The first theme regarding obesity and self perception, addresses research question one, and displays the ways in which five of the six participants described having a negative body image, resulting in some having negative thoughts regarding their body shape and weight. The second theme relates to research question two, as it was identified that some of the participants described experiencing low mood and this triggered binge eating behaviour that further impacted on their obesity. The second theme also related to research question three, as some of the participants described their eating behaviours as being emotionally driven and also described disordered eating patterns (including binge eating and restriction of food intake). The final theme, others perception of obesity, relates to the overarching research question that drove this thesis, how do obese youths seeking treatment for weight loss experience being obese? Five of the six participants expressed how they were criticised by others and experienced social stigma as a result of being female and being overweight.

#### **4.3. Comparisons to existing research**

The study findings will be considered in relation to existing research on obesity and associated body image concerns, emotional eating, binge eating, depression and self-esteem in the following section.

**4.3.1. Obesity and body image concerns.** This study identified that five of the six participants expressed body image concerns in the qualitative interviews and reported marked body image concerns on the Body Shape Questionnaire (BSQ: Cooper et al., 1986), indicating that they experienced moderate or extreme body image concerns. The nature of these concerns was complex and the ways in which these concerns impacted on the



participants' everyday lives varied. The same five participants expressed negative thoughts regarding their body parts, related to cognitive and attitudinal aspects of body image. This resulted in some avoiding their reflection in shop windows, and others avoiding looking at their own bodies when they undressed. Four out of six also described how such negative body image cognitions impacted on their social lives. Some avoided social situations and restricted themselves to staying indoors and others avoided specific activities (swimming) where their body would be on display. The participants were self-critical regarding their weight and shape and were particularly fearful of others criticism regarding their body, which further impacted on their social lives. Three also described how, in the past, they had engaged in self-harming behaviour which was associated with having negative thoughts about their body and overall appearance, as well as other distressing events they were experiencing at that time.

As indicated in chapter one, much of the research on body image concerns and youth obesity has focused on non-clinical populations and large school samples using non-British samples and administering quantitative self-report measures. Such studies have predominantly assessed the perceptual aspects of body image concerns using figure rating scales and questionnaires (Ceballos et al., 2010; Cinelli et al., 2009; Fonseca et al., 2008). All of these studies found that in community samples, obese young people did differ from their healthy weight counter-parts regarding their body image, and all reported having greater body image concerns. In particular, younger obese individuals (aged 10 – 14 years) reported greater negative attitudes towards their weight and shape and tended to overestimate their weight and shape, compared to those aged 15 years and above.

The present study sample were clinical treatment seeking young women and research that directly assesses body image in a clinical populations is limited, as identified in chapter one. As already stated, five of the six participants reported having body image concerns, and

the same five also scored high on the BSQ and the EDE-Q (Fairburn & Beglin, 1994) on the Weight and Shape Concerns subscales. This subscale measures body image dissatisfaction, preoccupation with weight and shape, a desire to lose weight and discomfort with seeing one's own body. Three of the five participant's who achieved particularly high scores on the BSQ and the EDE-Q also reported low mood (assessed by the Short Mood and Feelings Questionnaire, SMFQC: Angold, 1995) and low self-esteem (using the Rosenberg Self-Esteem Scale, RSE: Rosenberg, 1965). In other studies that included clinical obese youth populations similar findings were also reported (Decaluwé et al., 2003; Huang et al., 2007).

Huang et al. (2007) used the Body Dissatisfaction subscale of the Eating Disorder Inventory (EDI-BD: Garner, Olmstead & Polivy, 1983) to measure body image concerns and found differences in the levels of body image concerns for gender and weight. Overweight and obese female adolescents reported higher levels of body image dissatisfaction and lower self-esteem than males and those who were of a healthy weight. The present study sample consisted of females therefore gender differences were not able to be explored.

Decaluwé et al. (2003) explored the prevalence of binge eating behaviour and associated psychological factors such as self-esteem, depression and body image concerns (N=126, age range 12–16 years) in a clinical sample. They used the Eating Disorders Examination Questionnaire (EDE-Q: Fairburn & Beglin, 1994) not only to assess the frequency of specific eating behaviours but also to explore body image using the Weight Concern and Shape Concern subscales (as was used in the present study). It was found that 36.5% of the sample reported binge eating episodes. The sample was split and comparisons were made between the obese non-binge eaters and obese binge eaters. It was found that obese binge eaters reported greater levels of body image concerns and low self-esteem than non-obese binge eaters. The obese binge eating group was also found to be slightly younger (12–14 years old) than the non-obese binge eating group. In the present study, four of the six

participants described engaging in binge eating behaviour, however due to the small sample size comparisons between those who reported binge eating and those who did not were not able to be made. Those that reported binge eating behaviour in the present study also scored high (in the marked range) for body image concerns as was found by Decaluwé et al. (2003).

Therefore in both clinical studies outlined above, the participants reported significant body image concerns and also reported experiencing low self-esteem and low mood, as was identified in the present study. This was found to the case for females in particular, which relates to the findings of the present study. This may have implications for obesity treatment and our understanding of how obesity is experienced by young people, which will be further explored in section 4.5.

**4.3.2. Dislike of specific body parts.** In the present study it was also found that five of the six participants described particular parts of their body that they disliked. For example, some described disliking their stomach and their thighs. There was only one participant who did not report body image concerns or dislike for her body.

For two participants, their strong dislike of particular body parts evoked extreme negative feelings, which they conveyed by describing how they sometimes felt like ‘cutting’ and ‘chopping off the fat’ from their bodies. This was an extreme reaction and the same two participants also had a strong desire to be thinner. The same two participants scored the highest on self report measures pertaining to low mood, low self-esteem and body image concerns. These findings are similar to other qualitative study findings by Neumark-Sztainer et al. (1999) who found that some of their young obese female participants described wanting to ‘cut the fat off’, and some had a strong desire to be thinner as was found in the present study.

In the present study it was also identified that three of the participants reported engaging in self-harming behaviour which was associated with their obesity as well as

difficulties they were experiencing in their lives at that time. There is little research regarding self-harming behaviour and obesity. In one study by Sansone, Wiederman, Schumacher, Routsong-Weichers (2008) that focused on adult gastric band candidates and prevalence of self-harming behaviour, it was found that 22 of the 121 participants engaged in self-harming behaviour. This is a relatively under researched area and worthy of further study.

**4.3.3. Weight related bullying/teasing and body image concerns.** In the present study those that reported high levels of body image concerns were self-critical of their bodies and others were worried that they would be judged by their peers and society in general as a result of being obese. Therefore some avoided displaying their bodies in public (for example they avoided swimming or PE) and others avoided social situations for fear of others criticism. Three of the six participants in the present study were bullied and a further two were teased for being overweight. They also described how this impacted negatively on their mood and how they perceived themselves, regarding their weight and shape.

Thompson, Coover, Richards, Johnson & Cattarin (1995) found that teasing history was associated with the development of body image concerns and disordered eating behaviour, amongst a large non-clinical sample in the USA. Interestingly, there was no impact on BMI, in other words, those that were teased and had body image concerns and engaged in disordered eating did not differ in their weight status (BMI) compared to those that were not teased. This was supported in another non-clinical sample of adolescents by Haines, Neumark-Sztainer, Eisenberg and Hannan (2006) who explored whether weight-related teasing predicted the development of binge eating or unhealthy weight control behaviours over a five year period. They found that teasing history was associated with reported body image concerns as well as a predictor of binge eating behaviour amongst male participants. The association between weight-related teasing history and binge eating was weaker amongst females. However, they did not find an impact on BMI. Therefore there

appears to be a relationship between teasing and the development of body image concerns and disordered eating behaviours but this was not associated with BMI. The authors argue that teasing and bullying about weight results in the participants making comparisons between themselves and those around them. They suggest that these comparisons add to that person's sense of difference. It is this comparison that Thompson, Coover and Stomer (1999) argue mediates the influence of family/peers and the media on body dissatisfaction. They highlight the importance and negative impact that social comparison has on body image and eating behaviours (Cash, 2004; Rosen et al., 1996; Sarwer, Thompson & Cash, 2005). The other point related to this research is that it was found that not all who were teased and engaged in binge eating behaviour were obese. What has been suggested is that binge eating behaviour could lead to obesity in the future (Rosenberger, Henderson, Bell & Grilo, 2007), therefore teasing history could be related to obesity in adulthood and may be considered a risk factor for becoming obese. Thompson et al. (1999) also found that not all who were teased engaged in binge eating, suggesting that those participants may have had better strategies for coping with teasing/bullying compared to those that resorted to binge eating.

**4.3.4. Obesity, body image concerns and social stigma.** Five of the six participants in the present study were self critical regarding their weight and shape and were fearful of others criticism. This was found to be associated with social avoidance and could also be related to the social stigma attached to obesity (Schafer & Ferraro, 2012). Previous research on victimisation and social stigma towards those who are obese is well documented (Heuer, McClure & Puhl, 2011; Libbey, Story, Neumark-Sztainer 2008; Puhl & Heuer, 2009; Puhl & Latner, 2007) and the gender differences are also recognised. For example, female adolescents who are obese experience more victimisation and social stigma compared to their obese male counterparts (Puhl & Heuer, 2009). In the present study all the participants were female and five of the six reported experiencing some form of social stigma, similar to

previous research findings. These findings could also be related to the feminist perspective regarding body image as they argue body image dissatisfaction is a systemic social phenomenon. They adopt a social constructivist perspective which highlights that power and gender inequalities that are created in a social context also impact on women's body image. This perspective therefore takes away the focus of individual pathology and highlights '...the power inherent in social constructions that normalize gender inequalities' (McKinley, 2011, p.48). Furthermore, this viewpoint highlights that in western society the body and mind are separated and women are valued for the body due to the reproductive function the body serves, and men are valued for the mind (McKinley, 2006; Myers & Crowther, 2007). It is argued by McKinley (2011) that this has resulted in the female body being an object that is judged by how it fits with the specific cultural attitudes (McKinlye, 2011, p. 49). Therefore from a young age, girls are concerned with what they wear; their appearance and their body shape that extends to adulthood and they are constantly seeking reassurance and approval from others regarding their weight and shape (Moradi & Huang, 2008). The feminist perspective on body image suggests that women's negative body image concerns are socially constructed. There are also theorists who argue that in western society socio-cultural pressures to be slender result in females internalising a slender body as an acceptable form of attraction (Pressman, 2012). This theory could also be used to explain why some of the participants in the present study held negative opinions regarding obese individuals, as well as themselves. For example obese individuals were described as lazy and unattractive by some of the participants.

In summary, the findings from the present study are similar to existing research on young obese women as they have been found to have negative body image concerns and are self critical and fearful of others criticisms due to their weight (Boyington et al., 2008; Neumark-Sztainer et al., 1998). All of these studies have highlighted the negative impact that

such body image concerns have for female obese youth populations in particular. These findings could be related to the social stigma attached to obesity in western society. If this study was replicated using a sample of Indigenous Australians, the findings may have been different as was found by Cinelli and O'Dea (2009), due to cultural differences that exist regarding weight, shape and physical attractiveness amongst both men and women from different cultures.

In the present study it was also found that those who experience extreme dislike for their body parts report greater levels of low mood and low self-esteem and some engaged in self-harming behaviour, which adds to the limited research in this field.

What the present study also adds to existing research is the additional information obtained from the participants regarding the role of food and how mood and food were related, which has not been explored in previous qualitative research to date. The negative cognitions and appraisals described by some of the participants affected their mood and self-esteem and, for some, this triggered overeating behaviour in an attempt to improve their mood. This will be further discussed in the section below.

**4.3.5. Obesity and emotional difficulties.** In the present study five out of six participants described feeling low in mood during the qualitative interviews and also scored high for low mood on the SMFQ (Angold et al., 1995). The same five also scored high on the self-esteem measure (RSE: Rosenberg, 1965). Previous research has found that some obese youths report experiencing low mood and low self-esteem (Huang et al., 2007; Wadden, Womble, Stunkard, & Anderson, 2002), whereas others do not (Castellini, Lapi, Ravaldi, Vannacci, Rotella, Faravelli et al., 2008; Dierk, Conradt, Rauh, Schlumberger, Hebebrand, & Rief, 2006). There are differences between treatment seeking obese youth populations and non-treatment seeking obese populations. Those seeking treatment for weight loss have consistently been found to report elevated psychopathological symptoms such as depression

and anxiety compared to their healthy weight counterparts (Decaluwé et al., 2003; Francione, 2007). The following discussion provides an overview of the findings from the present study and related research in the field of mood, eating behaviours and emotionally driven eating amongst obese youth populations.

**4.3.5.1. Mood and eating behaviours.** In the present study four participants expressed that low mood and eating were linked and three also stated they engaged in binge eating behaviour. They reported that binge eating reduced their distress in the short term. This, however, passed quickly and they returned to feeling low in mood, due to the consequences of their actions, and the fear of gaining weight. Over eating in response to feeling low was also described as a ‘vicious cycle’ by two of the participants. These findings indicate that over eating was triggered by negative feelings, suggesting it was emotionally driven. These findings therefore could be related to research on emotional eating. Emotional eating has been described as ‘eating in response to a range of negative emotions such as anxiety, depression, anger and loneliness to cope with negative affect’ (Faith, Allison & Geliebter, 1997, p. 439).

**4.3.5.2. Obesity and emotionally driven eating.** In the present study of the five participants who reported having moderate to severe body image concerns (from the BSQ scores), three also reported engaging in binge eating behaviour regularly on the binge eating dimension of the EDE-Q (Fairburn & Beglin, 1994). Recent research has found an association between emotional eating and binge eating disorder (d’Autume, Musher-Eizenman, Viarme, Frelut & Isnard, 2012; Dingemans, Bruna & van Furth, 2002; Schulz & Laessle, 2010). In these studies adults with BED were found to eat in response to negative affect associated with stress and low mood and suffering from BED increases the risk of obesity (Sims et al., 2008).



There is also a small body of research on adolescents who are obese and have BED and report emotional eating (Eisenberg, Neumark-Sztainer & Story, 2003; Goldfield et al. 2010; Nguyen-Rodriguez, Unger & Spruijt-Metz, 2009). A key defining characteristic associated with binge eating behaviour is loss of control which has been found to be common amongst obese and healthy weight adolescents (Nguyen-Rodriguez, et al., 2009). Furthermore, Marcus and Kalarchian (2003) proposed that the defining criteria for BED should include 'food seeking in response to negative affect' (e.g. sadness, boredom, restlessness). In a study by Shapiro et al. (2007) that used the Children's Binge Eating Disorder scale (C-BEDS; Shapiro et al., 2007) as well as an additional item relating to emotional eating, (n=55, aged 5-13yrs), it was found that in children seeking treatment for weight loss, 30% met the diagnosis of BED and 63% reported eating in response to negative affect (emotionally driven eating). Therefore, these findings and the findings from the present study suggest that binge eating behaviour experienced by some obese youths may be emotionally driven.

In a more recent study by Ricca et al. (2009) evaluating general psychopathology and eating behaviour in treatment seeking obese adults, all participants reported high levels of psychopathology, particularly depression, anxiety, poor quality of life; 24.4% of the participants met the criteria for BED, and binge eating was significantly associated with emotional eating. There was also a relationship identified between emotionally driven eating and weight and shape concerns (body image concerns). These findings are similar to those by Barry and Grilo (2002) and Ramacciotti et al. (2008) who also found that participants with BED reported higher weight, eating, and shape concerns than overweight participants without BED.

The findings from the present study and those of Ricca et al. (2009) and Shapiro et al. (2007) could be considered in relation to the negative affect model. This model argues that

binge eating episodes are triggered by negative affect (Meyer, Waller & Waters, 1998) and also suggests that a decrease in negative affect results in a reduction of binge eating behaviour (Deaver et al., 2003). This model postulates that binge eating functions as a negative reinforcement, which reduces negative affect, albeit temporarily. It is proposed that binge eating decreases or numbs negative emotions, or acts as a distraction from negative emotional affect (Arnold, Kenardy & Agras, 1992). It is also suggested that binge eaters may lack particular coping strategies/skills required to manage negative emotions, therefore they are more prone to binge (Ricca et al., 2009; Wiser & Telch, 1999). This has resulted in the view that for some obese individuals, food is used as a form of self-medication and to regulate negative emotional states in both child and adult obese populations (Czaja, Reif & Hibert, 2009; Nguyen-Rodriguez, et al., 2009). This finding could also be related to two of the participants' descriptions of food being a drug, as it, 'takes the pain away', in the present study. By using food in this way, it could be argued that these participants were self-medicating to regulate negative emotional states, as described by the negative affect model. The idea that the participants who described using food to help overcome negative emotions suggests that they did not have other ways of coping with negative affect and that over-eating may have offered a form of escapism from emotional distress. The same could be applied to the participant who described engaging in daydreaming to escape her sadness.

There was however one participant in the present study who developed a different relationship with food, once she had lost weight. This participant had lost over three stone in weight and was determined to continue to lose weight, therefore she resorted to dramatically limiting her food intake and engaging in self-induced vomiting to control the amount she ate. There is some debate regarding dieting behaviour and its implications. For obese individuals it is argued that dieting results in the individual developing a different relationship with food and also leads to eating disorder symptoms (Johnson, Pratt & Wardle, 2011; Schwartz &

Henderson, 2009). The Restraint Theory (Stice, Presnell, Groesz & Shaw, 2005) could also explain the present study findings as it states, that when individuals restrict or limit their food intake by dieting, this results in decreasing the sensitivity of the body's 'natural hunger and satiety cues and an overreliance of contextual cues for eating' (Russell-Mayhew et al., 2012, p. 4). Therefore, individuals overeat, use compensatory behaviours to control their eating or restrict their food intake, as was found in the present study.

In summary, the present study findings addressed the research questions and it was found that obese young women in the present study described;

- 1) Having body image concerns that affected how they perceived themselves and some were fearful of others criticism and avoided social situations
- 2) Low mood and low self-esteem as a result of being obese and were self critical of their weight
- 3) Engaging in disordered eating behaviours, as three of the six engaged in binge eating behaviour that they described being emotionally driven, and a further participant was limiting their food intake dramatically in an attempt to lose weight.

These findings add to existing research on youth obesity and the factors affecting young people who are obese. It also offers a further insight into the experience of being an obese young woman from the young people's unique perspective which much of the previous quantitative research in this area does not offer. These findings also have implications for how obesity is conceptualised and treated, which will be further explored in the next section.

#### **4.4. Clinical Significance of the Findings: Theoretical Implications**

As already highlighted, the present study identified that five of the six participants experienced negative body image concerns, and associated negative cognitions regarding

their weight and shape and were self critical. This also impacted on how they experienced their everyday lives as some avoided looking in mirrors, whilst others avoided social situations where their body would be on display, as they feared others criticism and the social stigma attached to being overweight. These findings relate to existing research on youth obesity and associated psychosocial factors and have implications regarding how obesity is conceptualised as it has been suggested that over-evaluation of weight and shape concerns could be used in the new DSM criteria for BED (Friedman et al., 2005; Lo Coco et al., 2011; Mond et al., 2007; Neumark-Sztainer et al., 2000; Wilfley, Wilson & Agras, 2003). The main finding from the present study suggest that there are differences in how young people experience their obesity, as was identified in the aforementioned studies. In addition, in the present study, those who reported high scores on the additional questionnaires identifying low mood, low self-esteem, body image concerns and disordered eating behaviours indicated they experienced obesity in a different way to those who did not score in the high range. Therefore there does appear to be specific criteria that distinguish those who have symptoms associated with eating disorder psychopathology, especially binge eating disorder. Mond et al. (2007) and Lo Coco et al. (2011) argue that more focus should be on body image concerns amongst obese youth populations as they argue this would also distinguish those who are obese and have additional psychological problems, such as BED. This would also have implications for the understanding and treatment of obesity. Moreover, if those who are obese are identified as having body image concerns or meet the criteria for BED, they could be offered psychological treatment that targets more specific psychological symptoms, unlike the current treatments offered for obesity.

Many experts agree that BED should have formal diagnostic status in the DSM (Lo Coco et al., 2011; Mond et al., 2007; Wilfley, Wilson & Agras, 2003). What is debated is

which aspects of the criteria should be kept as Mond et al. (2007) argue that over-evaluation of weight and shape should be included in the diagnostic criteria for BED as it is for anorexia nervosa and bulimia nervosa. Since those with BED have reported elevated levels of body image concerns and extreme weight and shape concerns (Grilo, Mashed & Wilson, 2001; Wilfley, Schwartz, Spurrell & Fairburn 2000). In a study focusing on the differences between those who are obese and report behaviours meeting the provisional criteria for BED, it was found that those who had an 'undue influence of weight or shape on self-evaluation' (Mond et al., 2007, p. 930), also had marked psychopathology, commonly associated with eating disorder psychopathology (elevated levels of depression, low self-esteem and functional impairment). Those that did not were found to not engage in disordered eating behaviours and were labelled as 'obese non-binge eaters'.

In summary, based on all the findings from present study and previous studies on body image concerns and youth obesity, it could be proposed that some obese young people do have body image concerns and elevated levels of emotional distress. This is particularly the case for young obese women (Buckroyd, 2011). Also, it appears that some obese youths engage in emotionally driven eating behaviours in an attempt to reduce negative affect and manage difficult emotions. Emotionally driven eating can also result in binge eating episodes, which further maintain and contribute to obesity. It has been proposed that obese youths can be split into two groups, obese binge eaters and obese non-binge eaters (Mond et al., 2007). It has been suggested that obese individuals are part of a highly 'heterogeneous' group and that there are different psychosocial aspects related to obesity depending on how the obesity is experienced by the individual (Carr, Friedman & Jaffe, 2007; Lo Coco et al., 2011).

#### **4.5. Clinical Implications: Treatment Considerations**

The findings from the present study join a new body of research trying to conceptualise and understand obesity and develop recommendations for appropriate interventions. In the present study five of the six participants reported body image concerns, low mood and low self-esteem and four also reported disordered eating behaviours. This suggests that treatments that focus predominantly on dieting, exercise and improving education regarding food and nutrition and may be successful at helping some, but not all obese individuals seeking treatment for weight loss. The reason for this is that some obese youths also experience body image concerns, low mood and engage in disordered eating behaviours, all of which are not targeted in the standard treatments available.

There appears to be a lack of understanding regarding the complex nature of obesity, associated psychosocial factors and how it is experienced. It could be argued that the current treatment does not take psychological aspects into consideration (Lo Coco et al., 2011; Mond et al., 2007; Ricca et al., 2009). In addition the significance and impact of body image concerns are also not considered (Rosen, 2001). More specifically, studies that have focused on youth obese populations have suggested that elevated levels of body image concerns may be a mediating factor for psychological distress (Cinelli & O'Dea, 2009; Harriger & Thompson, 2012). This suggests that before treatment is offered, an alternative type of assessment should be undertaken that targets body image concerns, binge eating, and emotional distress. The findings from the present study and previous studies have found that young obese women may experience additional emotional distress as a result of their obesity and not complying with the cultural norms of what is attractive regarding weight and shape. Therefore young obese women seeking treatment for weight loss may need additional assessments that explore weight and shape concerns and how these issues may be maintaining or contributing to their obesity. This would help to determine how the young

person experiences being obese and whether additional psychological factors are present and contributing to the problem.

This could also help identify what treatment might be more beneficial as research to date suggests that the ‘one size fits all’ method is what is commonly offered, however the nature of obesity is more complex. If intervention is to be truly ‘person-centred’ as NICE (2006) guidelines suggest, then there may be more merit in considering more thorough assessment of obese treatment seekers problems and associated contributing and maintaining factors. Although there are psychological treatments developed to reduce binge eating (Wilson, Wilfey, Agras & Byson, 2010) and address body image concerns (Rosen, 2001; Palmeria et al., 2010), in practice, there are very limited services that offer such psychological treatments in the UK (Walker & Hill, 2009). This is partly due to how obesity is conceptualised, as a health problem and not a mental health problem

There is extensive literature on the treatment of BED and its relevance for obese youth populations (Fairburn, 2008; Wilson & Fairburn, 2003), as well as its suitability for obese clients, compared to standard weight management programmes that are currently offered (Alexander, Goldschmidt & Le Grange, 2013). The CBT model has been used to understand BED and has been the predominant psychological intervention for BED.

Most people who seek treatment for BED are obese and are able to lose weight; however, few are able to maintain the weight loss and subsequently regain the weight lost (Cussler et al., 2008; Jones, Wilson, & Wadden, 2007; Turk et al., 2009). Ways to help with maintaining weight loss have been considered and researchers have looked at recent developments in eating disorder research, as this may be of benefit to the field of obesity. Those who have eating disorders are successful at making lasting changes to their eating habits and develop a better relationship with food after psychological interventions (Lock, 2010; Schapman-Williams, Lock & Couturier, 2006). A recent review by Cooper et al.

(2010) however found that CBT was unsuccessful for preventing adult obese clients from regaining the weight they had lost. They concluded that obese clients may be resistant to psychological methods to help support those who have lost weight. Their sample consisted of adults and it is important to note that although CBT may not have helped the participants it could be suggested that other psychological methods, such as using mindfulness (Caldwell, Baime & Wolever, 2012) or a combination of different psychological therapies, known as third wave therapies may be more successful, as has been found by Buckroyd (2011).

For youth obese populations adopting more systemic interventions that include mindfulness and CBT combined with dietary advice and physical activity may be effective in helping such individuals lose weight and maintain weight lost (Caldwell, Baime & Wolever, 2012). There appears to be a drive by the government to develop weight loss programmes for young people that concentrate on physical activity and dietary advice, which all targets intervention. There is much less focus on maintenance of weight loss from such programmes and how to achieve maintenance of weight loss (Ohsiek & Williams, 2011).

There is limited research on family therapy approaches (Nowicka & Flodmark, 2011) or adopting a combination of 'third wave' approaches to tackling childhood obesity. Adopting third wave approaches and designing programmes that are more flexible rather than one size fits all could provide better long term effects however there is very limited research in this field and what works best is still unknown.

In summary the main clinical implications based on the findings from this study are related to how obesity is theoretically understood and how it is treated. As obesity is defined as a health problem, interventions target weight loss, by increasing physical activity undertaken by individuals and improving education about food nutrition. However, research to date has found that in clinical treatment seeking obese populations, some individuals report experiencing emotional distress, body image concerns and also engage in binge eating



behaviours, therefore some share similar psychopathology to those who suffer from an eating disorder, particularly BED. The mental health wellbeing model of childhood obesity (Russell-Mayhew et al. 2012) proposes that obesity is more than just problem associated with poor lifestyle choices and an increase in fatty foods. Russell-Mayhew et al. (2012) identified that obesity has associated psychological factors and quality of life (QOL) implications that play a part in the development and maintenance of this problem. These additional factors are not assessed or even considered in the current weight loss programmes that are advocated by the NICE (2006) guidelines on obesity weight management. Considerations should be given to assessing psychosocial factors contributing to the development of and maintenance of obesity.

#### **4.6. Study Strengths and Limitations**

The main strength of this study is in the qualitative method adopted. It allowed for obese young women to tell their stories and offer their version of what they experience. This study was exploratory by nature and aimed to offer a greater understanding of the impact of youth obesity from an obese youth perspective. There is little known regarding body image concerns and the psychological impact associated with youth obesity therefore this study's findings, that obese youths describe body image concerns, depressive symptoms, report low self-esteem and engage in disordered eating behaviours are adding to a relatively new area of research. The main limitation associated with this study is in the small sample size (n=6) and that all the participants were female. These two aspects limit the generalisability of the findings; however qualitative research does not necessarily seek to identify generalisability, rather truth and meaning regarding particular populations and offers an alternative, in-depth understanding of particular phenomena. The issue regarding what is considered an acceptable sample size in qualitative research has been a matter of debate as there are no clear rules for this, rather guidance depending on the research questions and the

population that is being explored (Guest, Bunce & Johnson, 2006). There are different views on the exact number of participants required, for example, Morse (1994) recommends at least six participants are required for qualitative enquiries (Morse, 1994, p. 225) which is also supported by Kuzel (1992). Creswell (1994) recommends at least five interviews are sufficient. The key point that all the aforementioned researchers make is that it is more about the topic of research being investigated, the difficulties in recruiting participants if the topic is sensitive and whether the findings reach a point of saturation. For the purpose of this study six participants agreed to take part which was considered sufficient as similar themes were identified and the research questions that guided the study were able to be addressed. Due to time constraints and difficulties with recruitment of this population, the decision was made to stop at six participants.

Also, as all the participants were female, it is unknown whether male obese youths of the same age experience being obese in the same way as females. Research on obese populations in general focuses on female populations overall. This may in part, be due to more females seeking treatment for weight loss than males (NOO; 2011). The reasons for this are complex, but research findings suggests that this associated with the social stigma attached to being overweight that is applicable particularly to females, (Friedman, Reichmann, Costanzo, Zelli, Ashmore & Musante, 2005).

Another possible limitation involves the interview being co-constructed and involves the interviewer. As the researcher is female and of a healthy weight this may have impacted on the participant's responses, however what the researcher brought to this thesis, regarding her own experiences and motivations were considered throughout this study.

#### **4.7. Future Research and Conclusions**

As highlighted in Chapter one, much of the research on obesity, body image concerns and associated psychopathology has been conducted using quantitative methods. This has its

benefits as large sample sizes could be used and standardised measures assessing specific aspect of obesity could be measured. However, this type of research also has its limitations, as by using questionnaires that contain pre-existing, pre-defined variables there is a risk that different information pertaining to the constructs being investigated is not gathered. This is particularly important when focusing research on samples where there is little known, such as obese youths, as there is a risk that important information is lost or not identified. Therefore, by adopting a more qualitative approach and using semi-structured interview, different aspects associated with obesity could be captured and this provided opportunities for unexpected information to be obtained. For the purpose of this exploratory study, it was decided that a qualitative approach would provide an opportunity to assess the experience of being obese from the participants by allowing them to ‘tell their story’.

Much of the research on obesity in both youth and adult populations uses predominantly female samples; therefore how obesity impacts on men is not well understood. Much of our understanding of male obese populations is based on large non-clinical samples and future research would benefit from devoting attention to male obese populations, particularly those seeking treatment for weight loss.

In light of the findings from the present study and from previous research on this topic, it can be concluded that obesity is a complex and ‘heterogeneous’ problem (Carr et al., 2007). Some obese youths have been found to have body image concerns and associated psychopathology, however others have not. Moreover, how obesity is related to eating disorders and BED is still being investigated.

Research to date has suggested that over-evaluation of weight and shape amongst some obese individuals is the key to identifying those who have additional psychological symptoms associated with BED, and therefore those who require more specific psychological

treatments that can target psychological symptoms. Whether obesity, BED or a subgroup of obese individuals should be classified as having a mental health problem rather than a health problem is still a matter of debate. What is clear is that for some, obesity causes great psychological distress associated with body image concerns, binge eating, emotionally driven eating, depression and low self esteem. This is particularly true for obese young women. More research is required focusing on youth obesity. Further qualitative research may help identify different features associated with obesity, which may help better understand this problem and provide information on how better to treat this problem.

The findings from the current study extends our understanding of obesity and how it is experienced, by highlighting the significance of psychosocial factors that affect some obese youths. The findings also add to growing interest regarding how obesity is conceptualised theoretically, as the findings are relevant to the Russell-Mayhew (2012) model regarding obesity and mental health and wellness.

The findings can also be used to inform treatment options for obese youths in general. It may be more beneficial to target the maintaining factors and to explore the function of the eating behaviours. Based on the findings from the present study and related research, it is proposed that obesity could be considered to exist on a continuum and alongside eating disorders, as it has been found that some obese youths experience similar symptoms associated with eating disorder psychopathology (low mood, body image concern, and binge eating behaviours). Individuals may move along the continuum and may share symptoms associated with anorexia nervosa at one time and then may develop more binge eating type symptoms at a different stage. It may be more beneficial to explore and assess the symptoms that individuals report rather than offering a 'one size fits all' approach to treatment and an intervention on the basis of BMI.

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## **Appendices**

- 1.A. The National Obesity Observatory (2011) summary of studies regarding moderators and mediators of youth obesity and mental health
- 1.B. Details of the search procedure for the review on body image concerns and youth obesity
- 2.A. Transcription example and a description of the development of the coding frame, format of transcript
- 2.B. The Interview Schedule used in this study
- 2.C. Researcher's background and experience description
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- 2.E. Ethical approval documentation

**Appendix 1.A. The National Obesity Observatory (2011) summary of studies regarding moderators and mediators of youth obesity and mental health**

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*Youth obesity as a cause of psychopathology*

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Behavioural: lower levels of physical activity, lower perceived athletic competence, unhealthy diets and loss of control in eating (Mériaux, Berg & Hellström, 2010)

Biological: disruption of hormonal pathways (Zametkin, Zoon, Klein & Munson, 2004)

Psychological: low self-esteem, body dissatisfaction, perception of being overweight (Flodmark, 2005; Hill, 2005; Martyn-Nemeth, Penckofer, Gulanick, Evlsor-Fridrich & Byrant, 2009)

Social: stigmatisation, social rejection and weight related teasing (Schwimmer, Burwinkle & Varni, 2003)

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*Psychopathology as a cause of youth obesity*

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Behavioural: lack of energy to exercise/engage in physical activity due to depressive symptoms (Faith, Leone, Ayers, Heo & Pietrobelli, 2002)

Biological: side effect of medication for psychological disorders (Wurthman, 2010)

Psychological: low expectations of weight loss attempts (Befort et al., 2006)

Social: psychosocial stressors in the household, e.g. financial or caregiver experiencing psychological difficulties (Gunderson, Mahatmya, Garasky & Lohman, 2010)

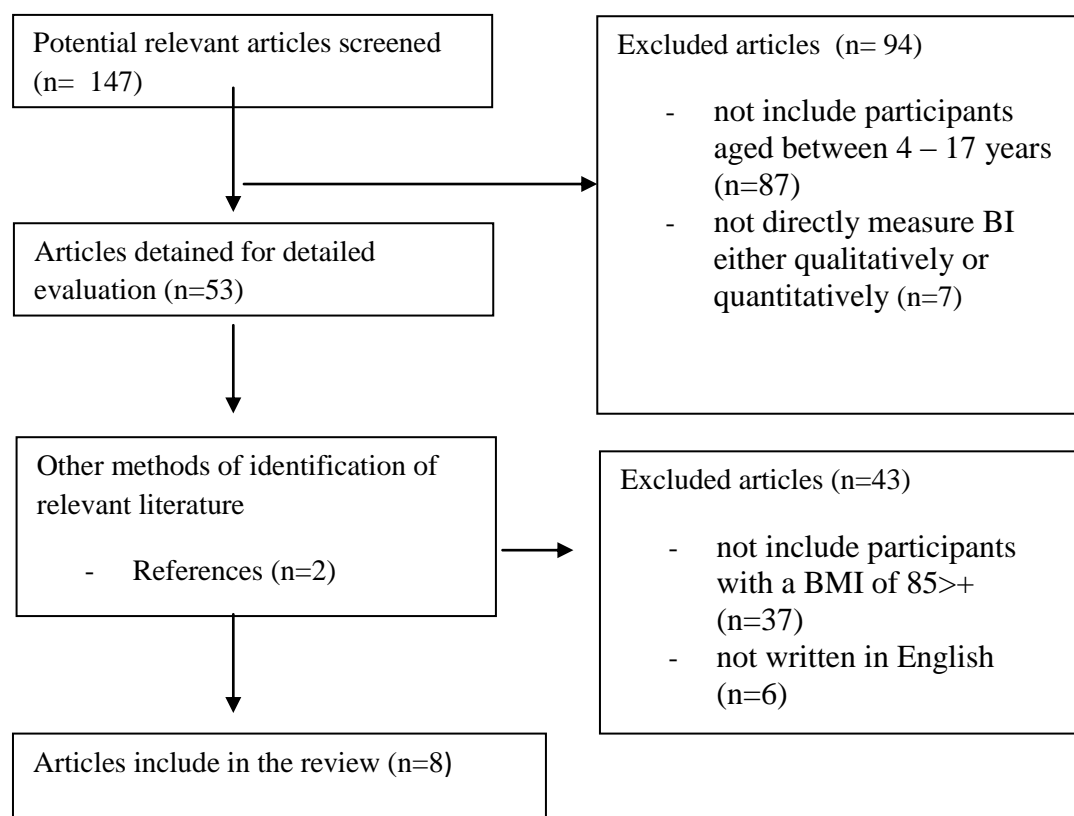
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(Source: NOO, 2011, p. 9).

### Appendix 1.B. Details of the search procedure for the review on body image concerns and youth obesity

**Inclusion and Exclusion Criteria.** Studies written in English and published in peer reviewed journals were included. Studies that included participants aged 4 – 17 were included, capturing both childhood and adolescence. Those that included individuals with a Body Mass Index (BMI) adjusted for age and gender at or above a the 95<sup>th</sup> centile, in according with the NICE (2006) guidelines for obesity diagnosis. Studies that included individuals with a BMI adjusted for age and gender at or above the 85<sup>th</sup> centile were also included as these are considered ‘severely overweight’ and the majority of the literature on youth obesity uses this as a benchmark in their inclusion criteria. Also studies that directly measured BI in some way, whether explored qualitatively or quantitatively were included. A total of 8 studies were identified.

Consort diagram: Total articles identified



## **Appendix 2.A. Transcription example and a description of the development of the coding frame, format of transcript**

### **Process for analysis process and theme identification**

#### **Stages of Analysis Process**

1. Interviews were conducted
2. Interviews were transcribed as soon as they were received by the researcher by the researcher and this process was ongoing until all the participants were interviewed (n=6)
3. Audio tapes were listened to alongside the transcripts and transcripts were read in detail and initial codes were developed
4. Codes were then summarised and further developed and defined
5. Transcripts were re-read and re-coded
6. The codes were then grouped and a map of the codes and what they represented were developed
7. Transcripts were then re-assessed with the map
8. All transcripts were also checked for any unusual comments, exceptions and repetitions
9. Based on process 8, themes and the map were amended
10. Final themes were developed
11. Themes and map were checked over by a clinical psychologist who has conducted qualitative research
12. Discrepancies were discussed with the other researcher and any amendments required were made
13. Results were written up

During the above process, the researcher also did the following:

- Read through the log book, added to the log book, made notes and reflected on her own experiences of the data and how it changed and evolved



**Example of Two Transcripts Chosen at Radom****Transcript A, Page 1 : tape time 0 – 1.05 mins**

01: INT: okay hopefully its one. Right so we are going to start with how old you are.

02: How old are you Rachael?

03: PT: 14

04: INT: 14 and when did you first start coming to the live well team? I know it used

05: to be called the weight management team before, when did you start?

06: I don't know, probably last year, don't know if it was last year or the year

07: before?

08: INT: so it's been quite a while

09: PT: yeah

10: INT: over a year?

11: PT: yeah

12: INT: okay so how was it when you first came to talk about your weight and your

13: shape and all those things with the team

14: PT: it was alright, I didn't really mind it I don't think

15: INT: no

16: PT: no

17: INT: not particularly difficult or you know anything that bothered you?

18: PT: no

19: INT: no, okay. Umm have you always struggled with your weight?

20: PT: I don't think so, I don't like mind it, I haven't really minded my weight

21: much

22: INT: no?

23: PT: no.

24: INT: so who referred you to the sort of weight management team? Who was it

25: that thought you needed to come?

26: PT: I think it was my Dr at XXX hospital.

27: INT: yeah

28: PT: I think so

29: INT: okay and was the purely for you to get healthier and lose weight or?-

30: INT: So when do you think these sort of problems with your weight started?

**Page 2 tape time: 1.05 – 2.09 mins**

01: PT: I don't know (*long pause*) Probably in high school I think

02: INT: yeah so what age is that roughly

03: PT: 12

04: INT: yeah

05: PT: something like that

06: INT: yeah okay. So was it the- I don't know, you tell me, what was it about that

07: time that you remember as being a time when you noticed your weight as

08: being something that might be a problem

09: PT: I don't know I think it's just cos I used to eat when I came home from

10: school cos my mum's never there

11: INT: right

12: PT: cos when I was at primary school mum used to work there and I used to go

13: home with my friend and I used to go to her house

14: INT: right

15: PT: and then I just went, when I was in high school, I went back home and I

16: used to eat after school until mum got back

17: INT: so who was at home when you got home from school at that time?

18: PT: my brother

19: INT: is he younger or older?

20: PT: he's older.

21: INT: okay, so, just help me understand a little bit, so you come home and when

22: say you sit and eat, what- what would you eat, would you-

23: PT: I'd eat like packets of crisps, and stuff like that

24: INT: okay and-

25: PT: it's not good things really

26: INT: okay. So would you go to the kitchen and get, one packet, two packets?

27: What would you do?

28: PT: I wouldn't do – I'd only get one

29: INT: yeah

30: PT: but then I'd eat like, other stuff. I can't remember what know, probably like

31: cereal bars and stuff like that or whatever I could find I think.

32: INT: yeah? Do you know you did that?

**Transcript B Page 12: tape time: 12.50 – 14.12mins**

01: INT: so healthier stuff maybe?

02: PT: and then, yeah. I must admit I did put watercress in my sandwich

03: today for some weird reason. I'm so- it's quite nice (joint laughter)

04: INT: so what about eating in general? Do you ever eat in secret at the

05: moment?

06: PT: sometimes, it depends if I'm really upset or just thinking about the

07: saddest times of my life.

08: INT: so you've just said something there that sort of made me think a bit

09: you sort of said about being sad and eating

10: PT: yeah

11: INT: can you tell me a bit more about that?

12: PT: when I was more younger I n- I used to comfort eat. And when I got really

13: really upset when I was in primary school I just got errm, I said mum can I have

14: some money. And then she gave me some money and so I went down to the

15: sweat shop and got loads of sweats and just ate them to myself

16: INT: do you find- do you remember that that was always a way that you

17: PT: yeah

18: INT: reacted when you were upset?

19: PT: yeah

20: INT: yeah.

21: PT: I've learnt not to do that as much now

22: INT: okay so-

23: PT: it kind of helps where we live actually to be honest

24: INT: is that because you are quite far out?

25: PT: yeah

26: INT: so you have not got the access

27: PT: no not really (laughs)

28: INT: so you know when you said comfort eat can you sort of describe what that

29: means to you?

30: PT: like eat when I was upset

31: INT: and wh- what does it do when you eat? What does it do for you on how you

32: are feeling? So you said upset, so you eat-

**Page 13: tape time: 14.12 – 15.30 mins**

- 01: PT: it- it depends what it was. If it was like chocolate, it would have  
02: made me feel like happy in some ways and then I'll just feel sad and then  
03: so like I ate more and more  
04: INT: so you said that you'd feel happy and then you'd feel sad afterwards?  
05: PT: yeah  
06: INT: why do you feel sad after you eat?  
07: PT: cos I've had some chocolate and that's not going to be good for me  
08: INT: and then what happens?  
09: PT: and then I just eat some more  
10: INT: and then what happens?  
11: PT: (laughs) and then I just eat some more  
12: INT: so you go- do you- would you say you go up and down with the feelings?  
13: PT: yeah. Yeah.  
14: INT: so how does it stop? Wh- when does it stop for you?  
15: PT: errm that I haven't got any chocolate left (laughs)  
16: INT: so you just keep going do you think?  
17: PT: yeah  
18: INT: but particularly when you are sad or other times as well do you think?  
19: PT: errm other times as well but it's not, errm it's not as much as I did when I  
20: was younger.  
21: INT: okay, okay. Okay. Do you find that sometimes that you feel like you lose  
22: control over your eating?  
23: PT: (long pause) errm, not really  
24: INT: no. So you know those times that you where you just described it-  
25: PT: I do- I do- maybe over eat at dinner times  
26: INT: but do you lose control or do you feel like you know what you are doing  
27: and you're wanting to do it?  
28: PT: I know what I'm- yeah  
29: INT: so do you feel you could stop?  
30: PT: yeah  
31: INT: but do you choose to or not is-  
32: PT: yeah

## Coding example:

This was an initial attempt at developing a coding frame from the first transcript. Some of these ideas were dropped and general questions I had were also included. This is included to demonstrate how some of the final codes were developed and to display some of the processes involved in coding and developing themes.

Themes and Subthemes	Talk
Weight and family issues	INT: okay. Do you think you have always struggled with your weight?
	PT: well yeah, since my mum left
Comfort eating subtheme	INT: when was that?
	PT: umm, five years in January, yeah.
	INT: and do you have much contact with mum?
	PT: yeah, I'm going over there in December
	INT: very nice
	PT: for my birthday
	INT: very nice. So you were saying that you think your weight problems started back then, umm
	PT: because I was comfort eating because i was only 10 and i did realise what was going on
	INT: so do you remember like...?
	PT: I remember cos a little while ago we had to like, we had to relax and zone out and I went back to like all the times I had with my mum and I just saw her drive away and it was just like, i was the last one to wake up and she saw me and i was just like sitting there and i was just like laying i was not moving and i was proper tense because i was thinking about it all
	INT: so do you think thats kind of whats made you comfort eat do you think?
	PT: yeah
	Top of page 3
Comfort eating (related to family issues)	INT: yeah and do you remember when you were younger than 10 if you did used to use food like you were saying to comfort? Was it always something that you used or was it just something that happened when..

	<p>PT: it was just something that cos my dad was upset about it or he wouldn't show it and he'd buy food so it would make me eat more, so we would both comfort eat ourselves because we didn't want to talk about it.</p>
<p>Comfort eating and bullying</p> <p><i>Behaviour attached to comfort eating – is this binge eating? Over eating?</i></p> <p>Bulling, comfort eating and Binging (is this a subtheme attached to overall theme of comfort eating??)</p>	<p>Bottom of page 4 and top of page 5</p> <p>INT: how does it make you feel when they call you names?</p> <p>PT: upset, I've gone home. If I'm not going to my mates I go home and I just find something that will make me eat. That will comfort myself, like sweats or like a fizzy drink or something.</p> <p>INT: so can you describe when come home what do you do?</p> <p>What's the first thing you do? Do you go to the cupboard or go to the fridge?</p> <p>PT: no I sit down, and I turn the telly on and its like, I'll be there for about 10 minutes thinking over everything that has happened at school and then I just all of a sudden I just rush to the kitchen and I get something and I regret it after</p> <p>INT: so say you have gone to the kitchen you've got something, do you get a lot of things, is it one thing? A couple of things?</p> <p>PT: well cos like, I usually have like these costume dramas at school on Fridays, so I buy a bag of sweats and I open it and if it will be a big bag I would take like 3 or 4 things and sit there and eat them and then hide them, the wrappers from my dad</p> <p>INT: so dad doesn't see?</p> <p>PT: hmmhmm</p> <p>INT: Okay. So, what about binging? Like, do you know what I mean by that? So would you sit down and eat I don't know 5, 6, 7 continuously something like biscuits or something</p> <p>PT: well if I was really bad, there was a day one, last week I was so wound up my mate, she like, burst out crying and everything had just gone wrong for me at school I literally had my tea then I had an ice cream then had like a snack bar, then I had like some</p>

<p><i>Recognition of mood and food being related – is this more about emotional eating for comfort or is eating used as a strategy to help her cope with negative feelings??</i></p>	<p>caramel short bread all after each other just because I was so mad at what had happened at school.</p> <p>INT: so I guess that you recognise, or that from what your saying you seem that recognise that when you are upset that equals you eating more</p> <p>PT: yeah</p>
<p><b>Social isolation</b> (sub theme of 'the perfect weight' ? Social isolation in relation to feeling bad about weight and appearance – related to Body Image Concerns??)</p>	<p>Last comment by PT on page 3</p> <p>how does having weight problems affect your life? Can you describe how it affects your life?</p> <p>PT: umm, there's like things I wanna do, like I wanna go out with my mates and like be happy with myself but I cant because I think oh if I wear this, too tight people or what ever people will be looking at me and going oh look at her she's not right or what ever cos there's there a thing at our school that if your not right, like a certain weight or something your not perfect</p> <p>Top of page 4</p> <p>how does having weight problems affect your life? Can you describe how it affects your life?</p> <p>PT: umm, there's like things I wanna do, like I wanna go out with my mates and like be happy with myself but I cant because I think oh if I wear this, too tight people or what ever people will be looking at me and going oh look at her she's not right or what ever cos there's there a thing at our school that if your not right, like a certain weight or something your not perfect</p>

Below is an excerpt of a format from a transcript, displaying topic shifts and when different themes occurred used as a way of mapping each transcript. The time that each topic occurred is detailed to the left of the summary of what was discussed.

- 15.16 - 1 part N self harm  
15.40 - BHM - bullying - weight  
16.28 - failure - felt upset  
16.55 - I used to steal money  
17.26 - bringing - v. sad  
- felt upset  
- do it all again, vicarious  
17.57 - food makes me feel good  
18.11 - taste - good then feel worse  
18.77 - high, drugs, headache  
18.50 - taste makes me happy, wants more  
19.01 - out of control  
19.41 - don't think  
20.00 - like someone else taking over me  
20.46 - eating in secret
- 7.47 - school perception of self/other  
- dance  
8.10 - boys go to skinny  
8.24 - bullying description  
9.14 - minor in my room  
- sketch marks  
- sport, nothing changes  
9.40 - my weight isn't like it  
10.00 - like values  
- like's dance  
10.24 - money issue  
11.24 - regarding  
11.43 - weight, dance, exercise, I didn't eat as much, was happier  
12.16 - put on weight since I stopped  
12.51 - dislike every thing, quiet - sad, stomach, arms  
13.24 - clothes help change my arms  
- skinny legs  
- wrists + hands  
14.40 - self harm? - sort of tried it + it didn't work
- 15.16 - 15 yrs old  
- attended men  
1.24 - big one from young age  
1.46 - polycystic ovary syndrome  
2.01 - weight not helpful  
2.33 - not helpful  
2.40 - did to go + talk to WHIT  
3.25 - polycystic ovary syndrome  
3.39 - weight + shape  
- diet for polycystic  
4.26 - always struggled with weight  
4.44 - from age 5  
- rivalry between families  
5.23 - school picked on  
5.54 - bullied about weight  
6.10 - PE - everyone laughing  
6.43 - Mum can't help me.  
- can't help herself  
7.16 - affects all the time  
- clear



- 21.44 - twice a week binges  
 21.59 - day dream a lot  
 ↓  
 - dancing  
 - being skinny  
 - dream in my mind  
 - always something better  
 - do it a lot in the mornings  
 23.49 - I'll be a dance.
- 24.00 - desire to be like others  
 ↓  
 - quote  
 - never been bullied  
 25.00 - more money  
 25.20 - skinner
- 25.36 - thinner - feelings would be better.  
 25.52 - you look clean's bullying  
 - v. sad - emotional  
 - crying  
 27.03
- 27.38 - do you feel different?  
 27.52 - how do you think does perceive you?  
 ↳ school lunch  
 28.46 - don't like PE  
 29.14 - still get changed in front of others.  
 29.31 - I don't go swimming  
 30.00 - kind  
 - friendly  
 - pretty  
 - self  
 30.25 - at church I can be myself  
 30.46 - God made me, school  
 31.00  
 31.44 - it's only me  
 32.02 - embarrass public if I were  
 32.26 - v. need to eat apples  
 v. sad.  
 36.10 - MOTIVATED TO LOSE WEIGHT
- 37.36 - poly + no evidence  
 - made me upset  
 38.34 - not out for 2 days  
 38.43 - give up  
 - away
- 38.54 - runaway  
 40.27 - no trust  
 - runaway  
 - from her  
 - stealing
- 40.48 - suicidal  
 - day dream  
 41.07 - cutting myself  
 need to, can't do it.  
 41.31 - always something  
 - shopping me.
- Risk as not.

**Appendix 2.B. The Interview Schedule used in this study**

**Interview guide** – Some of the questions have been created based on the Eating Disorders Interview (Fairburn, Cooper & O'Connor, 2008)

**1) Background Questions**

- Age
- When did you first attend the WMT?
- Do you know why you were referred to the WMT?
- How was it coming to talk about your weight with the team?
- Have you always struggled with your weight?
- When do you think your problems started with your weight?
- Can you describe how having problems with your weight affects your life?

**2) Body Image Specific Questions**

- How do you view your weight and shape?
- Do you like your body shape?
- How do you feel about your weight and shape?
- If you could change your weight, would you?
- If you could change your weight would you?
- What parts of your body do you like?
- What parts of your body do you dislike?
- Do you look at other people and wish you looked like them?
- Do you think your weight and shape affects how others view you? How and why?
- Do you feel uncomfortable seeing your body, in a mirror or when you undress?
- Do you feel uncomfortable when your body is on display in public, like when you go swimming?

**3) Eating Disorder Symptom Questions**

- Have you been deliberately trying to limit the amount of food you eat to influence your shape and weight (whether you have succeed or not)?
- Do you eat in secret? Can you describe what happens?
- Do you find you sometimes feel like you lose control over your eating?

- Question regarding overeating – over the last few weeks, have you experienced episodes of over eating or bingeing? If you have can you first describe what over eating and bingeing mean to you, and how often you have over eaten or binged in the last few weeks?
- Typically what have you eaten at these times?
- When did these incidents occur? Did you feel like you lost control?
- Can you describe how you feel after you overeat/binge?
- During these times, do you do the following-
  - Eat more rapidly than normal?
  - Eat until you feel uncomfortably full?
  - Feel sad afterwards? Can you tell me more?
  - Feel embarrassed by the amount you have eaten?
- After you eat do you sometimes feel guilty after you have eaten as you worry about it affecting your weight and shape? Do you often feel guilty after you eat? Can you tell me more about this?
- If you do over eat, how does this leave you feeling?
- Do you have times where you binge? If so, when and how often?
- Does your weight influence the way you think about yourself as a person?
- Does your body shape influence the way you think about yourself as a person?
- Over the last few weeks have you spent much time thinking about food and calories between meals?
- Has thinking about food and/or calories affected your concentration of everyday activities, e.g. school work, working? What other areas has this affected?

### **Appendix 2.C. Researcher's background and experience description**

I am Turkish Cypriot but born in the UK and have lived here all my life. My cultural understanding of weight, shape, attraction, eating disorders, and obesity is mixed as it has been influenced from my Turkish heritage as well as my British upbringing. Traditionally, (stereotypically), in Turkish culture voluptuous body shapes are considered to be attractive. A thin body shape is not something that is valued in the same way as it is in the Western world. However, things are changing. As North Cyprus and Turkey are becoming more modern and with the impact of the European Union, views on attraction, weight, shape and the desire to be thin is changing traditional perceptions.

I have a family member who is obese and my interest in eating disorders/disordered eating and obesity stems from this and is something that is personal to me. As a result I have done a specialist placement in an adolescent eating disorder clinic. This is where my interest regarding body image concerns and how they manifest in eating disorders stems from, as well as further exploring emotional distress and disordered eating behaviours that many suffers of eating disorders experience. I am also a new mother and have experienced my own body shape grow and change whilst being pregnant which has given me a new insight and perspective regarding my own weight and shape. I am also a clinical psychology trainee, in my final year. This has impacted on how I try and make sense of health and psychological disorders. My teachings on assessment and different lines of questioning to gain an understanding of individuals problems is something that I am aware may influence the qualitative interviews used in this study. This is something that will be highlighted and discussed in the results chapter as well as in the discussion.

I have also been shadowing the dieticians and the activity workers at the weight management programme who agreed to take part in this study. This has provided a way of

having firsthand experience of the assessment and treatment process that obese youths seeking treatment for weight loss undertake. This helped me fine-tune my line of enquiry and help mould my ideas further. This process is sometimes referred to as 'immersion in the setting' (Holloway & Wheeler, 2002). It has been argued that it is important to become familiar with the participants world as it aids in understanding their experiences and allows an insight, from a different perspective, experiencing it (in some form) yourself. Relevant literature, documentaries, talking to other professionals in the field of enquiry are also other ways in which I immersed myself to try and gain a greater understanding of the obese youth treatment seeking culture. A culture does not just exist within an environment it also consists of different values and ideologies and ways of thinking and these change over time as a result of different experiences and interactions (Holloway & Wheeler, 2002). By exposing and immersing myself in their (the participants) environment I also spoke to staff and family members and found out (through general conversations and observations) how others view the participants and their problems with obesity. It was a valuable insight and offered a different mode of access to the participants' world.

**2.D. Consent forms, information sheets and questionnaires used to collect data****Parents/carers consent forms and information sheets:****Information Sheet for Parents or Main Carers****Title of project: Young people's views about their shape and weight, eating habits and mood*****The Research***

I am a trainee clinical psychologist studying at University of East Anglia. This project is being carried out as part of my research for a doctorate in clinical psychology. The study is being carried out with the cooperation of XXXX. The focus of the research is on young people's views on their weight and shape. I would like to ask your child about what they think and how they feel about their shape and weight. I would like to find out how they have been feeling recently and to discuss their experiences of being overweight. In order to do this I would like to interview them at the XXX service offices at a time that is suitable. The interview will take no more than one hour. We would also like to ask you to complete a questionnaire regarding general information about your child (e.g. age, height, weight etc) and how they came to be referred to the service. It is hoped that the information from this study this will help provide a better understanding of young people who are overweight and may help inform future treatment in this area.

***What will I have to do and what will happen?***

Once you have read this information sheet please discuss this with your child. There is a separate information sheet for them that explain the study. If you and your child are interested in taking part in the study we need to be able to contact you and your child to discuss the study with you and your child and to make arrangements for them to take part. If you are both interested in taking part in the study please complete the attached slip and provide your

contact details. There is a posting box at the reception of the XXX team and you can post this slip in the box in order to be contacted by myself to arrange a suitable time to meet to carry out the interview.

We do not expect or ask you to be present for the interview but would ask that you remain available for this time. The interview will be audio recorded, transcribed and then anonymised (name removed). The tape will be destroyed once the interview has been transcribed. The interviews will take place on the XXX premises and can be arranged to be conducted after or before your child's appointment with the team if this is more convenient.

Once all the data is collected, the study will be over and you will not be contacted again unless you would like a copy of the results. If this is the case you can let us know once the interview is complete.

***Do I have to take part?***

It is up to you and your child whether you want to take part. If you decide that you would like your child to take part but they do not wish to we would not ask them to be included in the study. You or your child can decide not to take part at any time, without giving a reason. This will not affect your use of the XXX services currently or in the future.

IT IS IMPORTANT TO STRESS THAT IT IS ENTIRELY YOUR CHILD'S DECISION IF THEY WISH TO TAKE PART and we want to make sure they are entirely sure they are aware of what their involvement will mean and therefore we encourage you to discuss this study with your child.

***Who is taking part?***

All young people who are receiving treatment from the XXX Team will be asked if they want to take part. In total, I need 10 young people to take part in order to collect the sufficient amount of information.

Your son/daughter will also be entered into a raffle to win an iPod to acknowledge their contribution to the study as part of the study.

***Confidentiality***

All information which is collected about you during the study will be kept strictly confidential, and any information about you which leaves the XXX service will have your name and address removed so that you cannot be recognised. You and your child will only be identifiable by a number, not by name. If you or your child tells me something that might suggest they are putting themselves or others at risk I will have to notify the appropriate services to tell them my concerns. However I would not do this without telling you or discussing this with you.

The only people who will see the information are those who are involved in the study, for example, the researcher and the research supervisors from the University of East Anglia in order to check that the study is being carried out correctly and that all information has been collected and stored in a safe and secure way.

***What will happen to the results?***

The information will be coded and some information will be entered into a database on a computer. This will be analysed to see what young people's views are about their shape and weight, eating habits and how this might be affecting their mood. Once the study is completed the data will be gathered and stored in locked and secure office at the University for East Anglia and archived along with all research that is carried out by the University.

***What if there is a problem?***

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions, contact details are below. If you remain unhappy and wish to complain formally, you can do this by contacting the researcher's supervisor, Dr Sian Coker, at the University of East Anglia, [s.coker@uea.ac.uk](mailto:s.coker@uea.ac.uk) or telephone: 01603 593544.

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by East of England, Norfolk Research Ethics Committee.



***Advantages and disadvantages of taking part?***

The advantages of taking part are that we hope this research will help us better understand young people's feelings when they are going through treatment for their weight. The disadvantages are that there will be no direct benefit for you or your child and it will take some of your time to attend the interview and complete the questionnaires. If for any reason your child becomes upset whilst reading the information sheet or filling in the questionnaires any time after the interview please contact the researcher (details below) or the XXX team, who will guide you to help provide appropriate support. Your child's GP will also be informed of their involvement in the study, should they choose to take part.

***Contact for More Information***

If you would like any more information, or have any questions, you can contact:

**Dr Imren Sterno (Trainee Clinical Psychologists) at the University of East Anglia:  
07974 64 34 21**

-----  
REPLY SLIP – to be returned to the Weight Management Team reception and posted in the box labelled RESEARCH STUDY.

I agree for to be contacted in order to for my child to participate in this study on Youth Obesity and Body Image Concerns.

Address:.....  
.....  
.....

Post code:.....

Telephone number:.....

Mobile number.....

Best time to contact?.....



**Title of project: Young people's views on their shape and weight,  
eating habits and mood**

**Consent Form for Parent/Main Carer (REF: 11/EE/0268)**

Participant Identification Number \_\_\_\_\_

OFFICE USE ONLY: \_\_\_\_\_

Please initial each box

If you agree

1. I confirm that I have read the information sheet for the above study and have had the opportunity to ask questions

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. Withdrawal from the research will not affect my legal rights.

☐

3. I agree to my child taking part in this study (if child is 16 years or under)

☐

4. I agree to take part in the above study

☐

5. I agree for the interview with my child to be audio recorded during the interview and for the information to be transcribed

☐

6. I agree that my child's GP will be informed of their part in the study

☐

7. I would like to receive a copy of the results of the research

☐

Please provide address details below only if you would like a copy of the results:

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Name of Parent/Main Carer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

1 copy to be retained by participant

1 copy to be retained by researcher



## **Information Sheet for Young People**

### **Title of project: Young people's views on their shape and weight, eating habits and mood (aged 14 – 16 years)**

#### ***The research***

I am training to be a clinical psychologist studying at the University of East Anglia. A clinical psychologist is someone who tries to understand and help people with their problems. This project is being carried out as part of my studies. The staff at the XXX service is helping me with this study. My study is trying to find out more about how young people feel about their weight and how they look. To find out about this I would like to interview you and have a discussion with you about how you feel about your weight, how you look and how you have been feeling in yourself. The interview will take place in the offices at XXX and will take no longer than one hour.

#### ***What will I have to do?***

If are interested in taking part in this study please read this information sheet and discuss it with your parents. There is also an information sheet for them to read which tells them about the study. If you agree to take part in the study we will ask you to fill in and sign a form to say that you understand the research and that you are happy to take part. Your parents will also have to sign a form to say that they are happy for you to take part in the study. Once you agree to take part you can contact me using the telephone number at the end of this sheet and then we can arrange a meet up for the interview which will take place on the XXX premises.

Your GP will be told that you have taken part in this study also. However, they will not have any of the information that you give us.

#### ***Do I have to take part?***

No you don't have to take part. It is up to you if you want to take part or not. You can stop taking part at any time during the study. You do not have to give a reason if you decide to

stop. Whether you decide to take part in the study or not this will not affect you being seen by the XXX team.

***Who is taking part?***

All young people who have come to an appointment with the XXX Team in Ipswich will be asked if they want to take part. In total, I need about 10 young people to take part.

You will also be entered into a raffle to win an iPod to acknowledge your contribution to the study as part of the study.

***Who will see the information you give us about yourself?***

All information which is collected about you during the study will be kept strictly confidential, and any information about you which leaves the XXX service will have your name and address removed so that you cannot be recognised. The interview will be audio recorded and everything that is talked about will be written down. Your name will not appear on any of the information. You will be given a special code number to replace your name so no one will see your name on any of the information.

***What will happen to the results?***

The information from the interview will be put into a database on a computer and looked at to see how young people feel about their weight, how they look and to find out how they feel about themselves.

The information will be coded and some information will be entered into a database on a computer. This will be analysed to see what young people's views are about their shape and weight, eating habits and how this might be affecting their mood.

The interviews will give young people a chance to tell us their views and help us find out more about the young people who attend the XXX service and understand how they are feeling.

The information will be written up as part of my studies and a report will also be given to the XXX Team to help them find out more about how young people feel about their weight and how they look.

Once all the information is collected the study will be over and you will not be contacted again unless you would like a copy of the results of the study. If you want a copy of the results you will need to provide your name and address or your parent/carer can do this. The information regarding this study will be kept until the study is completed and the information you have given will then be stored securely at the University of East Anglia, in a locked building that stores research information from different studies that are done at the University.

### ***Confidentiality***

All of the personal information that you give will be kept separately from your interview recorded interview and all information will be made anonymous, therefore no one will be able to tell that it was you who was interviewed. All the information you give us will be kept safe and secure in the XXX team offices and locked away. The only people who will see the information are those who are involved in the study, for example, the researcher and the research supervisors from the University of East Anglia in order to check that the study is being carried out correctly and that all information has been collected and stored in a safe and secure way.

### ***What if there is a problem?***

If you have any questions or worries about anything to do with this study, you should ask to speak to the researchers who will do their best to answer your questions, contact details are below. If you remain unhappy and wish to complain formally, you can do this by contacting the researcher's supervisor, Dr Sian Coker, at the University of East Anglia, [s.coker@uea.ac.uk](mailto:s.coker@uea.ac.uk) or telephone: 01603 593544.

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by East of England, Norfolk Research Ethics Committee.

***Advantages and Disadvantages***

We hope that this study will help us understand more about young people's feelings about their weight and eating habits when they are going through treatment for their weight problems. We don't see any disadvantages to taking part in the study but if for any reason you become worried or upset we will stop the study and try to find out why you are upset and talk to you about this and if you need to discuss your feeling further the XXX team or your GP will be contacted.

***For Further Support***

For any further support you might feel you need after reading this information sheet and the questionnaires please contact either your GP or other helpful organisations such as BEAT or the MEND project. You can also contact the weight management team.

**BEAT:** Beat is the leading UK charity for people with eating disorders and their families.

Beat is the working name of the Eating Disorders Association Tel: 0845 634 1414

**MEND:** is an organisation for overweight children that helps them become fitter, healthier and happier and to reach or maintain a healthy weight

Tel: 0800 230 0263

***Contact for More Information***

If you would like any more information, or have any questions, you or your parents can contact: **Dr Imren Sterno (Trainee Clinical Psychologists) at the University of East Anglia: 07974 64 34 21**



## **Information Sheet for Young people**

**Title of project: Young people's views about their shape and weight, eating habits and mood**

**(16 years+)**

### ***The Research***

I am a trainee clinical psychologist studying at University of East Anglia. This project is being carried out as part of my research for a doctorate in clinical psychology. The project is being carried out with the cooperation of the XXX team in Ipswich. The focus of the research is on young people's views on their weight and shape, eating habits and mood. I would like to ask you about what you think and how you feel about your shape and weight. I would like to find out how you have been feeling recently and to discuss your experience of being overweight. In order to do this I would like to interview you at the XXX Team offices. The interview will usually take about one hour. I would also like to ask you to complete a questionnaire about how you were referred to the Live Well team and some general information regarding your current weight. It is hoped that the information from this study this will help provide a better understanding of young people who are overweight and may help inform future treatment in this area.

### ***What will I have to do and what will happen?***

Once you have read this information sheet and if you are interested in taking part in the study please discuss the study with your family and pass on the information letter for them to also read. We need to be able to contact you to discuss the study with you and make arrangements for you to take part. Please complete the attached slip and provide your contact details. There is a posting box at the reception of the XXX team and you will be asked to post this slip in the box in order to be contacted by myself to arrange a suitable time to meet with you to carry

out the interview. The interview will take place on the XXX premises and can be arranged to be conducted before or after your appointment with the team if this is suitable.

If you agree to take part, you will be asked to sign a consent form, which indicates that you are happy to take part in the research. We will do this together when we arrange to meet up for the interview. You will also be asked to fill in the enclosed questionnaires and provide some general information regarding your age, height, weight etc and how you were referred to the XXX Team.

If you agree to take part we will make an appointment for you to meet with me in order to be interviewed and asked about your views of your shape, weight, eating habits and mood. The interview will last about one hour. The interview will be audio recorded, transcribed (written down) and then your name will be removed and the interview will be given a number code. Only the people involved in carrying out the research will know the code for your interview. The tape will be destroyed once the interview has been transcribed.

Once all the information is collected, the study will be over and you will not be contacted again unless you would like a copy of the results. If this is the case you can let us know once the interview is complete.

Your GP will be informed of your involvement in the study also.

***Do I have to take part?***

It is up to you whether you want to take part. If you decide that you would like to take part but change your mind after you have been interviewed, the information collected can be destroyed at anytime and you can be removed from the study. You do not need to give reason for deciding that you no longer want to take part in the study. This will not affect your use of the XXX services currently or in the future.

You will also be entered into a raffle to win an iPod to acknowledge your contribution to the study as part of the study.



***Who is taking part?***

All young people who are receiving treatment from the XXX team will be asked if they want to take part. In total, I need about 10 young people to take part in order to collect the sufficient amount of information.

***Confidentiality***

All information which is collected about you during the study will be kept strictly confidential, and any information about you which leaves the XXX service will have your name and address removed so that you cannot be recognised. You will only be identifiable by a number, not by name. If you tell me something that might suggest you are a risk to yourself or others, I would need to inform your GP or your parents, however I will always tell you if I am concerned and will discuss this with you first.

***What will happen to the results?***

The information will be coded and some information will be entered into a database on a computer. This will be analysed to see what young people's views are about their shape and weight, eating habits and how this might be affecting their mood.

The information gathered will be written up as part of my course work and a report will be presented to the XXX Team. We hope that the information from the study will help the XXX service to have a better understanding of this area. If you would like a copy of the results of the study please let me know and we can send you one when the study is finished. Once the study is over (June 2012), all data collected will be stored securely in locked offices at the University of East Anglia, along with other research data that has been done by other researchers who are also part of the university.

***What if there is a problem?***

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions, contact details are below. If you remain unhappy and wish to complain formally, you can do this by contacting the

researcher's supervisor, Dr Sian Coker, at the University of East Anglia, [s.coker@uea.ac.uk](mailto:s.coker@uea.ac.uk) or telephone: 01603 593544.

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by East of England, Norfolk Research Ethics Committee.

### ***Advantages and disadvantages of taking part?***

The advantages of taking part are that we hope this research will help us better understand young people's feelings about their weight and shape, eating habits and mood when they are going through treatment for their weight problems. There are no foreseen disadvantages in taking part and if, for any reason, you become upset at any point during your involvement in the study, the study will be stopped. We will try to find out why you are upset and discuss this with you. You can also be offered a referral to the appropriate health professionals, if required.

### ***Contact for More Information***

If you would like any more information, or have any questions, you can contact:

**Dr Imren Sterno (Trainee Clinical Psychologists) at the University of East Anglia:  
07974 64 34 21**

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REPLY SLIP – to be returned to the Live Well reception and posted in the box labelled RESEARCH STUDY.

I agree for to be contacted in order to participate in this study on young people's views about their shape and weight, eating habits and mood

Address:.....  
.....  
.....

Post code:.....

Telephone number:.....

Mobile number.....

Best time to contact?.....



# Title of project: Young people's views on their shape and weight, habits and mood

## Consent Form for Young Person aged 14 -16 years

Project Number: (REF: 11/EE/0268)

Participant Identification Number \_\_\_\_\_

OFFICE USE ONLY: \_\_\_\_\_

Please initial each box

1. I Confirm that I have read the information sheet for the above study and have had the chance to ask questions. ☐
2. I understand that the information collected during this study may be looked at by other people who work at the University of East Anglia and the NHS. I agree to this ☐
3. I understand that my taking part is voluntary and that I am free to withdraw at any time, without giving any reason. Withdrawal from the research will not affect my legal rights. ☐
4. I agree to take part in the above study ☐
5. I agree for my GP to be told about my involvement in this study ☐
6. I agree to my interview being audio recorded and written up ☐
7. I would like to see a copy of the results of the research  
Please give your address details below only if you would like a copy of the results: ☐

Address \_\_\_\_\_

\_\_\_\_\_

_____ Name of Young Person	_____ Date	_____ Signature
_____ Name of Parent/Main Carer	_____ Date	_____ Signature
_____ Researcher	_____ Date	_____ Signature

1 copy to be retained by participant  
1 copy to be retained by researcher



**Title of project: Young people's views on their shape and weight, eating habits and mood**

**Consent Form for Young Person aged 16 years+**

**Project Number: 11/EE/0246**

**Participant Identification Number**

**OFFICE USE ONLY:**\_\_\_\_\_

Please initial each box  
If you agree

1. I confirm that I have read the information sheet for the above study and have had the chance to ask questions ☐
2. I understand that the information collected during this study may be looked at by other people who work at the University of East Anglia and the NHS. I agree to this ☐
3. I understand that my taking part is voluntary and that I am free to withdraw at any time, without giving any reason. Withdrawal from the research will not affect my legal rights. ☐
4. I agree to take part in the above study ☐
5. I agree to being interviewed and my interview being audio recorded and written up ☐
6. I agree that my GP will be informed of my part in this study ☐
7. I would like to see a copy of the results of the research  
Please give your address details below only if you would like a copy of the results: ☐

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Name of Young Person      Date      Signature

\_\_\_\_\_  
Name of Parent/Main Carer      Date      Signature

\_\_\_\_\_  
Researcher      Date      Signature

1 copy to be retained by participant  
1 copy to be retained by researcher

**BSQ-34:** We should like to know how you have been feeling about your appearance over the **PAST FOUR WEEKS**. Please read each question and circle the appropriate number to the right. Please answer all the questions. **OVER THE PAST FOUR WEEKS:**

	Never						
		Rarely					
			Sometimes				
				Often			
					Very often		
						Always	
1. Has feeling bored made you brood about your shape?.....	1	2	3	4	5	6	
2. Have you been so worried about your shape that you have been feeling you ought to diet?.....	1	2	3	4	5	6	
3. Have you thought that your thighs, hips or bottom are too large for the rest of you?.....	1	2	3	4	5	6	
4. Have you been afraid that you might become fat (or fatter)?.....	1	2	3	4	5	6	
5. Have you worried about your flesh being not firm enough?.....	1	2	3	4	5	6	
6. Has feeling full (e.g. after eating a large meal) made you feel fat?.....	1	2	3	4	5	6	
7. Have you felt so bad about your shape that you have cried?.....	1	2	3	4	5	6	
8. Have you avoided running because your flesh might wobble?.....	1	2	3	4	5	6	
9. Has being with thin women made you feel self-conscious about your shape?.....	1	2	3	4	5	6	
10. Have you worried about your thighs spreading out when sitting down?	1	2	3	4	5	6	
11. Has eating even a small amount of food made you feel fat?.....	1	2	3	4	5	6	
12. Have you noticed the shape of other women and felt that your own shape compared unfavourably?.....	1	2	3	4	5	6	
13. Has thinking about your shape interfered with your ability to concentrate (e.g. while watching television, reading, listening to conversations)?.....	1	2	3	4	5	6	
14. Has being naked, such as when taking a bath, made you feel fat?.....	1	2	3	4	5	6	
15. Have you avoided wearing clothes which make you particularly aware of the shape of your body?.....	1	2	3	4	5	6	
16. Have you imagined cutting off fleshy areas of your body?.....	1	2	3	4	5	6	

	Never					
		Rarely				
			Sometimes			
				Often		
					Very often	
						Always
17. Has eating sweets, cakes, or other high calorie food made you feel fat?	1	2	3	4	5	6
18. Have you not gone out to social occasions (e.g. parties) because you have felt bad about your shape?.....	1	2	3	4	5	6
19. Have you felt excessively large and rounded?.....	1	2	3	4	5	6
20. Have you felt ashamed of your body?.....	1	2	3	4	5	6
21. Has worry about your shape made you diet?.....	1	2	3	4	5	6
22. Have you felt happiest about your shape when your stomach has been empty (e.g. in the morning)?.....	1	2	3	4	5	6
23. Have you thought that you are in the shape you are because you lack self-control?.....	1	2	3	4	5	6
24. Have you worried about other people seeing rolls of fat around your waist or stomach?.....	1	2	3	4	5	6
25. Have you felt that it is not fair that other women are thinner than you?.	1	2	3	4	5	6
26. Have you vomited in order to feel thinner?.....	1	2	3	4	5	6
27. When in company have you worried about taking up too much room (e.g. sitting on a sofa, or a bus seat)?.....	1	2	3	4	5	6
28. Have you worried about your flesh being dimply?.....	1	2	3	4	5	6
29. Has seeing your reflection (e.g. in a mirror or shop window) made you feel bad about your shape?.....	1	2	3	4	5	6
30. Have you pinched areas of your body to see how much fat there is?.....	1	2	3	4	5	6
31. Have you avoided situations where people could see your body (e.g. communal changing rooms or swimming baths)?.....	1	2	3	4	5	6
32. Have you taken laxatives in order to feel	1	2	3	4	5	6

thinner?.....

33. Have you been particularly self-conscious about your shape when  
in the company of other people?..... 1 2 3 4 5 6
34. Has worry about your shape made you feel you ought to  
exercise?..... 1 2 3 4 5 6

**Rosenberg's Self-Esteem Scale**

STATEMENT		Strongly Agree	Agree	Disagree	Strongly Disagree
1.	I feel that I am a person of worth, at least on an equal plane with others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	I feel that I have a number of good qualities..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	All in all, I am inclined to feel that I am a failure.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	I am able to do things as well as most other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	I feel I do not have much to be proud of.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	I take a positive attitude toward myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	On the whole, I am satisfied with myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	I wish I could have more respect for myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.	I certainly feel useless at times.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	At times I think I am no good at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The scale ranges from 0-30. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem.



Self-report version

## SHORT MOOD AND FEELINGS QUESTIONNAIRE

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way  
*in the past two weeks.*

If a sentence was true about you most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about you, check NOT TRUE.

	TRUE	SOME TIMES	NOT TRUE
1. I felt miserable or unhappy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I didn't enjoy anything at all .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt so tired I just sat around and did nothing .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I was very restless .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I felt I was no good any more .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I cried a lot .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I found it hard to think properly or concentrate .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I hated myself .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was a bad person .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt lonely .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I thought nobody really loved me <i>worthless</i> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I thought I could never be as good as other kids .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I did everything wrong <i>blame</i> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## EATING QUESTIONNAIRE

**Instructions:** The following questions are concerned with the past four weeks (28 days) only. Please read each question carefully. Please answer all the questions. Thank you.

**Questions 1 to 12:** Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days) only.

On how many of the past 28 days .....	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
1 Have you been deliberately <u>trying</u> to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
2 Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?	0	1	2	3	4	5	6
3 Have you <u>tried</u> to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
4 Have you <u>tried</u> to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
5 Have you had a definite desire to have an <u>empty</u> stomach with the aim of influencing your shape or weight?	0	1	2	3	4	5	6
6 Have you had a definite desire to have a <u>totally flat</u> stomach?	0	1	2	3	4	5	6
7 Has thinking about <u>food, eating or calories</u> made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
8 Has thinking about <u>shape or weight</u> made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
9 Have you had a definite fear of losing control over eating?	0	1	2	3	4	5	6
10 Have you had a definite fear that you might gain weight?	0	1	2	3	4	5	6
11 Have you felt fat?	0	1	2	3	4	5	6
12 Have you had a strong desire to lose weight?	0	1	2	3	4	5	6

Questions 13-18: Please fill in the appropriate number in the boxes on the right. Remember that the questions only refer to the past four weeks (28 days).

Over the past four weeks (28 days) .....

- |   |       |
|---|-------|
| 13 Over the past 28 days, how many <u>times</u> have you eaten what other people would regard as an <u>unusually large amount of food</u> (given the circumstances)?  | ..... |
| 14 ..... On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)?  | ..... |
| 15 Over the past 28 days, on how many <u>DAYS</u> have such episodes of overeating occurred (i.e., you have eaten an <u>unusually large amount of food</u> <u>and</u> have had a sense of loss of control at the time)? | ..... |
| 16 Over the past 28 days, how many <u>times</u> have you made yourself sick (vomit) as a means of controlling your shape or weight?   | ..... |
| 17 Over the past 28 days, how many <u>times</u> have you taken laxatives as a means of controlling your shape or weight?  | ..... |
| 18 Over the past 28 days, how many <u>times</u> have you exercised in a "driven" or "compulsive" way as a means of controlling your weight, shape or amount of fat, or to burn off calories?                            | ..... |

Questions 19 to 21: Please circle the appropriate number. Please note that for these questions the term "binge eating" means eating what others would regard as an unusually large amount of food for the circumstances, accompanied by a sense of having lost control over eating.

- |   |                   |                    |                |                   |                |                  |            |
|---|-------------------|--------------------|----------------|-------------------|----------------|------------------|------------|
| 19 Over the past 28 days, on how many days have you eaten in secret (ie, furtively)?<br>..... Do not count episodes of binge eating   | No days           | 1-5 days           | 6-12 days      | 13-15 days        | 16-22 days     | 23-27 days       | Every day  |
|   | 0                 | 1                  | 2              | 3                 | 4              | 5                | 6          |
| 20 On what proportion of the times that you have eaten have you felt guilty (felt that you've done wrong) because of its effect on your shape or weight?<br>..... Do not count episodes of binge eating | None of the times | A few of the times | Less than half | Half of the times | More than half | Most of the time | Every time |
|   | 0                 | 1                  | 2              | 3                 | 4              | 5                | 6          |
| 21 Over the past 28 days, how concerned have you been about other people seeing you eat?<br>..... Do not count episodes of binge eating   | Not at all        | Slightly           | Moderately     | Markedly          |                |                  |            |
|   | 0                 | 1                  | 2              | 3                 | 4              | 5                | 6          |

Questions 22 to 28: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days).

Over the past 28 days .....	Not at all		Slightly		Moderately		Markedly
22 Has your <u>weight</u> influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
23 Has your <u>shape</u> influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
24 How much would it have upset you if you had been asked to weigh yourself once a week (no more, or less, often) for the next four weeks?	0	1	2	3	4	5	6
25 How dissatisfied have you been with your <u>weight</u> ?	0	1	2	3	4	5	6
26 How dissatisfied have you been with your <u>shape</u> ?	0	1	2	3	4	5	6
27 How uncomfortable have you felt seeing your body (for example, seeing your shape in the mirror, in a shop window reflection, while undressing or taking a bath or shower)?	0	1	2	3	4	5	6
28 How uncomfortable have you felt about <u>others</u> seeing your shape or figure (for example, in communal changing rooms, when swimming, or wearing tight clothes)?	0	1	2	3	4	5	6

What is your weight at present? (Please give your best estimate.) .....

What is your height? (Please give your best estimate.) .....

If female: Over the past three-to-four months have you missed any menstrual periods? .....

If so, how many? .....

Have you been taking the "pill"? .....

**THANK YOU**



**Appendix 2.E. Ethical approval documentation****NRES Committee East of England - Norfolk**

Victoria House  
Capital Park  
Fulbourn  
Cambridge  
CB21 5XB

Telephone: 01223 597597  
Facsimile: 01223 597645

04 November 2011

Dr Imren Sterno  
Clinical Psychology Trainee  
Cambridgeshire and Peterborough NHS Foundation Trust  
Doctoral Programme in Clinical Psychology  
UEA, Elizabeth Fry Building  
Norwich  
NE4 7TJ

Dear Dr Sterno

**Study title:** An exploratory study of body image concerns, eating habits and mood in youth obesity  
**REC reference:** 11/EE/0268

Thank you for your letters and email, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Ethical review of research sites**

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Advertisement	Poster, 2	01 October 2011
Covering Letter		30 June 2011
Evidence of insurance or indemnity	Letter from UEA	29 June 2011
Evidence of insurance or indemnity	Zurich Municipal certificate	25 May 2011
Evidence of insurance or indemnity	Zurich Municipal certificate	16 June 2010
Investigator CV	Mrs Imren Sterno	
Letter of invitation to participant	Young Person 14-16, 4	01 October 2011
Letter of invitation to participant	Young person 14 -16 years qual, 4	10 October 2011
Letter of invitation to participant	Young person 16+ qual, 4	01 October 2011
Letter of invitation to participant	Parent/main carer quant, 4	01 October 2011
Letter of invitation to participant	Young person / quant 16+, 3	01 October 2011
Letter of invitation to participant	Parent/main carer Qual, 4	01 October 2011
Letter of invitation to participant	parent/main carer qual, 4	01 October 2011
Letter of invitation to participant	Young person 16 years=+quant, 4	01 October 2011
Other: Academic Supervisor CV	Sian Coker	
Participant Consent Form: Consent form for young person 14+ quant interviews	2	01 October 2011
Participant Consent Form: young person 16 years + qual	2	06 October 2011
Participant Consent Form: young person 14+ qualitative interviews	2	06 October 2011
Participant Consent Form: consent forms young person 14 + Quant interviews	2	01 October 2011
Participant Consent Form: parent or main carer Qual form interviews	1	06 October 2011
Participant Consent Form: young person 16+ quant	2	06 October 2011
Participant Consent Form: parent of main carer quant form interview	1	06 October 2011
Participant Consent Form: Parent or main carer Qual	2	06 October 2011

Participant Consent Form: Parent or main carer	2	06 October 2011
Quant questionnaires		
Participant Information Sheet: Qualitative interview, 16+	4	01 October 2011
Participant Information Sheet: Qualitative interview	4	01 October 2011
Participant Information Sheet: Quant info sheet main carers	4	01 October 2011
Participant Information Sheet: Quantitative questionnaires 14-16	2	01 October 2011
Participant Information Sheet: parents/main carers qualitative interview	4	01 October 2011
Participant Information Sheet: qualitative interview 14-16	2	01 October 2011
Participant Information Sheet: quantitative questionnaires 14-16	2	01 October 2011
Participant Information Sheet: Quant postal questionnaires 16+	4	01 October 2011
Protocol	- study proposal (undated)	
Questionnaire: Eating questionnaire		
Questionnaire: BSQ-34		
Questionnaire: Interview guide for qualitative interview	1	26 April 2011
Questionnaire: Rosenberg's Self-Esteem Scale		
Questionnaire: SMFQ		
Questionnaire: Demographic parents main carers	4	01 October 2011
Questionnaire: Demographic 16+	3	01 October 2011
REC application	Submission code 55740/227520/1/370	29 June 2011
Response to Request for Further Information	Several letters and emails with revised and further revised documents last one received 04 November 2011	

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

#### Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of

changes in reporting requirements or procedures.

#### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

<b>11/EE/0268</b>	<b>Please quote this number on all correspondence</b>
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With the Committee's best wishes for the success of this project

Yours sincerely

**Michael Sheldon MA, PhD**  
**Chair**

Email: [lynda.mccormack@eoe.nhs.uk](mailto:lynda.mccormack@eoe.nhs.uk)

*Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments*

*"After ethical review – guidance for researchers"*

*Copy to: Ms Tracy Moulton  
The Registry  
UEA  
Norwich NR4 7TJ*

*Mrs Frances Farnworth  
Ipswich R&D office  
Ipswich Hospital  
Ipswich  
Suffolk IP4 5PD*



**NRES Committee East of England - Norfolk****Attendance at Sub-Committee of the REC meeting on 04 November 2011****Committee Members:**

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Ms Leanne Groves	Psychological Therapist/Occupational Therapist	No	Apologies given
Dr Linda Harvey	Senior Research Scientist	Yes	
Michael Sheldon MA, PhD	Retired Clinical Psychologist	Yes	

**Also in attendance:**

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Lynda McCormack	REC Co-ordinator



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Steps to a healthier future

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**1<sup>st</sup> November 2011**

**To whom it may concern**

**RE: Study on Youth Obesity**

This is to confirm that Livewell Suffolk is happy to host the study on Youth Obesity and Body Image Concerns, and for Dr Imren Sterno to ask our clients to participate, if they fit the inclusion criteria. We will also be providing indemnity cover for this study.

Please do not hesitate to contact me if you require any further information.

Yours Sincerely

**Tim Roberts**  
**Director Livewell Suffolk**