Practice makes perfect

- a longitudinal, qualitative study of obese adolescents’ and their parents’ experiences of the adolescents’ obesity and weight loss attempts

PhD dissertation

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Aarhus University
2011
Acknowledgements

I would like to thank my supervisors, Birthe D. Pedersen and Claus Vinther Nielsen. A very special thanks goes to my wife, Dorte Lindelof, whose thoughts and ideas have contributed to a great extent to the dissertation.

The project was financed by the Faculty of Health Sciences, Aarhus University, and received a donation from the Danish Heart Foundation.
Articles of the thesis

Article 1
Lindelof A, Nielsen CV, Pedersen BD. Obesity treatment more than food and exercise: a qualitative study exploring obese adolescents’ and their parents’ views on the former’s obesity
International Journal of Qualitative Studies on Health and Well-Being
2010;5:5073 DOI: 10.3402/qhw.v5i2.5073

Article 2
Lindelof A, Nielsen CV, Pedersen BD. A qualitative, longitudinal study exploring obese adolescents’ attitudes towards physical activity
Journal of Physical Activity & Health (Submitted)

Article 3
Lindelof A, Nielsen CV, Pedersen BD. Obesity stigma at home: A qualitative, longitudinal study of obese adolescents and their parents
Childhood Obesity (Submitted)
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Puterbaugh 2009
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This thesis reports from a longitudinal study that explored how obese adolescents’ and their parents’ experience the adolescents’ obesity and possible attempts to reduce weight in daily life. The incentive was to increase the understanding of obese adolescents’ practice and the factors contributing to their practices regarding their obesity and attempts to reduce weight. Insights gained can hopefully be of relevance when supporting obese individuals to permanently adopt a healthier lifestyle and help in formulating preventive strategies that can avoid the development of obesity.

A century ago obesity was relatively unknown. Since then, the prevalence of overweight and obesity has increased dramatically. By the turn of the millennium the number of adults with excess weight surpassed those who were underweight (Gardner et al 2000). In 2005 a third of the world’s inhabitants were overweight or obese and it has been predicted that by 2030 nearly 60% of the world’s inhabitants will be overweight or obese (Kelly et al 2008). Obesity has exceeded smoking as the leading preventable cause of death in the US (Jia et al 2010) and in today’s North America, children’s life expectancy is expected to be shorter than that of their parents due to obesity (Olshansky et al 2005). Obesity, therefore, is considered one of the most urgent health issues in modern times.

The physiological aetiology of obesity is complex. However at a basic level obesity can be reduced to a matter of calorie intake versus expenditure (Ebbeling et al 2002). Thus, obesity is, partly, a matter of individual choices and lifestyle – i.e. it concerns individual’s ability to eat non-fattening products and attend to regular physical activity. In that light the treatment of obesity seems easy: eat less and exercise more. The majority of the obese population can comply with this simple message for a short period. However, it is extremely difficult for many obese individuals to adhere to a healthier lifestyle in the long run and the great majority regains weight after behaviour-induced weight loss (McGuire et al 1999). There are many reasons why obese individuals have trouble sustaining changes of habits over time and more research is needed to point out areas that could support obese individuals to permanently maintain healthier practises or, preferably, avoid becoming obese in the first place.
The overall objective underlying this thesis is therefore to gain knowledge that can support obese individuals to reduce weight permanently or, alternatively, prevent individuals in general becoming obese. Although other assumptions could have been made, the assumption in this thesis is that people turn obese because they live a sedentary life and/or eat fattening foods. They do this, it is further assumed, because they find such a lifestyle attractive and not because they are irrational, irresponsible human beings. Another assumption made is that obese individuals’ practices are not solely an individual matter. Hence, an individual cannot be thought of as only an autonomous subject, but should rather be seen as belonging to specific collectives (e.g. family, social network, community, type of education, occupation). Thus, a concept of a relational subject directs the understanding of the individual in this thesis. Nevertheless, it is by no means implied that the approach chosen is the only valid approach to obesity. But other approaches, for instance of a biological or a psychological nature, are not within the scope of this thesis. The interest for the present investigation’s approach is to be found in the researcher’s interdisciplinary background. Besides being a medical doctor, he has a degree in anthropology and has previously conducted anthropological investigations among obese children and their parents and obese adults (Lindelof 2005, Lindelof 2005a).

The thesis is divided into eight chapters: The following chapter, Background, first gives a basic overview of relevant insights into obesity. Then, a review of literature that addresses obese individuals’ and their relatives’ practice is outlined – this allows for a sketching-out of the aim. Chapter three, Scientific Framework is divided into: reflections on data collection, data interpretation, and theoretical framework. The fourth chapter, Material and methods, addresses setting, participants, data collection, the relationship between the researcher and participants, data analysis and ethical matters. Chapter five presents the Findings. Chapter six, Discussion, first discusses the findings. Two focal points are addressed: why obese adolescents become obese, and why obese adolescents are unable to reduce weight. Secondly, the discussion discusses the methodological design. Chapter seven, Conclusion, outlines the overall conclusions from the study. The last chapter, Perspectives, puts forward some implications drawn from the study into perspective.
2 BACKGROUND

This section first outlines basic insights into the field of obesity, e.g. epidemiology, health-related consequences, economics, aetiology, and prevention and treatment. Then, literature addressing obese individuals’ and their relatives’ practices regarding the formers’ obesity is reviewed. This leads on to a statement of the aim of the thesis.

General topics regarding obesity

Diagnosis

Overweight and obesity are a medical condition and can be diagnosed using the body mass index (BMI) (WHO 2000), which is a statistical measure that compares weight and height. An adult person is considered overweight if their BMI is between 25 and 30 and obese if above 30. Obesity can further be divided into three degrees. For children, WHO recommend the use of an age and gender-adjusted score, as recommended by Cole et al (2000). Although it is clinically important to differentiate between overweight and obesity, the latter term will be used throughout the thesis, unless otherwise specified.

Epidemiology

In Denmark and most other countries in the world obesity prevalence has steadily increased since World War II, and in particular since the 1970s (Dehghan et al 2005). For instance, girls aged six to eight living in Copenhagen were eight times more likely to be overweight and 20 times more likely to be obese in 2003 compared to 1943. In the same period the risk for boys to be overweight had increased 11 times while their risk of being obese had increased 115 times (Pearson et al 2005). Among the entire adult Danish population, 40% of males and 26% of females were overweight or obese in the year 2000. Of these, 10% of males and 9% of females were obese (BMI>30) – representing a 75% increase compared to 1987 (Motions- og Ernæringsrådet 2007). Within the adult population in Europe, Denmark has the seventh lowest prevalence of overweight/obesity (WHO 2007). In comparison Albania is at the top with nearly 80% being overweight/obese, while Norway has the lowest prevalence. In
North America nearly 75% of the adult population has a BMI greater than 25 while the republic of Nauru, an island in the South Pacific, has the world’s highest prevalence with 94.5% of the population being overweight or obese (www.forbes.com).

Obesity is seen in all social classes. However, the risk of being obese is three to four times higher among adults with little or no education, compared to more educated individuals (Singh et al 2010, O’Dea et al 2010). In addition, due to a more rapid increase in obesity prevalence among children in lower socioeconomic groups social inequalities in obesity prevalence are increasing (Singh et al 2010). Also a study has shown that a person’s risk of becoming obese is nearly 60% greater if he/she has an obese friend. Likewise, a spouse has nearly 40% risk of becoming obese if his/her partner becomes obese (Christakis et al 2007).

**Health-related consequences**

Obesity increases mortality and morbidity rates and has a negative impact on psychological and social well-being. In 1999 an estimated 280,000 premature deaths were ascribed to obesity in the USA (Allison et al 1999). In addition, obesity is a risk factor for other leading causes of death, such as heart disease, stroke, diabetes and some types of cancer. Obesity impacts on practically all medical specialities, e.g. cardiology, respirology, endocrinology, neurology, oncology, rheumatology (Haslam et al 2005), orthopaedics (Bergkvist et al 2009), urology, nephrology (Ejerblad et al 2006). Although somatic health-related consequences primarily affect obese adults, children as young as five years of age are increasingly diagnosed with diabetes, hypertension, and disturbed lipid metabolism due to obesity (Livingstone et al 2006).

Compared to non-obese individuals, obese adults have weakened psychological and social well-being; including for example, reduced quality of life (Kolotkin et al 2001), increased risk of depression (Luppino et al 2010), or less chance of getting married (Gortmaker et al 1993). Obese children and young people suffer from many of the same conditions and experience, for instance, reduced quality of life (Williams et al 2005), fewer friends (Strauss et al 2003), or are more frequently subject to name-calling and bullying (Janssen et al 2004), compared to non-obese peers.
Obese individuals are to a large extent stigmatised and exposed to prejudice in practically all major social settings, including, for instance, the family, workplace, and in health service settings (Puhl et al 2007, Puhl et al 2009). It is hypothesised that the stigma surrounding obesity is a product of the overall perception in society of obese individuals: numerous studies have demonstrated that both non-obese and obese individuals attribute obesity to negative characteristics such as lack of self-control and a weak character that, put in simple terms, reduces the obese individual to a lazy glutton (Neumark-Sztainer et al 1999, Sechrist et al 2005, Puhl et al 2008). One study has shown that children as young as three years of age have these negative attitudes about obese individuals (Tiggemann et al 1998). Thus, the general perception is that obesity is a self-induced condition that can be cured by regular exercise and a moderate diet.

**Economics**

A calculation from 2006 shows that 2-3% of the Danish Gross National Product (GNP) is spent directly on health-related costs associated with obesity and 0.2-0.5% is spent on indirect costs, primarily related to the employment sector (Pedersen et al 2006). In 1998 nearly 10% of total U.S. medical expenditure was allocated to obesity and its consequences (Finkelstein et al 2003).

**Aetiology**

It is widely agreed that the recent rapid rise in obesity prevalence can only be explained by environmental changes that favour a certain practice that leads to obesity (WHO 2000, WHO 2004, Jeffery et al 2003, Jones et al 2007). These environmental changes are related to other global phenomena like increased globalisation, urbanisation, economic wealth, technological development, centralisation and individualisation. An obvious example of an environmental change that parallels increased rates of obesity is the invention of the television: in 1950 nine% of households in the U.S. owned a TV set – in 1978 it was 98% (www.tvhistory.tv). Furthermore, in 1970 six% of American children had a TV set in their bedroom – in 1999 it was 77% (Putnam 2000). Coupled with the increased number of TV sets there has been an increase in the number of available programmes: in Denmark, the first TV channel was launched in 1951, airing for one hour, three times a week. In 1988, a second national channel was
established and a third and private channel came in 1990 (www.en.wikipedia.org). Today the vast majority of the population have unlimited access to TV programmes due to the advent of satellite dishes, DVDs and through the internet. According to an analysis by TNSGallup, the average Danish child watches two hours of TV a day, (www.yousee.dk), while an American child watches nearly five hours a day (Putnam 2000). American children thereby spend more time in front of the screen than any other activity, excluding sleeping, but including time spent in school.

Other examples of environmental changes that have developed alongside increased rates of obesity are the increased use of cars (Kay 1998), increased fast food intake (Schlosser 2001), and a decrease in physical activity (Puterbaugh 2009). These and other environmental changes have, in the second half of the last century, laid the foundation of the so-called ‘obesogenic environment’ – a term developed in the 1990s (Lake et al 2006) and defined as ‘the sum of the influences that the surroundings, opportunities or conditions of life have on promoting obesity in individuals and populations’ (Swinburn et al 1999). The obesogenic environment therefore refers to a society where everyday life can be lived without being physically active, due to, for example, non-physical work and energy-saving devices such as the car, remote controls, TVs and lifts and escalators. At the same time, high calorie food is available everywhere and effectively marketed by the industry (Jones et al 2007). A major difference between the current obesogenic environment regarding the cause of obesity compared to, for example, 50 years ago is that physical activity and a healthy diet no longer are a natural ingredient in daily life. Thus, in the obesogenic environment the individual has to prioritise and choose to be physically active and eat a healthy diet if he/she has those ambitions. 50 years ago the individual did not have such choices but automatically lived an active life and ate a fairly healthy diet, as there were no or few alternatives. To avoid any misunderstandings, no claim is being made that the incentive of individuals to be active and eat a healthy diet in the obesogenic environment is slimness. Rather, it is claimed that the engagement with such practices presupposes a positive attitude towards them. In other words, although slim individuals may not explicitly pursue slimness, it is hypothesised that they may find meaning and pleasure in the practices associated with slimness.
**Prevention and treatment**

There are different approaches to the management of obesity. Many institutions and researchers (Müller et al 2001, International Obesity TaskForce 2002, WHO 2004, Summerbell 2005, British Medical Association 2005) argue that the best solution is to prevent individuals becoming obese in the first place. However, apart from small-scale initiatives a large-scale and comprehensive preventive strategy to tackle the obesogenic environment has not been prioritised in Denmark (Ernæringsrådet 2003, MandagMorgen 2006). The treatment for obesity often comprises behaviour modification that tries to alter eating and exercising habits. Behaviour modification may be supported by pharmacological treatment or such drugs can form the principal treatment. Finally, surgery is an option that is primarily aimed at severely obese individuals.

Various models of behaviour modification initiatives or weight loss programmes, which intend to alter obese individual’s practice, have been launched. Although different in form (e.g. duration, intensity, specialities involved, or involvement of others), the main objective of weight loss programmes is to pinpoint unfavourable practices and educate the obese individual about healthier eating and exercising practices. A widely used approach is to have a dietician to inform participants on a weekly basis about healthier food products. At the same time it is common to offer the obese individual a weekly session exercise. The underlying assumption in these programmes is based on a cause-effect model where increased knowledge about food and exercise is seen as the key to healthier practice (Lupton 1995, Puterbaugh 2009, Johannessen 2010). Although weight loss programmes generate weight reductions while the individual is engaged in the programme and for a short time thereafter (Strychar 2006), the great majority who participate experience limited effects over time (Wooley et al 1991; McGuire et al 1999; Jeffery et al 2000). Long term (> 2 years) success at weight loss has been reported from insignificant (NIH Technology Assessment Conference Panel 1993) to 20% (Wing et al 2005). Also, long-term weight loss is often modest (<5 kilo) and may not improve general well-being (Anderson et al 2001, Douketis et al 2005).
Few studies have been carried out to evaluate the reasons for almost universally poor dietary and exercise long-term adherence after ending a weight loss programme (Puterbaugh 2009). Although there could be many reasons, it may be hypothesised that weight loss programmes fail to alter underlying factors associated with the obese person’s practice. Such critique has been articulated by the sociologist Deborah Lupton (Lupton 1995) who has written on the problematics of the tendency of modern health promotion to regard individuals as rational actors who automatically will improve practice once educated about practices that are presumed to be better. She writes: “If people do not find themselves interpellated by governmental discourses, if they do not recognize themselves therein or have no investment in these discourses, they will not respond accordingly” (p.131). Therefore, it could be hypothesised that a way to improve the weight loss programmes or otherwise support obese individuals to reduce weight or preferably, help individuals from becoming obese in the first place, could be to target the behavioural aetiology of obese individuals’ dietary practices and practices of being physical active – and not necessarily the unfortunate practices per se.

The following literature review focuses on obese individuals’ and their relatives’ practices regarding obesity.

**Literature review**

Obesity is a major scientific topic within the field of medicine – a simple search in PubMed on “obesity” generates more than 140,000 articles (March 2011). However, compared to traditional biomedical areas of obesity research obese individuals’ practice receive relatively little attention. To illustrate this, a search on the word “obesity” was conducted in Statsbiblioteket’s (State Library, Aarhus, Denmark) electronic journals (Fig. 1). Eleven peer-reviewed journals that selectively address obesity (excluding areas within surgery) were found. A review of the table of contents from these journals’ latest issue revealed 192 articles\(^1\). Of these, 185 articles had a biomedical approach while seven articles dealt with obese individuals practice or social issues. Thus, and as illustrated in

\(^1\) Childhood obesity 2010 6(4); Current opinion in endocrinology, diabetes, and obesity 2010 17(5); Diabetes, metabolic syndrome and obesity: targets and therapy 2010; Diabetes, obesity & metabolism 2010 12(9); International journal of pediatric obesity 2010 5(4); International journal of obesity 2010 34(8); Journal of obesity 2010; Obesity (Silver spring) 2010 18(9); Obesity facts 2010 3(4); Obesity research & clinical practice 2010 4(3); Obesity reviews 2010 11(9).
Figure 1, within the medical field exploring obesity, the practice associated with obesity is not a major priority. Nevertheless, although rarely published in obesity-specialised journals, research that focuses on obese individuals’ practice is published elsewhere. To encapsulate these, repeated searches were conducted throughout the study period, primarily in PubMed (Fig. 2). Although obesity has been a medical problem for many years, a limited search period of approximately 15 years was chosen. Thus, the search included publications from 1995 to the present. The start date of 1995 was chosen because more recent literature was preferred in order to ensure relevance of the research. Older studies may be out of date due to, for instance, recent additional knowledge or new perspectives on obesity.

However, it should be kept in mind that a concept such as practice is complex and difficult to capture in a few terms. To identify relevant articles the keywords obesity/overweight were combined with terms such as anthropology, attitude, everyday life, experience, perception, everyday practice, health behaviour, lifestyle, qualitative investigation, qualitative research, and qualitative study. The searches generated about 2500 articles. However a screening of the titles revealed that the majority did not focus on practice – these were therefore excluded. The reasons for exclusion were primarily biological, pharmacological, surgical, epidemiological or psychological approaches, interventionist study, focus on non-obese or non-obese relatives or articles written in a language other than English. After the first exclusion 163 articles remained. The abstract or the main text of each was read and an additional 128 articles were excluded – using the same exclusion criteria as mentioned above. Finally, 33 articles were found. Relevant literature cited in these 33 articles but not found in the searches were
also included. In total, 47 articles dealing with obese individuals’ and their relatives’ practice were included in the review.

The included articles could be divided in two major categories: 1) obese individuals and 2) the caregivers of obese – or in risk of becoming obese – children and young people.

**Obese individuals**

This section can further be subdivided into obesity in general, diet and exercise.

*Obesity in general*

A general finding in the literature is that obese individuals – from children to adults – wish to reduce weight (Tyler 2004, Murtagh et al 2006, Davis et al 2008, Barberia et al 2008). Reasons for wanting to lose weight given by both children and adults include physical appearance and negative experiences associated with social torment and exclusion. Obese children also wish to improve their physical condition while obese adults express health concerns as a motivator to reduce weight (Murtagh et al 2006, Alm et al 2008, Davis et al 2008, Visram et al 2009, de la Martinez-Aguilar et al 2010). According to the literature, obese individuals have the correct knowledge to lose weight, and can correctly distinguish between healthy and unhealthy behaviours (Snethern et al 2007, Mériaux et al 2010). Despite the awareness of factors associated with obesity de la Martinez-Aguilar et al (2010) found that a group of obese adolescents believed their obesity was due to hereditary factors and therefore not subject to change.
Another finding in the literature is that obese individuals often try to attain healthier practices but fail to maintain these changes over time (Borra et al 2003, Murtagh et al 2006, Davis et al 2008, Alm et al 2008, Heading 2008). Besides factors related to diet and exercise, which are addressed below, the literature indicates that social support is important when trying to lose weight (Grignard et al 2003, Tyler 2004, Chen et al 2005, Barberia et al 2008). However, Grignard et al (2003) found that, although obese adolescents appreciate support in reducing weight, they are not explicit about the importance of the support, as they believe weight reduction is a matter of primarily dietary change, thereby neglecting the significance of, for instance, social support. Alm et al (2008) found that the families that were less likely to support obese adolescents to reduce weight were themselves less likely to engage in healthier practices. Furthermore, to a higher degree than families supporting their obese adolescents to lose weight, the less supportive families blamed their obese child for lack of willpower to lose weight. Mériaux et al (2010) found that obese children are lonely and in particular miss parental company and, as comfort, use eating and sedentary activities. Mériaux et al’s study indicates that social support may not necessarily have an explicit focus on supporting healthier habits but on a safe and confident home environment. This corresponds with other studies indicating that quarrels, accusations and a generally unstructured daily life are factors in obese children’s and adolescents’ homes (Chen et al 2005, Alm et al 2008, Edmunds 2008). Low self-esteem and lack of confidence are also regarded as an important barrier when trying to engage in healthier living (Murtagh et al 2006, Borra et al 2003). Borra et al (2003) found that a group of obese children’s low self-esteem made them sensitive about their weight and thereby less eager to involve others in the attempt to lose weight. Low self-esteem therefore induces loneliness and hence reduces the obese individual’s ability to get social support.

Diet

Tyler (2004) found that a group of obese children’s diets were high in calories and that two-thirds of the study participants did not eat fruit and vegetables. To explain regular intake of unhealthy food, studies have found that obese children prefer unhealthy food, for instance fried chicken, fried potatoes, French fries, pizza, macaroni and cheese, and therefore tend to eat those products (Hesketh
et al 2005, Murtagh et al 2006, Davis et al 2008). As mentioned above, the fondness for unhealthy food is not due to lack of knowledge and therefore contradicts their knowledge about food (Grignard et al 2003, Chen et al 2005, Hesketh et al 2005). The preferences for unhealthy food lead Heading (2008) to argue that people in general eat what they enjoy. Thus, according to Heading, increased availability or focus on healthy food may not necessarily lead to a change in food habits as peoples’ preferences are not changed.

**Exercise**

Tyler (2004) also investigated obese children’s actual and perceived health status and found that the majority (90%) watched TV after school and lived a sedentary life, with 40% being completely sedentary. To explain such inactive lifestyle studies have found that overweight and obese children and adolescents are less positive towards physical activity compared to normal weight children and young people (Zabinsky et al 2003, Deforche et al 2005). To explain this negative attitude Deforche et al (2005) found that obese adolescents’ have barriers towards participating in physical activity, which include in particular factors such as “insecure about appearance”, “not being good at it” and “physical complaints”. Zabinsky et al (2003) found that obese children experience lower levels of support from caregivers to become involved in physical activity compared to non-obese children. Lee et al (2009) investigated 11-13 year old obese children’s perception of physical activity and found that besides weight loss, the children believed that increased levels of physical activity would increase social relations and generate more friendship. On the negative side, many felt discomfort after exercise and had excuses for not engaging in such activities, like telling the teacher in physical education that he/she was ill. Other barriers have also been identified as important when understanding obese children’s and young people’s reluctance to engage in physical activities, which include: lack of money, lack of outdoor safety or lack of time (Hesketh et al 2005, Alm et al 2008). As a consequence, Borra et al (2003) have argued that to increase physical activity in obese children, the initiative must be integrated into daily life and therefore should not be something chosen only when, for instance, time is available. Thus, according to Borra et al, a regimented exercise programme has little chance of success as it is disconnected from everyday life.
The caregivers of obese – or in risk of becoming obese – children and young people

Many parents fail to acknowledge that their child is obese (Baughcum et al 2000, Jain 2001, Hackie et al 2007, Vuorela et al 2010). Guendelman et al (2010) compared Mexican mothers in Mexico with Mexican mothers settled in California, USA, in regard to their perception of their obese child. They found that “Californian mothers” prefer a much thinner child and to a larger degree are dissatisfied with their obese child’s weight compared to Mexican mothers. Guendelman et al’s study indicates that perceptions of obesity are dependent on context. A study (Baughcum et al 2000) found that less well educated mothers to obese children are three times as likely to misidentify their child’s weight status compared to more educated mothers. Contrary to this, Hackie et al (2007) found that the perception of their child’s obesity was independent of age and education.

The literature also indicates that parents to obese children may believe that their child’s obesity is caused by factors not necessarily associated with diet and exercise, such as genes, slow metabolism or a natural drive to be sedentary (Jain et al 2001, Jackson et al 2005, Rhee et al 2005). This belief may explain why some parents, although identifying their child as obese, fail to improve the home environment in a healthier direction (Hackie et al 2007). Similar, St John Alderson et al (1999) found that although mothers to normal weight children believe they serve a healthy diet to their child, they in fact eat healthier themselves. The explanation given by the mothers for this difference was that when choosing food for their child they valued nutrition and long-term health benefits, whereas they valued calories, preparation time, and cost when choosing for themselves. Kelly et al (2006) explored the factors that influence low income caretakers when they prepare meals for their children. From most to least preferred factors, the order was: house tradition, money, time, role modelling. Thus, although the caretakers were aware that they were role models for their child in regard to eating habits it was not an important issue when the household diet was chosen. The issue of role modelling was also addressed by Zehle et al (2007), who found that less active mothers fail to see the association between their own sedentary lifestyle and presumed future activity level in their child. These mothers believe they support their child to be physical active just as
well with words compared to actively participate. Zehle et al also addressed the mothers’ perception of their child’s TV habits and found that although the mothers were aware of the dangers of watching too much TV they could not offer an alternative and therefore made no attempt to substitute their child’s use of screen viewing with other activities. Similarly, Borra et al (2003) found that parents are in need of tools to deal with their child’s obesity, especially in relation to improving their child’s practices of eating and exercising.

**Direction of the thesis**

To conclude this review, it can be stated obese individuals wish to reduce weight and they attempt to do so. One motivator for success in maintaining healthier habits is social support. Obese individuals’ food preferences contradict their knowledge about food as they tend to eat unhealthy products. Obese individuals are sedentary and experience a range of different barriers towards participating in physical activity. Caregivers to obese children and young people do not necessarily recognise their child as obese and if they do, they are not automatically concerned, as they may associate their child’s obesity with non-modifiable factors, such as genes. Although parents are aware they are role models for their obese children, this does not significantly influence their household’s practices of eating and being physically active.

As regards the choice of method, the majority of the studies found in this review used individual and focus group interviews or questionnaires; thus, no study was based on participant observation and the establishment of a personal relationship with participants. Also, the majority operated within pre-defined research questions, thereby limiting participants’ ability to express themselves. Furthermore, few studies took a longitudinal approach, which means that little is known about changes, continuities and matters that would be revealed over time. In addition, few studies related their findings to a broader context, such as the environment. Although many authors concluded that intervention must address the environment, the environment was in fact rarely used to explain individual practice, thereby making the individual solely responsible for the practice leading to obesity. However, as a major cause of the recent rise in obesity prevalence is presumed to be the obesogenic environment, a sufficient analysis of obese individuals’ practice could profitably focus on the relation
between the environment and the practices leading to obesity. In summary therefore, the included studies primarily described the practices associated with obesity and to a lesser degree explored why the identified practices made sense for obese individuals or their relatives. Insight into the latter could shed light on underlying factors that stimulate obese individuals to behave as they do and could, it is hypothesised, make room for an intervention that addresses the root of obese individuals’ practices. However, the shift in focus of interest in “what individuals do” to “why they do as they do” calls for, it is suggested, an alternative epistemological standpoint. Thus, to understand underlying factors contributing to obese individuals’ and their relatives’ practice it could be fruitful to adopt an anthropological approach that is fully explorative and empirical and, hence based on a personal relationship with participants.

By conducting an anthropological and longitudinal investigation the present study intends to improve the understanding of obese adolescents’ and their parents’ practice regarding the adolescents’ obesity and attempts to reduce weight during his/her teen years. However, rather than merely describe the practices, the study intends to shed light on why adolescents and their parents do as they do in daily life. As the context for this, the obesogenic environment will be used. However, the factors that have contributed to the obesogenic environment will not be addressed. Also, although pharmacological interventions and surgery are successful in facilitating weight loss these do not lie within the scope of the study. Neither are strictly individual characteristics, like matters related to genes, metabolism or the like addressed.

**Aim**

A logical approach to improve the understanding of obese adolescents’ practice and presumed factors contributing to their practice is to get their and their close social relatives’ perspective on it. Thus, a reasonable methodological approach is to participate in participants’ daily lives and to talk with them (Atkinson et al 1994, Emerson et al 1995, Kvale et al 2009). To understand these matters a fully empirical and explorative investigation was carried out that aimed to: explore

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2 Here and in the following ‘anthropological’ refers to an anti-positivistic approach that, contrary to the positivistic approach that is dominant within the scientific field of medicine, aims to explore cultural practices, norms and values from a subjective perspective. An anthropological approach therefore does not seek invariant and generalisable explanations but seeks to understand what gives people meaning in their specific context.
how obese adolescents’ and their parents’ experience the adolescents’ obesity and possible attempts to reduce weight in daily life.

To fulfil this aim two research questions were formulated:

1) What seem to be the important in obese adolescents’ ability to continue to manage their weight in the years following weight loss

2) What seems important for obese adolescents’ parents regarding their obese children’s ability to continue to manage their weight in the years following weight loss.

Adolescents were chosen as participants, as it was possible through the study to follow their transition from puberty to early adulthood, and for instance explore how they experienced their gradual independence from parents in regard to their obesity and attempts to reduce weight. To improve the understanding of the adolescents’ daily lives their parents were also included in the study. Inclusion of the parents was hypothesised to give insights into their experience of their child’s obesity and thereby contribute to a greater understanding of the adolescent’s heritage and family life.
3 SCIENTIFIC FRAMEWORK

This chapter illustrates the theoretical understanding underlying this thesis. The first section addresses reflections on data collection, i.e. participant observation, interviews, and data interpretation. The second section addresses the theoretical understanding that underlies the elaboration and discussion of the findings.

Reflections on data collection

As the study investigated how participants experience their own/their children’s obesity its focus was concerned with the social reality in which participants are engaged. In simple terms it can be said that social reality is not an objective fact in a strict sense but is socially constructed (Berger et al 1966). A socially constructed reality means that the reality individuals take for granted is produced and communicated through social interaction. In social interaction individuals act in accordance with their representation of their perceived reality and expect and find that others can understand and relate to such representations. Individuals’ sense of reality is therefore maintained and derived through the representations they share and live by. Therefore, a constructionist perspective on social reality in many ways opposes the essentialist notion applied to physical reality. These different notions of reality represent differences in epistemology: while physical reality may be divided into independent variables that exist in itself and have a causal relation this cannot be done with social reality. A characteristic (or variable) in social reality only gets its meaning in the relations it is applied within hence, a given characteristic does not exist independent of other characteristics (Bourdieu 1984). Following from this, and according to Holy et al (1983), social reality consists of two domains: “notions” and “actions”. The former deals with ideas and norms while the latter concerns practice and social processes. These domains are qualitatively different as notions can be verbalised while actions cannot, but instead need to be explored in situ. Holy et al argue that this methodological insight has implications for method: in order to understand social reality it is necessary both to observe how people live their lives and to talk to them about
their practices. Consequently, the study underlying this thesis is based on participant observation and interviews.

**Participant observation**

Central to anthropological research is that, in order to gain insight into participants’ lives and explore non-measurable concepts like for instance practice the researcher needs a close and intimate familiarity with participants (Atkinson et al 1994; Emerson et al 1995). Participant observation is a way that enables a personal relationship with participants and gives a rich and detailed exploration of how participants’ daily lives are actually lived. Basically, participant observation implies that the researcher takes part in participants’ lives and tries to experience events in the manner in which participants experience these events. Thus it is a method that can be used to gain insight into the social reality in which participants live (Atkinson et al 1994, Bernard 2005).

Participant observation takes place on a continuum (Spradley 1980): at one end, the researcher is highly participative while, at the other end, the researcher observes solely. Thus, when conducting participant observation the researcher must constantly shift between participating and observing and thereby track some lines of information while closing others. The researcher, therefore, needs to be flexible and, it could be argued, acts as his/her own research instrument (Bernard 2005).

The study underlying the thesis applied participant observation at a weight loss camp and at participants’ homes. It was thereby possible to get personal and qualitative insights into the adolescents’ and their parents’ daily lives. For instance – and related to practices of eating – it was possible to see participants’ home and kitchen, see the content of the refrigerator, see how they used the kitchen when they cook, see possible fruit or sweets bowls. Also, it was possible to eat with them and thereby experience the atmosphere when they ate. All these small impressions contribute to a thorough understanding of how the adolescents and their parents relate to eating and hence contribute to a greater understanding on how they all live with the adolescents’ obesity and presumed weight loss attempts. These and other impressions were written down as field notes and subsequently analysed (Emerson et al 1995). Field notes were both written in the field and upon return from the field. The notes taken in the field were often descriptive or addressed an idea the researcher had got through his
participation with participants. The notes taken when returning from the field were more reflective and elaborated upon the notes taken in the field. Besides impressions from participants’ lives participant observation includes small talk and unstructured conversations that spontaneously crop up when together with participants – these are addressed below.

When analysing, the data collected from participant observation both serve as data in itself, and as data used when interviewing. Also, and as described below, impressions from participant observation at the camp and participants’ homes gave the researcher ideas about what to explore further and what to subsequently look for when analysing the data.

**Interviews**

Interviews are an important way of getting insight into peoples’ perspectives. According to the French philosopher, Paul Ricoeur (1913-2005), interviews, or stories in his words, serve a greater purpose than just communication. Ricoeur (1984, 1985, 1988) argues that people make sense of their identity by the stories they tell, as these stories bring forth connections and interrelatedness and thereby give the individual a sense of coherence. Besides a core identity that reflects a certain heritage, an identity, according to Ricoeur, is mobile and dependent on context. Thus, a story is never fixed, but open to revision as long as it follows a certain narrative logic, e.g. takes the character of a plot which has a beginning, middle, and an end. Although the elements that form the plot are brought together by coincidence, they take on the guise of necessity when plotted and hence, make the identity seem stable and coherent. Finally, the elements that form the story are not just actions, but also events and other characters. A person’s story, or identity is therefore constituted by other individuals and events and therefore not to be seen as isolated or non-contextual.

The research underlying the thesis used group and individual interviews to explore how the adolescents and their parents live with the adolescents’ obesity in everyday life. For instance – and related to practices of eating – by telling about both actual and desired eating practices the obese adolescent reveals part of his/her identity in regard to eating and life in general. Thereby it is possible to get their perspective on, for instance, why they believe they eat as they do, what can be done to support them to eat differently, how they would like to eat and
why they believe they have difficulties attaining another eating practice. The incongruence between current and desired eating practices can further be explored by asking about and discussing related matters, for instance in regard to home availability of the food, peer pressure, comfort eating or the like. Also, when talking about practices of eating it is possible to explore the emotions and values that participants relate to such practices; for instance talk about cakes and junk food may generate a genuine excitement, while talk about vegetables and low-fat products may be expressed less positively.

Although such detailed talk regarding the adolescents’ eating habits was primarily explored through the interviews, the present study to a large extent also made use of unstructured, or ordinary, conversations. Such conversations are, as argued above, a natural element of participant observation but they do also reveal, as Ricoeur argues, part of the person’s identity. For instance, when visiting the adolescents and their parents to conduct a formal interview, some time was spent small talking before interviewing. The parents were, as elaborated below, eager in these initial, unstructured conversations to justify their role in their child’s failed attempt to reduce weight. Hence, such conversations revealed how the parents viewed themselves and thereby gave important insights into their lives with their obese child.

The data from interviews were primarily used when conducting a formal analysis. As noted above however, there are not clearly demarcated distinctions between data from participant observation and interviews, as they are interwoven. For example questions asked in the interviews may be generated by data from participant observation and when conducting participant observation focus may be on data from the interviews.

To sum up, the most suitable way to explore how obese adolescents and their parents experience the adolescents’ obesity and possible attempts to reduce weight is to adopt participant observation and interviews to gather data. Initially three weeks of participant observation at a weight loss camp for obese adolescents was conducted. At the camp the adolescent was also interviewed. In the following years, adolescents and their parents were interviewed in their homes. When visiting participants for interviews participant observation was also used.
Data interpretation

To convert the collected data into scientific findings suitable for academic discussions a model inspired by Ricoeur’s (1976) theory of interpretation was used (Pedersen 1999, Lindseth et al 2004). Combining phenomenological description with hermeneutic interpretation Ricoeur developed a theory on the creation of meaning that says that meaning is always open to interpretation. However, Ricoeur argues, some interpretations are better than others and the better interpretation, is the one or the ones that in the dialectic process of guesses and validation are more probable than other interpretations. The beginning of such interpretation process starts with a naïve guess, which is validated in the following steps. It is difficult to explain how a naïve guess is made – Ricoeur says that the interpreter has to look for something that touches him/her. The validation, or the second step, is an argumentative discipline and based on – using Ricoeur’s words – the logic of uncertainty and of qualitative probability. The objective of validation is to reject or validate the previous guess by grasping the validated guess’s future and therefore new meaning. To illustrate this movement of the interpretation, Ricoeur develops a structural analysis that links the naïve guess to the deeper interpretation. In the structural analysis the interpretation goes from “what it says”, e.g. the initial meaning, to “what it speaks about”, e.g. the broader meaning, to a new meaning. According to Ricoeur therefore, meaning is not to be found within the initial interpretation but within its future references.

A number of Scandinavian researchers within health science have converted Ricoeur’s theory of interpretation into a model for analysing empirical collected data (Pedersen 1999, Lindseth et al 2004, Hounsgaard 2004, Angel et al 2009, Dreyer et al 2009, Bruun 2011). The model involves three levels: 1) naïve reading, 2) structural analysis, 3) critical interpretation and discussion (Fig. 3). The intention of the naïve reading is to gain an initial idea of what the data is about. To gain this initial idea, the researcher reads the data several times with an open and explorative attitude and looks for something in the data that may be of importance in regard to the subject studied. Hence the researcher makes a qualified guess based on his/her pre-understanding of the field. This idea is then in the second level of the analysis, the structural analysis, validated or rejected and, if validated it is turned into a deeper interpretation. The structural analysis
involves three steps: the first step is linked to the empirical data (what the data says), while the second step makes room for a new interpretation (what the data speaks about). This new interpretation is in the third step condensed into themes and subthemes. To assure the validity of the interpretation of the data the structural analysis constantly tests the developed themes and subthemes by relating them to the naïve readings’ guess and its associated interpretation. The structural analysis is therefore a circular process as it constantly validates and tests a given interpretation by moving back and forth between ideas and interpretations. In the last level of the analysis, critical interpretation and discussion, themes and subthemes are discussed in accordance with relevant theory and other investigations within the field. In this part of the analysis, the themes and subthemes that reflect the initial idea from the naïve readings are generalised and made suitable for common interest. This level therefore is argumentative, as the researcher has to choose one of many possible ways to elaborate and comprehend the developed themes and subthemes.

Fig. 3. Process of data interpretation. The three levels and their relatedness are illustrated.

Theoretical framework

Pierre Bourdieu’s (1930-2002) theory of practice (1984, 1990) was a source of inspiration in order to elaborate on and discuss the themes and subthemes. Bourdieu’s theories serve as an overall framework in regard to understanding participants’ everyday life. However, to elaborate upon the families’ everyday
interaction, the theories of the sociologist Erving Goffman (1922-82) were applied, particularly his thoughts on face-to-face interaction (1956, 1959, 1963). This section outlines basic concepts in first Bourdieu’s theories and then in Goffman’s theories. However, as both scientists have contributed with extensive theoretical ideas within their respective fields, the presentation here is related to the present use of their theories. Thus the presentation – and the latter use of these theories – is by no means definitive and complete in regard to the theories of Bourdieu and Goffman.

**Pierre Bourdieu**

A central stance in Bourdieu’s academic career has been to develop a theory of practice; e.g. a theory that can explain why people do as they do. A major ambition in his work is to avoid the tendency of many previous theories to either allow individual agency to be determined by overall structures or, at the other end of the scale, let individual agency be the product of free will. These two positions are represented, for instance, in Lévi-Strauss’ structuralism and Sartre’s phenomenology. Bourdieu aims to mediate between these polarities and thereby integrate the objective into the subject. The theories of Bourdieu are therefore chosen because they highlight that individuals are social beings, interwoven in relations that can for example be of a physical, cultural or economical nature. Related to the present study such an approach is relevant as it can be expected that the participants’ everyday practice, as individuals in general, is influenced by a host of different factors, e.g. immediate environment, media, parents, family and friends, peers or economic factors. All these factors are accounted for in Bourdieu’s theory. Based on extensive empirical observations and statistical analysis, Bourdieu argues that the individual within these relations acts on the basis of an implicit practical logic that, although not consciously possessed or articulated, regulates everyday practice. Bourdieu finds that this regulation is structured in certain ways but that individuals often fail to appreciate this structuring; hence in life individuals act in specific and predictable ways without their knowing.

To develop a theory of practice, Bourdieu introduces concepts like field, capital and symbolic violence and habitus. These concepts do not exist independently of each other but are integrated and should therefore not be seen in isolation.
Field: in Bourdieu’s terminology a field is a partly autonomic space of social relations, with its own rules and legitimate opinions defined by the dominant class within the specific field. Fields are not geographical entities but social spaces devoted to specific activities or practices. In modern society there are, for instance, fields of arts, sports, health, politics and economics; theoretically, however, a field can be any matter that individuals relate to. Within these fields people relate and struggle and try to pursue and optimise desirable outcomes using implicit and/or explicit power relations. For instance, within the field of education students strive to achieve good grades and academic recognition.

According to Bourdieu, fields, and hence society, are structured in a way that ensures that the dominant class keep defining and thereby ruling the specific field. Thus, the rules and legitimate opinions valued within the field favour, according to Bourdieu, a specific group of individuals that have better insight into these rules and opinions compared to other groups. For instance, within the field of education children of academic parents will always be favoured because these children have learned through their upbringing how to cope and manage within such a field, e.g. they possess the required amount of capital (for instance parents who help with homework) and the right habitus (for instance an ability to appreciate and find interest in schoolwork) to manage in school.

By introducing the concept of field Bourdieu, among others, avoids analysing society in solely economic terms. In addition he integrates power and inequalities in his analysis. More importantly, by focusing on social positions Bourdieu aims to transcend the traditional dualism between objectivity and subjectivity; thus, a field does not exist without subjects and subjects do not exist without fields. Therefore, in Bourdieu’s theory an individual cannot be understood without reference to the relations he/she is engaged and positioned in.

Capital and symbolic violence: within the specific fields people are not equal in regard to power. Thus, people can be rich or poor in different kinds of capital; being rich in capital ensures a better position with the field. Bourdieu distinguishes between three main forms of capital, e.g. economic, social and cultural, that can be translated into a superior form, e.g. symbolic capital. Economic capital refers to the amount of money or goods that individuals possess that can be converted into money. Social capital refers to the network
that individuals have. Cultural capital is sub-divided into 1) an embodied form, for instance knowing how to behave in school so one is on good terms with the teacher, 2) an objectified form, for instance wearing cloths that signalise a certain style and 3) an institutionalised form, for instance an academic degree. Economic, social and cultural forms of capital cannot be seen in isolation but are connected and can be translated into one another. For instance, to be successful within the field of education, an individual may use his/her economic capital to buy private lessons and improve his/her cultural capital. Also, by knowing the teacher personally (social capital) one may achieve better grades in school and thereby also improve one’s amount of cultural capital. Lastly, capital is not static but is dependent on the specific field. For example, within the field of education cultural capital may be of greatest importance while economic capital may be the most important form within the field of housing.

When one’s capital is recognised and esteemed it is turned into symbolic capital, which is a sign of acknowledgement and greater power. People with high levels of symbolic capital therefore have highly valued social positions within the field, hence they are part of the dominant class. Symbolic violence on the other hand occurs when symbolic capital is used to patronise and devalue persons or groups with less capital. Also, symbolic violence happens when people with less capital within the field take their inferior position for granted and devalues their own skills.

By operating with four forms of capital and symbolic violence Bourdieu points to the fact that to be successful within a field it is necessary to possess different attributes. Thus, money is only one form of capital; of equal importance are - depending of the field - network and cultural capital.

**Habitus:** habitus may be Bourdieu’s most famous concept. Nevertheless he does not offer a definite definition of habitus but keeps defining it according to its specific use and purpose in his works. Habitus is a form of socialisation where external structures and subjective experiences are internalised into the individual and transformed into embodied, individual dispositions. Therefore, habitus cannot be seen in isolation from the concepts of field and different forms of capital. For instance, the participants in this study, as individuals in general, will have a certain amount of capital and certain positions within the fields. This will influence their habitus. In addition, habitus influences the
individual’s amount of capital and position in the field. According to Bourdieu therefore, habitus is both structured (by capital and field) and structuring (for capital and field). Although the individual continually develops habitus, it is in particular in childhood and adolescence and among parents and close relations that habitus is shaped.

Habitus therefore internalises previous experiences (experienced from a specific position determined by amount of capital) and externalises them as dispositions. Dispositions in Bourdieu’s terminology refer to a certain propensity in regard to expectations and practice that the individual has in life and which he/she unconsciously follows. In other words dispositions both outline the individual’s expectations and aspirations in life but at the same time make sure that these expectations and aspirations are met in one’s practice. According to Bourdieu, habitus therefore makes a virtue out of necessity, e.g. individuals in general live the life they want to and strive for. To follow the positions outlined by habitus, Bourdieu argues that habitus equips the individual with a socially inherited, unconscious, practical logic that makes possible the practice that corresponds to the outlined dispositions. This logic is a fundamental, deeply founded embodied practical sense that influences every action and thought the individual has. It is important to understand that this logic is not a set of standard rules. Rather it is an inherited generative principle, or a specific, self-evident approach, that predisposes a certain action that corresponds to the outlined disposition. Therefore, habitus is generative, meaning that the individual has similar preferences in different arenas, for instance in regard to furniture, clothing, vacations, political views, food tastes etc. Besides such preferences habitus also works at a more immediate and embodied level. Thus habitus also influences the way individuals, for instance, eat, walk and talk.

Habitus is not an anatomical unit but is embodied within the individual, only showing itself in practice. Habitus therefore is not something that individuals can avoid passively. To avoid the influence of habitus, the individual must reflect upon his/her practices and actively choose otherwise. If not reflective he/she will behave according to habit and hence habitus.

Lastly, Bourdieu discusses a class habitus, e.g. a similar habitus that similar individuals hold. Although individuals do not share the exact same experiences
it is more likely, Bourdieu argues, that individuals holding similar positions in society have been confronted with similar experiences compared to individuals occupying different positions. Thus, according to Bourdieu, individuals develop a class habitus. It is class habitus that generates affinities in lifestyles. For instance, Bourdieu empirically and statistically (1984) shows how different classes in France around 1960 have similar tastes and preferences. However, it is not possible to causally explain why this is so. On the contrary, habitus is the product of multiple and non-causal factors experienced from a specific position in society and these factors cannot be isolated and causally made accountable for its influence.

A major advantage of habitus is that it integrates social experiences and objective conditions into the individual and thereby offers a societal explanation to individuals’ practice. Individuals therefore do not have a free will in a classic sense. Neither are they controlled by objective structures. Instead, Bourdieu argues, their practices are a product of the interplay between subjective and objective conditions experienced from a specific position in society.

Naturally, this thesis does not suggest that Bourdieu’s theories can explain all aspects of the practices associated with obesity. But it is hypothesised that they are useful as an overall framework that can be used to address obese individuals’ practice. In the following it is primarily Bourdieu’s notion of habitus that will be used. However, as mentioned, habitus integrates the different forms of capital and positions within the field. Thus it makes little sense to perceive habitus as independent of capital and fields. Furthermore, to account for capital and thereby positions a statistical analysis is necessary, according to Bourdieu. Thus, the present study did not focus on forms or capital and positions. Christensen (2011) however, recently statistically explored parental capital in regard to childhood obesity. In support of other studies that have correlated obesity with the lower social classes (Singh et al 2010, O’Dea et al 2010), Christensen (2011) found that high amounts of especially cultural capital among parents serve as a protective factor in regard to childhood obesity.

**Erving Goffman**

Bourdieu’s theory of practice serves as an overall framework for understanding and elaborating on participants’ practice in daily life. However, in order to
elaborate upon the interaction between parents and adolescents within the families’ everyday lives, Goffman’s theories on face-to-face interaction has been applied. A key issue in Goffman’s work is to explore how individuals relate and behave in everyday encounters. In his main work, The presentation of self in everyday life (1959), Goffman applies a dramaturgical analysis and shows that individuals in an encounter always try to control the impression that the other party in the encounter might make of him/her. Thus, a central stance in his theory is that, in an encounter individuals are cautious to present a certain impression of themselves. Furthermore, as much as all parties to the encounter are interested in controlling and presenting their impression, they are just as interested in making sure that the other party in the encounter is able to control and present his/her impression. Therefore, Goffman argues, in an encounter, individuals both try to control their own but also others’ impressions. If the intentional impressions are received correctly coherence in the interaction is assured. To assure coherence individuals behave with, according to Goffman, “tactful inattention”, e.g. in a discrete and often implicit way they make the interaction smooth and acceptable for all. Thereby no one loses face and experiences a discrepancy between the impressions one wishes to present and others’ reception of this impression.

The process of controlling the impression others might make primarily takes place on ‘frontstage’. Frontstage, according to Goffman following his dramaturgical metaphor, differs from backstage where the atmosphere is more relaxed. These two concepts are briefly sketched.

In frontstage one’s self is at stake, thus the individual is cautious to control his impressions of him/her self. Naturally this is very context dependent, e.g. dependent on, for instance, place of the encounter, number of individuals in it, meaning involved, or time available. Besides the bodily presentation (e.g. speech, attitude, gesticulation) the individual will also use the setting to control the impression. Regarding the latter, Goffman for instance found when doing fieldwork at a girls school that the number of phone calls the girls received was used to rank the girls’ popularity. Thus, Goffman found: the girls make outsiders call them and actively use the setting to present a certain impression of themselves that is valued within the interaction.
In backstage individuals relax and do not have to perform and present their selves in a specific way. In backstage therefore, other definitions of the encounter are practised than the ones applied on frontstage. It is difficult to define backstage; however family and other close acquaintances provide a typical context where the rules of the encounter may be looser and individuals can behave differently compared to public arenas. Backstage therefore, is not a geographical entity but a social space involving specific individuals with whom one feels safe.

The thesis’ elaboration of the families’ internal communication is inspired by Goffman’s work on face-to-face interaction, especially his thoughts on coherence in the encounter and possible ways to ensure such coherence. This approach is interesting, it is argued, because according to the literature obese individuals in modern society are stigmatised and perceived as deviant (Puhl et al 2007, Puhl et al 2009) and therefore, it could be expected, may experience difficulties dealing with their obesity in life. Goffman’s theories enable a social perspective on the adolescents’ everyday encounters with their parents.

However, Goffman’s work on embarrassment in social interaction (1956) is of interest to elaborate upon presumed difficulties that the adolescents may experience when encountering their parents due to their deviant status. Goffman (1956) explores how individuals act in the encounter when one party suddenly gets embarrassed and ashamed. When this happens, Goffman argues, the coherence of the encounter is compromised. To restore coherence the other parties in the encounter will most likely use tactful conduct, and, for instance, ignore aspects related to this embarrassment or draw attention towards other and more neutral subjects. The embarrassed individual will, according to Goffman, experience both a somatic reaction, for instance, blushing, sweating, elevated pulse, and a behavioural reaction. Behaviourally, argues Goffman, the embarrassed person might get a fixed smile, a high-pitched voice or otherwise behave nervously. If coherence is not established within a short period of time a critical point is reached where the embarrassed person might burst into tears or fly into a blind rage and eventually leave the encounter. Regardless of how the encounter ends, Goffman argues, the ashamed and thus embarrassed individual will bring this experience with him/her and in future encounters try to avoid similar situations.
Goffman’s thoughts on embarrassment are useful in this context because they highlight that when communicating individuals will, by using tactful conduct, avoid making each other feel embarrassed and ashamed. This is particularly important when studying obese individuals, who, as shown above, are stigmatised and perceived as deviant. As noted below, stigmatised people are very often ashamed of being deviant and may get embarrassed when their deviance is brought into focus. By applying Goffman’s thoughts on embarrassment and coherence to the parents’ and adolescents’ interaction, it is possible to examine how and to what degree the adolescent’s obesity influences their everyday communication.

To elaborate upon possible reasons that may account for the stigmatisation of obese individuals, Goffman’s work on stigma is useful. In Stigma. Notes on management of spoiled identity (1986(1963)) Goffman explores the nature of stigma, e.g. why individuals get stigmatized, how it works and how encounters are influenced when a stigmatized individual participates. Stigmatisation, according to Goffman, is not a characteristic but a relation or a social process that individuals use to characterise others but also one’s self, e.g. by characterising others as deviant the one characterising cements his/her normality. According to Goffman stigmatisation primarily affects three main groups of individuals representing three forms of deviance; a bodily deviance, for instance individuals with scars or deformities, a deviance related to different character flaws, for instance individuals that are perceived to be weak willed, mentally ill, criminals, and lastly a deviance related to tribes, for instance of a racial or a religious matter. These groups are perceived as deviant, Goffman argues, because they fall short of meeting society’s norms and values in regard to basic attributes. Goffman does not relate stigma to obese individuals but as obese individuals both have a large body that opposes the desired and valued body (Lupton 1995, Lupton 2003) and are perceived as having a character flaw (Neumark-Sztainer et al 1999, Sechrist et al 2005, Puhl et al 2007, Puhl et al 2008, Puhl et al 2009), it seems legitimate to perceive obese individuals according to his theory.

A major point in Goffman’s work on stigma is that individuals constantly evaluate each other according to the classification defined by the valid norms and values within society. The deviant therefore through everyday encounters,
will always be reminded that he/she is deviant. Consequently, argues Goffman, the deviant and stigmatized individual will not feel like a full member of society but experience a discrepancy between the impression he/she tries to give and the reception others might make of him/her. For instance, a symptomless mentally ill person may not feel stigmatized but when with individuals that know his/her diagnosis may be approached and treated in a stigmatised way. To accomplish full membership and minimize such discrepancy, the stigmatised individual will try to “pass” into the world of the normal, for instance by downplaying or hiding the characteristics associated with the stigma, acting out the associated stereotypes or avoiding situations where there is a possibility that the stigmata is brought into focus. Thus, a major aspect in Goffman’s theory is that stigmatised individuals are aware of their deviance and the characteristics associated with this deviance. Furthermore, due to this awareness they unconsciously stigmatise themselves and become, Goffman argues, ashamed and embarrassed that they cannot adhere to society’s norms and values.

The cited three works by Goffman all revolve around the ideas outlined in The presentation of self in everyday life. This work therefore serves as an overall perspective to explore the adolescents’ and their parents’ interaction. Goffman’s thoughts on stigma will be used to view and elaborate upon the presumed status of the obese adolescents as stigmatised. However, to elaborate and explore on the consequences of such stigmatisation his exploration on face-to-face interaction including embarrassment in the interaction are suitable.
4 MATERIAL AND METHODS

The following presents the field and its specific methods. This section is subdivided in setting, participants, data collection and a description of the relationship between the researcher and participants, data analysis and ethics. An anthropological, longitudinal method was chosen. The anthropological approach is justified in chapter two. The longitudinal approach (Table 2) has two functions; firstly, since one core element of anthropological research is familiarity with participants, one way to ensure such familiarity is to have a long term relationship with them. Secondly, by knowing participants over time it is possible to explore temporal dimensions, for instance, changes, continuities, and dynamics. This is particularly interesting when studying adolescents, who move from being dependent on to being relatively independent of parents.

Setting

The researcher initially discovered in the press that a weight loss camp targeting obese teenagers was to take place the following summer. Camp officials were contacted and approval to conduct the study at the camp was given. Three weeks prior to the camp, an information meeting for camp participants and their parents took place. The researcher was invited and presented the study proposal.

The camp took place at a julemærkehjem (Christmas-seal home), which is a private organisation that aims to improve children’s sense of self worth by offering marginalised children and young people eight to ten weeks’ stay in one of the four homes in Denmark. In the summer period the homes are closed and used for other events, such as the weight loss camp where part of this study was conducted. The weight loss camp lasted three weeks and aimed to reduce adolescent obesity. Participation was free of charge. Participants each had their own bedroom. Meals were served three times a day and were generally healthy, e.g. low in sugar and fat and included fruits and vegetables, if appropriate. Guidelines for quantity and composition of meals were distributed at the

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3 Julemærkehjem translates directly into Christmas-seal home. The name refers to the funding of the homes which partially are financed by the income the Christmas-seal Foundation gets from selling Christmas seals.
beginning of the camp and participants were corrected if they did not follow these guidelines. Everyday a compulsory morning run (1.2 km) was scheduled. In the mornings and afternoons different kinds of physical activity were arranged, for instance soccer, squash, tennis, athletics, bike riding, canoeing, dancing, gymnastics or swimming. In the evenings camp participants had free time and engaged themselves in different activities, such as soccer, watching TV, playing or socialising. On Fridays participant had the afternoon off and where allowed to use a limited amount of money to buy products of their own choice in the nearby town. At the weekends most parents came to visit and camp participants had free time but were not allowed to leave the premises. Participants were weighed and measured weekly. There was no follow-up when the camp finished.

Apart from at the camp, the study was also conducted in the adolescents’ homes. All adolescents lived with their parent(s)/grandparents. Four families lived in the greater area of Copenhagen, another six lived in Zealand outside Copenhagen, three lived on Fyn while two families lived in Jutland. Nine families lived in rented apartments. Four families owned their own house while two families owned an apartment (Table 1).

**Participants**

Participants were recruited at the information meeting prior to the camp. In total, 28 adolescents, aged 13-16 years of age participated in the meeting and subsequently at the camp. A criterion sampling approach (Patton 2002) was used and all adolescents and parents were invited to participate in the study. The criteria for inclusion in the study were that the adolescent was overweight/obese and that he/she and his/her parents were willing to participate in the study over the following years. As all adolescents were invited to participate there were no exclusion criteria. In total, 15 adolescents, aged 14-16 years of age, and 20 parents signed up for the study. Participant characteristics are presented in Table 1.
There were three parent couples, two couples of grandparents, eight single mothers and one single father. Poor parental abilities had led both couples of grandparents to take over their grandchild’s upbringing at three and six years of age respectively. The two adolescents had therefore lived the majority of their lives with their grandparents and in many ways considered them as their parents. There will be no further distinction between parents and grandparents, with the former term being used. Three families withdrew throughout the study: two in round two and one in round three (see below). The three families informed about their withdrawal in phone calls prior to the interview (see below). One family, a mother, gave an explanation and said that her son was “in
trouble” and therefore not available for interview. In accordance with ethical guidelines (Spradley 1980) this was not further investigated. Likewise, the remaining two families were not asked for reasons for withdrawal. According to the adolescents and their parents the adolescents had developed their obesity in the first three years of school. All adolescents had been involved in other weight loss projects prior to the camp – for instance other weight loss camps, weight loss programmes involving regular meetings with dieticians and structured exercise. Many had also regularly seen their general practitioner, exercise coaches, psychologists and dieticians in order to reduce weight. Although they had lost weight when participating in these interventions, all of them had regained weight when participation had stopped. In round one (see below) participants’ weight and height were gained from the camp data prior to the camp start. In rounds two and three (see below) the researcher weighed and measured the adolescents prior to the interview. All adolescents lost weight at the camp. In round two (see below) all but three had a higher BMI compared to round one. In round three (see below) all but one had a higher BMI compared to round one. Data regarding parents’ weight were obtained in the first interview with parents by asking them how they perceived their current weight status (normal weight, overweight or obese). Details about the level of education and job status were also verbally attained in the first interview.

**Data collection**

Data was collected over almost two and a half years in three yearly rounds. Round one took place at the camp and at participants’ homes. Rounds two and three took place at participants’ homes (Table 2).

At the camp an anthropological fieldwork was conducted using participant observation (Atkinson et al 1994; Emerson et al 1995). The researcher resided at the camp in a bedroom in close proximity to the camp participants. He participated in all scheduled activities, e.g. the morning run, meals, physical activities and social activities. At the weekends the researcher talked to and got acquainted with study participants’ parents. Field notes (Emerson et al 1995) were written regularly – this was done both as quickly written notes when participating in the field and when alone, for instance in the evenings. The latter notes were often more reflective. Approximately 20 pages (2,400 characters a
At the final week of the camp interviews with study participants were conducted. Besides knowledge gained from the literature, the researcher used data collected in the previous two weeks of participant observation to create an interview guide. The guide contained issues related to, for instance, dietary habits, exercise habits, childhood, family, friends, everyday life, satisfaction with life, obesity anamnesis and wishes for the future (Table 3). The interview guide is not to be seen as a set of direct questions but rather as a list of issues to be addressed when interviewing. At the camp study participants were interviewed in groups. Group interviews were chosen because the participant observation, in accordance with the literature (Puhl et al 2009), had revealed that the obese adolescents were reluctant to explicitly deal with their obesity due to negative emotions, such as shame and embarrassment about being obese. According to Kvale et al (2009) group interviews encourage a freer dialogue and allow interviewees to share perspectives and thereby reduce discomfort. It was therefore hypothesised that interviewing the adolescents in groups would generate more insight compared to single interviews. To form the groups, the adolescents were asked to find a person among the other participants with whom they felt safe discussing matters regarding their obesity. Six groups of two
and one group of three were created. Interviews at the camp were conducted in a separate room and behind closed doors.

During the weeks following the end of the camp, parents were interviewed in their homes. The adolescent/others were if home asked not to disturb the interview and were therefore not present. A guide similar to the one used for the adolescents was used but it also included closed questions, such as level of education, current job status and perceived weight status. When the interview was finished the researcher asked to see the adolescent’s room if he had not seen it prior to the interview. If the adolescent was home the researcher spend some time socialising with him/her.

Table 3. Interview guide. Issues addressed when interviewing

<table>
<thead>
<tr>
<th>Issues addressed when interviewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Obesity anamnesis; when, why, possible episodes related to the obesity</td>
</tr>
<tr>
<td>• Previous attempts to lose weight; why, how, motivation to do so, motivation after the attempts</td>
</tr>
<tr>
<td>• Attitudes to food; amount and type of food intake, food bought in secret, eating habits</td>
</tr>
<tr>
<td>• Attitudes to exercise; type and time spent on exercise, non-formal exercise like bike riding and walking</td>
</tr>
<tr>
<td>• Relations to parents; in general, with regard to obesity/weight loss</td>
</tr>
<tr>
<td>• Home environment; in general, with regard to obesity/weight loss</td>
</tr>
<tr>
<td>• Relations to peers; in general, with regard to obesity/weight loss</td>
</tr>
<tr>
<td>• Social well being; relation between weight and mood</td>
</tr>
<tr>
<td>• Hopes for the future; in general, with regard to obesity/weight loss</td>
</tr>
<tr>
<td>• Future attempts to lose weight; what has he/she learned from previous attempts, what should be different in the future</td>
</tr>
<tr>
<td>• Feelings evoked when talking about obesity/weight loss</td>
</tr>
</tbody>
</table>

Note: These topics are to be viewed as themes that guided the interviews and not questions asked

In rounds two and three, a letter regarding the interview addressed to both adolescents and parents was mailed. After a few weeks they were contacted by phone and if positive, a date for the interview was made. When interviewing in rounds two and three many of the same issues from round one were covered. In addition, attention was paid to participants’ previous statements and to issues revealed through the analysis of previous data. Besides interviewing time was spent small-talking and socialising with participants. Especially in round three the researcher was invited to dinner (in nine homes). He was also in some of the homes invited to meet grandparents, see old photographs, invited for a walk in the local environment, and the like.
In total 72 interviews were conducted, of which 32 were with adolescents. All interviews were recorded and transcribed by the researcher. On average they lasted 66 minutes; the shortest lasted 33 minutes and the longest 102 minutes. In total close to 600 pages (2,400 characters a page) of transcription were made. Interviews with parents lasted on average 13 minutes longer than interviews with adolescents. There were no major differences in length between the three rounds of interviews. However, an average visit in round three lasted nearly three and a half hours, which was 45 minutes longer than in round two.

**The relationship between researcher and participants**

This section describes how the researcher attempted to establish a personal and trusting relationship with participants and it gives examples that illustrate that the bond between the researcher and participants became personal and trusting and thereby allowed thorough insight into the adolescents’ obesity.

At the camp the researcher participated in the activities along with the adolescents. When participating he was as friendly and considerate as possible and participated in a discreet and unobtrusive way. For instance, the researcher did not run the morning run as fast as he could, he followed the dietary guidelines when eating and he was attentive to avoiding ridicule or otherwise making the adolescents feel guilty about being obese. The researcher tried constantly to signal that he enjoyed the adolescents’ company regardless of their weight. These and other gestures made way for a trusting relationship between researcher and young participants. The following examples illustrate this: as the adolescents at the camp gradually came to feel safe and confident with the researcher, he could address their obesity in a direct and often humorous way. The researcher could, for instance, poke their stomachs with his finger, grab their fat, accuse them of cheating with the camp’s eating rules, call them lazy when participating in sports or otherwise make fun of them because they were obese. Although the adolescents in general disliked such attention they had great fun when the researcher did this. The aim of this behaviour was primarily for amusement and general socialisation but it was also used scientifically as the researcher could discuss these situations with the adolescents later. The familiarity between researcher and adolescents was important particularly when interviewing, as the researcher, through his personal acquaintance with the
latter, was able to tell if, for instance, the adolescents’ answers seemed unrealistic. For example, at the beginning of the second and third interviews the adolescents often said that they had lived very healthily in the past year and therefore could not understand why they had not lost weight. Due to the familiarity between the researcher and adolescent the former could explicitly doubt and question such explanation and hence seek for a presumably more honest description of their past practices. A final example of the intimate relationship with participants is that, when visiting the family to conduct the interview, as indicated above, the researcher was welcomed positively and for example often invited to dinner, asked to stay for longer and tell about the project, see old photographs or the like. Thus, participants enjoyed the researchers company and were interested in the project.

Although this relationship made way for a thorough exploration of the adolescents’ obesity it also had some disadvantages. For instance, when entering the house for an interview, parents and adolescent usually came to the door and welcomed the researcher. Especially in round three, the parents were quick to comment on their child’s weight and thereby set the direction for the initial 15-30 minutes of small talk before interviewing. Parents could for example say that, they had been busy and therefore not been able to support their child properly, which could explain why their child was still obese. Also, parents could involve the researcher in their strategy about how their child could reduce weight. These unstructured conversations were often unpleasant for the adolescent as the implicit message in the parents’ statements often could be boiled down to the adolescent’s perceived lack of will power as he/she had failed to reduce weight. When having these conversations the researcher was put in an awkward situation as he could not please both parents and adolescent. If he, for instance, agreed and supported the parents’ story he contributed to the adolescents’ uncomfortable feelings. Also, he could not completely deny or ignore the parents’ statements, as that would be impolite. To deal with these issues, the researcher developed a strategy where he engaged himself in the conversations but said that this study among others showed that young obese individuals have difficulties increasing will power and reduce weight. The researcher thereby tried to defend the adolescent. However, the researcher was careful that he did not take a therapeutic role.
To sum up, when together with participants the researcher tried to be as friendly, positive, non-judgemental and, if the situation was appropriate, humorous in his everyday contact with the adolescents and their parents. The researcher thereby established a trusting and friendly relationship with participants that allowed a thorough and open discussion of the adolescents’ obesity. Besides the ability to openly talk about their obesity, by personally knowing participants the researcher gradually came to view their obesity in terms of their experience (Hastrup 2004), rather than in terms of theoretical categories, like, for instance, a strict focus on diet and exercise. Thereby he was able to ask more relevant and personal questions and gain personal insight into the adolescents’ obesity within the context of the family.

**Data analysis**

Prior to the analysis, the researcher transcribed all interviews word for word. Data was analysed according to the above-outlined Ricoeur-inspired analysis of data interpretation (Fig. 3). The analysis primarily uses quotations from interviews. This does not mean however, that data gained from participant observation are inferior to data gained from interviews. For instance, data gained from participant observation was used when interviewing and data from interviews are explored when conducting participant observation.

The analysis of the transcripts from the interviews data was on three levels: naïve reading, structural analysis and critical analysis and discussion.

Naïve reading: to achieve an immediate understanding of what the data was about, all data was read after each round of data collecting. The readings of the data primarily concentrated on reading adolescents and parents separately, hence, first all transcripts from adolescents were read and second transcripts from parents. However, the readings also involved a “family reading”, hence, first the transcripts from the adolescent were read and subsequently the transcripts from his/her parent(s) were read. The reading following round three in addition explored the temporal dimension by focussing on the data longitudinally, for instance, data concerning a specific adolescent or family from all three rounds was read. When conducting a naïve reading the researcher often had an idea of what to look for in the data. This idea often originated from the participant observation and was described in the field notes. Field notes
therefore afford the potential of contextualising and qualifying the naïve reading.

Structural analysis: based on the immediate understanding from the naïve reading, when conducting the structural analysis the researcher found quotations in the transcripts that could illustrate and validate the idea from the naïve reading. If, however, the validation was poor the researcher returned to the naïve reading and nuanced or abandoned the immediate understanding. If validated the quotations were gathered and inserted in the first column in the model illustrating the structural analysis. The researcher then wrote down in his own words what he believed the quotations meant, i.e. the second column. In the last column, the researcher turned the meaning of the quotations into general themes and subthemes.

Critical interpretation and discussion: to discuss the developed themes in relation to relevant literature the researcher searched the literature related to the themes disclosed. Furthermore, while gaining insight into the themes the researcher gradually came to view the theories of Bourdieu and Goffman as relevant for a theoretical discussion of the findings. Subsequently, an argument based on literature within the field and relevant theoretical perspectives was developed. All steps in the analysis involved close interaction with the study’s supervisors. In addition the findings and its discussion were discussed with colleagues.

Ethics

The study followed the recommendations of the Declaration of Helsinki (www.wma.net). Participants were invited to participate in the study both orally and in writing. They were assured anonymity and the possibility of immediate withdrawal at any time without consequences. Data that could contribute to recognition of participants has been erased or changed. The regional Committee for Scientific Ethics and the Danish Data Protection Agency were contacted regarding the study.

Besides the formal requirements the researcher was attentive to avoiding making participants feel uncomfortable. Nevertheless, as the adolescents’ obesity within the family was an area of shame, embarrassment and guilt (see below) participants were often emotionally moved when talking to the
researcher. The researcher was careful to reduce the sense of discomfort before finishing an interview and leaving the house, by for example small talking or focusing on positive aspects of life. In addition, as illustrated above, the researcher ensured that he did not take on any therapeutic role but was neutral and supportive in regard to any practice the adolescents had.
5 FINDINGS

The findings have been presented in three articles: article one, *Obesity treatment - more than food and exercise: a qualitative study exploring obese adolescents' and their parents' views on the former's obesity* draws from round one and addresses diet, physical activity and matters regarding responsibility. Article two, *A qualitative, longitudinal study exploring obese adolescents’ attitudes towards physical activity* develops upon the first articles’ focus on physical activity and builds on all three rounds of data collection, but addresses only the adolescents. The third article, *A qualitative, longitudinal study exploring the impact and consequences of obesity stigma within the homes of obese adolescents* addresses matters related to stigma and shame, which is a refinement of the first article’s focus on responsibility; it integrates all three rounds of data collection and all participants.

Below the findings are summarised thematically. The same themes as used in the three articles are applied, i.e. ‘diet’, ‘physical activity’ and ‘shame and stigma’. An overview of the structure of the presented findings is sketched in Figure 4 (Fig. 4). As the articles, due to space limitations, have primarily been based on findings from the interviews, the first section of this chapter presents findings from participant observation. By illustrating incidents or impressions from participant observation this section intends to qualify and contextualise the findings from the interviews and thereby expand and nuance the presentation of participants’ daily lives. The second section of this chapter presents the findings from the interviews. This section therefore summarises the findings from the articles and applies the same subthemes as in the articles. As this section is meant as a summary the naïve reading, the structural analysis and quotations from participants are not included below but are to be found in the articles. However, the interpretation of the data generated findings that gave valid insights into participants’ experience of the adolescents’ obesity and possible attempts to reduce weight which have not yet been presented in an article: thus three new subthemes are added: “Eating – findings from round one to round three”, “Home meal environment” and “Parents’ and the families’ views and practice of physical activity”. To increase the transparency of the
Findings from participant observation
- Diet
- Physical activity
- Shame and stigma

Findings from the interviews
- Diet
  - Eating – findings from round one (article 1)
    - The adolescents have unhealthy food habits
    - The adolescents are ashamed of this behaviour and want to change it
    - The parents believe the home is an environment where healthy food is prioritised
    - The parents blame their child for unhealthy eating habits
  - Eating – findings from round one to round three *
    - The adolescents have unhealthy food habits
    - The adolescents are ashamed of this behaviour and want to change it
    - The parents believe the home is an environment where healthy food is prioritised
    - The parents blame their child for unhealthy eating habits
- Home meal environment

Physical activity
- Adolescents’ views and practice of physical activity (article 2)
  - Perceive themselves as inactive
  - Believe physical activity is equal to formalised exercise
  - Wish they could be more active
  - Do not enjoy being physically active
- Parents’ and the families’ views and practice of physical activity

Stigma and shame (article 3)
- Mutual avoidance of drawing attention to the adolescent’s obesity
- Ashamed of being obese – the reason for avoidance
- In need of support to reduce weight – a consequence of avoidance
- Obesity as a field of conflicts – when the avoidance cracks

*New subthemes are written in italics

The reason for adding these subthemes is that they supplement the first and second article, e.g. “Eating – findings from round one to round three” gives a longitudinal view on matters related to eating and thereby supplements the first article which dealt with eating in round one. Likewise, “Parents’ and the
families’ views and practice of physical activity” gives insight into the parents and the families regarding physical activity and thereby supplements the second article that addressed only the adolescents’ perspectives and practices regarding physical activity. Lastly, the subtheme “Home meal environment” addresses an issue that the researcher throughout the study came to see as important. In summary, these new themes are important because they give valid insight into obese adolescents’ daily lives.
Lastly, a condition for the findings presented below is that all adolescents had an immense wish to reduce weight and become slim. Nevertheless, as illustrated in Table 1, all but one adolescent increased their weight over the course of the study. Although the findings related to the adolescent who lost weight hold potentially valuable insights, they have not yet been prepared for publication and are therefore not explicitly dealt with in the following.

Findings from participant observation
This section intends to qualify and contextualise the themes and subthemes developed in the structural analysis on the basis of the interviews. The following therefore contributes to a more nuanced understanding of participants’ lives. The following abbreviations are used: X = adolescent, boy; Y = adolescent, girl; Z = camp official.

Diet
Participant observation at the camp revealed that the adolescents were dissatisfied with camp rules regarding eating. They particularly criticised the fact that they had to eat their vegetables in order to get seconds. The following field note is written on the fourth day at the camp right after dinner and illustrates that the adolescents were not used to being restricted in their eating habits: “X refused to eat the salad (carrots, cauliflower). He got angry and frustrated when he was not allowed to get more meat. He yelled at Z and said that he was used to eating more and better food and that he did not like the salad, so why should he eat it. He clearly felt he was treated unjustly.” Another field note addresses the second Friday’s “sweets-shopping” and illustrates the familiarity with such purchases: “I (researcher) went shopping with X1-3. When they found out that I did not care if they bought more than they were allowed
to, they bought three to four times as much. They enjoyed themselves and had specific preferences about what to buy. They eagerly discussed and exchanged perspectives on taste, texture, price, availability, etc.” A last example addresses having dinner with a family in round three. It points to the fact that the family is not used to eat together. While the researcher interviewed the adolescent his mother had prepared the meal. The field note says: “A nicely set table, good food (chicken, potatoes, salad, gravy). While eating the mother was enjoying herself ... she primarily told about her child’s obesity, e.g. when he had become obese, what she had done to help him, that he was lazy and had trouble exercising. It seemed like she had looked forward to having visitors for dinner. ...

I (researcher) sensed that she had given her son instructions prior to the meal on how and what to eat as she gave X a look a few times as if she was communicating to him, “Remember what we have talked about”. X ate his food, including the salad. He was a bit silent and did not engage himself in the conversation. He didn’t enjoy his mother talking about his obesity and it did not look like he enjoyed socialising with me (researcher) and his mother.” The discomfort the adolescent felt during the meal is related to obesity stigma and further addressed below.

**Physical activity**

At the camp the researcher experienced that camp participants were in poor physical conditions. No one could run the morning run (1.2 km) and many needed to walk after a few hundred metres. Also, they did not enjoy being physically active and complained vociferously about how hard it was. The following is a field note written after a 20 km bike ride at the camp: “Many came in “professional” bike riding outfits. X1 even had bike riding shoes and a new racing bike. He was not used to use it. ... The majority looked forward to the bike ride, although some girls complained bitterly about how hard it was going to be and how stiff and sore they were going to be tomorrow. ... All enjoyed themselves during the first hour. I (researcher) had racing competitions with “the boys”. Many began complaining during the second hour, e.g. too hard, too difficult, too sweaty. Y had a puncture and was picked up by a car. She did not seem disappointed and many envied her as the ride continued. ... Nearly all complained in the third hour. X2 refused to ride any longer and began to cry, although he tried to hide it. He was picked up by a
car. ... When returning home those who had completed were proud that they had and many praised each other for completing”. The following is a field note written after visiting a family in round two. It points to the fact that the adolescents lived a sedentary life: “At the back of the driveway: Y’s bike is punctured and has spider webs on it. It has not been used for a long time. ... Four TV sets in the house. One in her room - it was turned on when I (researcher) came in.” A field note from round three illustrates that the parents viewed physical activity as structured exercise and that they believed they supported their child in the best possible way to reduce weight. The note is taken immediately after interviewing, i.e. the researcher wrote in his car just before driving home: “While interviewing (Y’s parents) the mother found a note (made for me (researcher)) where they (parents) had written all the exercise equipment they had bought over the previous years to encourage Y to reduce weight. They complained that she did not use it and that she was too lazy, not motivated, that they felt foolish because they kept buying stuff that was not used. The list had 8-10 items, among which featured an exercise bike, running shoes/clothes, fitness shoes/clothes, fitness membership, pedometer, I-pod.” These parents’ materialistic approach was very common and the parents to a large degree paid for their child’s exercise equipment and membership fees. In addition they had an expectation that these purchases would make their child more active.

**Shame and stigma**

The following illustrates that the adolescents’ obesity often formed the fulcrum for embarrassment, conflicts and a negative atmosphere. A field note written after 15 days on the camp says: “I (researcher) was playing cards with X1-4. X1’s mother called and asked how the morning’s weighing had gone. ... X1 got angry and told his mother she should leave him alone. ... X2-4 (after X1 hung up) supported X1 and agreed that parents constantly nagged and criticised. ... They did not go into detail about X1’s or each others’ obesity but just talked about their annoying mothers”. A field note from round three illustrates the unpleasant situation that is generated when the adolescents’ obesity is articulated within the home: “They (adolescent and parents) were happy to see me (researcher). ... In front of X and his mother X’s father told me (researcher) that they (X’s parents) had made a plan for X to lose weight, and it just needed
X’s acceptance. Basically the plan indicated that X needed to make an effort to lose weight over the next four months. Then he could join a weight loss camp for adults. The parents implicitly wanted my approval. ... X said nothing, looked to the floor, he seemed sad and embarrassed to be talked about”. The following field note is written after having dinner with a family in round three. Present at the meal were the mother, the adolescent, a slim, younger brother (aged 13) and the researcher: “X did not enjoy socialising at the meal, he was moody, silent, did not have a “friendly approach”. His mother was very friendly and told me (researcher) that X would look so much better if he was slimmer and that he probably would be going out with girls as well. The mother expressed that X just needed to do a few things differently, e.g. stop eating junk food and drinking sugary drinks and stop watching TV all day. She often referred to his younger brother who was active and never was home because he had so many friends. X sometimes defended himself and among other things said that after Easter he would have more time to go to the gym as he would be finished taking driving lessons.” Throughout the study it was common for the parents to decide for their obese child what was good for them and that therefore the only thing the child needed to do was to participate in the plan the parents had scheduled.

**Findings from the interviews**

The section presents the findings from the interviews and is structured according to the themes and subthemes of the articles. Besides summarising the findings that is presented in the articles three new subthemes are included: *Eating – findings from round one to round three, Home meal environment and Parents’ and the families’ view and practice of physical activity*. The naïve reading, the structural analysis and participants’ quotes regarding the findings that have been outlined in the articles and are therefore not to be found in this chapter. The structural analysis underlying the additional subthemes is enclosed as Appendices 1-3 and the naïve reading is presented prior to the findings (the naïve reading underlying the subtheme “Eating – findings from round one to round three” is found in the first article). In addition the three new subthemes contain quotations from participants.
Diet

Eating – findings from round one
This part follows the structure and subthemes from the first article.

- The adolescents have unhealthy food habits
The interviews conducted with the adolescents in round one confirmed the findings from participant observation at the camp: the adolescents were not used to regulations in their home diet and they were fond of unhealthy products. They defined unhealthy products as products high in white flour, sugar, and fats. The interviews with the adolescents in round one also revealed that they believed that their home diet was too fattening. Also, and as illustrated with the “sweets shopping” example above, the adolescents expressed that besides the food served by their parents they were used to buying and eating unhealthy products when not with their parents. On further exploration, it was revealed that the adolescents bought and ate such products on a daily basis. This was primarily done when alone and feeling sad, bored or hungry. Also, these purchases were to a great extent hidden from their parents and the adolescents believed that their parents would be upset if they knew how much they ate through the day.

- The adolescents are ashamed of this behaviour and want to change it
The adolescents were ashamed of their eating habits and they wished they could alter their habits in a healthier direction. In particular they wished that they could reduce their food purchases when alone. They expressed that they sometimes tried to reduce their intake of unhealthy products in order to reduce weight but that they lost motivation after a short while.

- The parents believe the home is an environment where healthy food is prioritised
The parents believed that the food served at home was healthy. In addition they believed that they had served healthy food for many years. The parents’ reason for serving healthy food was primarily to support their child (and possibly other

4 In the following “unhealthy foods” refer to the perception participants had of these products, e.g. food products high in fat, white flour, sugar and for instance found in junk food, cake, white bread, biscuits, chips, sweets, chocolate and sugary drinks. Healthy foods also refer to participants’ perception and was characterised by being high in fibres, low in fat and sugar, for instance dark bread, lean products, fruits and vegetables.
family members) to reduce weight. The parents did not associate quantities of food with weight loss, and they did not regulate, for instance, their child’s portion sizes or number of portions.

- The parents blame their child for unhealthy eating habits

The parents were well aware that the child had unhealthy eating habits but they underestimated the quantum of unhealthy food their child consumed. However, as they believed the home environment was healthy in regard to food they primarily blamed their child for buying and eating unhealthy products when out of their sight. Thus, they blamed their child for not being motivated to lose weight.

Eating – findings from round one to round three

The structural analysis is to be found in Appendix 1.

The four above-mentioned subthemes were found in round one and do not grasp the longitudinal dimension of the adolescents’ eating habits. Therefore, the following follows these four subthemes longitudinally. The naïve reading is to be found in the first article.

- The adolescents have unhealthy food habits

Throughout the study the adolescents continued to prefer unhealthy food compared to healthy food. Nevertheless, many adolescents were able to alter their eating habits in a presumably healthier direction. This alteration was primarily the effect of reduced solitary purchases of sweets, cakes, chips and similar products. One girl said in round three: “A few weeks ago I bought some chips, I ate them and afterwards I couldn’t believe I used to do it every day.” As a reason for this change, the adolescents’ expressed that they did not feel a need to practice such behaviour any more. Also many felt that the urge to eat something just because they were alone was childish. However, many adolescents continued to buy fast food when alone but the reason for buying it changed over the course of the study: in the beginning of the study the adolescents bought fast food due to boredom, sadness, hunger or the like. In round three their primary reason for buying fast food was to supplement the home diet or as an alternative to the home diet. Thus, as the study progressed the adolescents increasingly came to view fast food as a legitimate source of their everyday diet. Although the adolescents were fond of for instance junk food
they recurrently tried to minimise their intake of such products in order to reduce weight. However, they lost motivation after a short time. A boy said in round three: “after maybe two or three days (eating healthily) I just get so sick and tired of apples and dark bread and stuff like that”. Like this boy the adolescents viewed healthy food as boring and they came miss food they liked better when dieting.

The adolescents continued to eat unhealthy food when at home. In particular they ate the unhealthy food their parents saved for special occasions. One boy said in round three: “Before, I was afraid that my mother would yell at me when I took something I was not allowed too, she still does but I don’t care now. ... If there is something (“unhealthy” food in the house) I have to eat it, I can’t resist it.” Throughout the study this tendency increased, e.g. if the adolescents knew of food they liked in the house they had trouble to resist their urge to eat it.

The adolescents are ashamed of this behaviour and want to change it

The adolescents never got comfortable eating unhealthy products in front of their parents. However, as the study progressed the majority of the adolescents abandoned hiding their unhealthy eating habits and they were to a higher degree unconcerned with their parents’ reaction if they were caught eating on their own. One boy said (round three): “When I was younger I always had some chewing gum to take before coming home so my mother didn’t notice I just had a burger or something. Now I don’t care. ... I know she wishes I didn’t, and I try not to, but it is hard”. Although the adolescents to a higher degree ate without fearing their parents’ reaction their shame about being obese did not decrease. As indicated below the shame moved from being associated to a specific situation where they ate a certain product at a certain time to being an overall condition of their self-image. This is illustrated by one girl who sadly said (round three): “I have tried so many times (to eat healthier) and I can’t, it’s my own fault ... I am incompetent, I guess.” Thus, in the beginning of the study the adolescents’ shame was associated with a specific episode, for example eating a burger on the way home from school or watching TV for a whole weekend. In round three the adolescents to a higher degree attributed their shame to a general self-perceived incompetence. As the study progressed therefore the adolescents’ shame came to be a general part of their self-image or identity.
The parents believe the home is an environment where healthy food is prioritised

The parents continued to perceive their home food environment as healthy and all parents believed they did everything they could to support their child to reduce weight with regard to eating habits. However, as the study progressed many parents began to hide unhealthy products they saved for special occasions, like having visitors, so their child could not find them. This was a consequence of the adolescents’ increased urge to eat these products. One mother in round three said of her daughter: “She is so fixated on eating that I have been forced to hide even packets of biscuits in the garage, she is terrible... whenever I’m not home, I tell you (researcher) she vacuums the house for food”. The hiding of products was the prime way for the parents to restrict their child’s eating practices. Thus, the parents continued to view weight loss as generated by certain food products and not with quantum.

The parents blame their child for unhealthy eating habits

As the study progressed the parents increased their blame on the child, as he/she (child) did not alter his/her eating habits. Thus, the parents’ perception of their child as an uncontrollable glutton increased. A father said in round three: “Three years ago he (adolescent) was a child and ok, you cannot expect that a child can do such a thing (eat healthier), but he has just turned 18... I can’t understand why he doesn’t do something (eat healthier)”. The parents were disappointed that their child had not, as they had expected, been able to “pull him/herself together” and reduce weight when growing up. One mother for instance said in round three: “I really thought that he (adolescent), when he got older would stop being so irresponsible. ... I can yell at him one night, roaring thunder and the next day he buys a coke and a burger. I can’t understand why he does it, he is killing himself and he knows it and he doesn’t care.” Although the parents knew it was difficult to change food habits they did not view it as impossible and hence, they believed that their obese child should be able to do so.

Home meal environment

The structural analysis is to be found in Appendix 2.

Both participant observation and interviews revealed that the families did not in major ways perceive and practise eating as a way to socialise. The researcher
therefore became interested in exploring this dimension of their eating habits. Thus, a last issue regarding diet, which has not been addressed in the articles concerns the general atmosphere that characterised the eating practices in the homes of the adolescents.

Although the parents throughout the study wished the family could sit around the dinner table and eat their food together, this seldom happened. One mother said (round three): “I keep hoping that we can eat together and have normal conversations, you know, like normal families. But he (adolescent) just does not want to and if I force it through (eating together) he gets moody and then the good atmosphere is ruined and it doesn't matter”. Thus, the majority of the family meals were eaten on the sofa in front of the TV and as the study progressed it increasingly became the family norm to eat in separate rooms in front of separate TVs. Although the parents kept wishing they ate together around the dinner table their motivation decreased through out the study and they, especially the single parents, increasingly defined a good dinner as low on conflicts, e.g. the food served was likeable to all and quickly made, in regards to shopping, preparation, eating, and cleaning. A mother put it simple in round three: “To avoid fights we don’t spend much time or energy on meals. I know it is sad but it is the way it is”.

In addition many families, as the study progressed, abandoned time-specific meals (e.g. breakfast, lunch, dinner) and implicitly allowed the adolescent, and other family members, to eat whenever they wanted. One boy for instance said (round three): “I don’t eat breakfast (at home). I buy something for lunch and when I get home (after school) I make some food and eat while I watch TV, then it’s dinner and then in the evening I make something again, maybe pasta or something”. The adolescents expressed that they enjoyed eating alone because they felt their parents were watching them, ready to comment on their eating habits. A girl said (round three): “I know my parents would like it better if we ate together, but I just feel they keep expecting that I only should eat salad and healthy stuff and I really hate it when they see me as fat and useless.” Consequently when eating alone the adolescents could eat what they wanted and they did not have to worry about eating specific ingredients they disliked. As the study progressed therefore eating within the family increasingly
became a non-social event. Thus, within the families eating primarily had a nutritional purpose, hence, they ate to become full.
Lastly, through out the study it was not custom that the adolescents helped with, for instance groceries, cooking, cleaning after eating nor were they integrated in other aspects associated with eating or meals in the families.

**Physical activity**

*Adolescents’ view and practice of physical activity*

This part follows the structure and subthemes from the second article.

- **Perceive themselves as inactive**
  Throughout the study the adolescents increasingly became more sedentary. When exploring this, the analysis revealed that they had gradually deselected functional forms of activity, e.g. bike riding or walking to school. They explained this decline as relating to increased autonomy from parents and thereby greater freedom to decide how to live their lives. Thus, in round three the majority perceived themselves as sedentary and they did not regularly engage themselves in physical activities. On the contrary they spent many hours daily watching TV/on the computer.

- **Believe physical activity is equal to formalised exercise**
  The adolescents did not view their increasing sedentary lifestyle as hindering weight loss. The reason for this was that they associated physical activity as a means to lose weight with hard exercise, like going to the gym or running. In their minds therefore, weight loss was gained by participating in hard exercise and not by, for instance, going for a walk or riding the bike. Therefore, although the adolescents had stopped riding their bikes to school they did not associate it with a decline in “proper exercise”. As the study progressed the adolescents increasingly came to view weight loss as achieved through formalised exercise (and a healthier diet). Hence, they also increasingly came to perceive non-formalised exercise as unimportant with regards to weight loss.

- **Wish they could be more active**
  As the adolescents wanted to reduce weight they regularly attempted to engage themselves in what they believed was proper exercise. Thus they occasionally went to the gym or for a run. But contrary to their intention they quickly lost
motivation and continually failed to make such forms of exercise a natural element of their everyday life. Therefore, in tandem with their wish to be more active in the gym or on running paths, in fact they became more inactive over the course of the study, as they deselected non-formalised forms of exercise.

Do not enjoy being physically active
One reason why they could not sustain such regularity was revealed at the camp: they did not enjoy being physically active and, as the field note describing the bike ride at the camp illustrates, in particular they disliked vigorous hard exercise. When exploring their antipathy to engage in physical activities the adolescents mentioned their family which they characterised as sedentary and not valuing a physically active life. In addition the adolescents explained that they had felt that their parents had forced them to participate in local sports clubs in their childhood and early youth. Few had pleasant memories from these clubs and they had often changed club due to, for instance, bullying, lack of skills or interest. Besides factors related to their family which had contributed to their sedentary lifestyle, the adolescents believed that they had a biological drive to be sedentary, which could not be overruled.

Parents’ and the families’ view and practice of physical activity
The structural analysis is to be found in Appendix 3.
The four above-mentioned subthemes only addressed the adolescents. This section outlines the findings regarding the parents’, and hence the families’, views and use of physical activity. There were no major difference in the adolescents’ and parents’ views and practice of physical activity. A father for instance jokingly said, when asked about his and his wife’s habits regarding being physically active (round two): “We don’t. That’s why we have a car.”

As was the case with this father, the majority of the parents lived a sedentary life and had within the family no tradition of perceiving and practising physical activity as a way to socialise. A mother said (round three): “I guess we’re not the kind of family who goes walking in the woods or bike-riding holidays or the like.” Thus, the families rarely participated in activities that involved being physically active. Also, they rarely used physical activity, for instance bike-riding or walking, as transportation and if they did it was because the car or similar non-active forms of transport were unavailable.
Many parents expressed a negative or surprised attitude towards slim and presumably healthy individuals that exercised. The parents saw limited purpose in such activity and characterised otherwise slim and healthy individuals who exercised regularly as extreme, fanatic and foolish. A mother said (round three): “Honestly, I think this whole healthiness-thing is too far out. Every day I see slim, beautiful women running just around the corner. Some are even too thin. ... For me it makes no sense. Why are they doing it?” The parents therefore viewed physical activity as something to do when for instance being obese and in need to reduce weight. Thus, they did not view physical activity as a preventive practice or a practice to be used for other reasons than health. As the parents perceived physical activity as a means to reduce weight and thereby gain health they had a genuine wish that their child lived a more active life so he/she could reduce weight. As illustrated with the abovementioned example of the parents’ list of bought exercise equipment the parents, like the adolescents, also viewed physical activity as formalised exercise (e.g. running, going to the gym, sports). Therefore, continually throughout the study all families bought membership fees to the local gym for their obese child. However, none of the children frequented such a place regularly. Regarding this paradox a mother said (round three): “I won’t have her saying that I won’t support her (e.g. by not paying the gym) but I feel like a fool and you know I am, I pay for nothing (because her daughter does not use the gym).” Thus, the parents believed they supported their child by purchasing equipment and membership fees and they were annoyed that their child did not make use of these purchases. The adolescent’s lack of use of what the parents believed was an obvious and easily available option increased the parents’ perception of their child as unmotivated and lazy.

**Stigma and shame**

*The impact and consequences of obesity stigma within homes of obese adolescents*

This part follows the structure and subthemes from the third article.

- Mutual avoidance of drawing attention to the adolescent’s obesity

As indicated in the field notes above the adolescents were highly uncomfortable when attention was drawn to their obesity. If such a situation occurred, the adolescents got embarrassed, sad, felt guilty and frustrated. When exploring
this, it was found that the adolescents and their parents both had behavioural strategies that deliberately aimed to avoid bringing attention to the adolescent’s obesity, and thereby avoid such unpleasant situations. These behavioural, preventive strategies were very pervasive and happened multiple times a day and created a home atmosphere characterised by a fundamental lack of attention to the adolescents’ obesity. A strategy used by the adolescents was, for instance, to read the TV-guide and see if there was a programme on about obese people. If so, they had informed their parents in advance that they had other plans so they avoided seeing the programme with the parents. Thereby the adolescents avoided the attention such a programme would bring on their own obesity. Other strategies the adolescents made use of was, for instance, to hide their attempts to reduce weight from their parents or give the impression that they were more active and healthier than they actual were. For instance and regarding the latter, if they had watched TV all day in their room and could sense their parents’ annoyance by this behaviour they could turn off the TV and open the door for a while and thereby signal that they were doing something else besides watching TV. The parents had similar strategies; a mother for instance explained that she was cautious not to make dinner look too healthy as that would bring attention to her child’s obesity and thus create an unpleasant situation. Also, the parents, if they needed to address matters regarding their child’s obesity, for instance if they had gained information about a nearby weight loss programme, tried to approach their child as discretely as possibly. A strategy could be that a third person delivered the message, or the parents could plan a coincidence were it would be appropriate to deal with such an issue.

- Ashamed of being obese – the reason for avoidance
The reason behind these preventive behavioural strategies was that the adolescents were highly ashamed that they were obese and not able to lose weight. To explain their shame the adolescents expressed that they perceived their obesity as self-induced and caused by them being lazy, immature and lacking will power. As the adolescents matured throughout the study, the shame increased and changed character. For instance, in round one the shame was associated with a specific situation, e.g. eating a fattening product or being sedentary for a longer period. In round three they associated their obesity and inability to adhere to healthier practices with a general personal incompetence.
The adolescents’ parents’ motivation for not bringing their child’s obesity into focus was that they would spare their child the negative feelings such attention would evoke. Hence, they believed they did their child a favour and took care of the child by avoiding explicit attention to his or her obesity.

- In need of support to reduce weight – a consequence of avoidance
One consequence of these behavioural preventive strategies was that the adolescents lacked the possibility of involving their parents in their obesity and attempts to reduce weight. Hence, as the adolescents could not involve their parents in matters related to their weight they were solely responsible for planning, implementing and sustaining healthier everyday practices.

- Obesity as a field of conflicts – when the avoidance cracks
The adolescents’ obesity was rarely the subject of positive attention. However and in spite of the abovementioned strategies of avoidance their obesity was frequently the focus of fights and conflicts. Such conflicts were often initiated by the parents’ frustration and anger related to their obese child’s habits of being sedentary and eating unhealthily.
6 DISCUSSION

The following discussion is in two parts. The first part discusses the findings; the second part discusses the methodological design. The discussion of the findings has two themes: 1) why do obese adolescents become obese? And 2) why are obese adolescents unable to reduce weight? Naturally, these themes do not fully encompass these matters but are meant as a contribution that, together with other approaches, can shed light on obese adolescents’ everyday lives with regard to becoming obese and trying to reduce weight. The discussion of the methodological design is divided into limitations, reliability and validity, generalisability and suggestions with regard to the applied methods.

Discussion of the findings

Why do obese adolescents become obese?

This section first outlines obese adolescents’ habitus regarding the practices associated with obesity, e.g. physical activity and healthy eating. Then the development of obese adolescents’ habitus is sketched. Lastly, the habitus is applied to the obesogenic environment.

Obese adolescents’ habitus

In line with previous research (Borra et al 2003, Tyler 2004, Murtagh et al 2006, Alm et al 2008, Barberia et al 2008, Davis et al 2008, Heading 2008) this study found that obese adolescents want to reduce weight and continually attempt to alter their practices by adopting a more active lifestyle and a healthier diet. Although hoping for a permanent change of lifestyle they quickly lose motivation and return to old practices. The theories of Bourdieu (1984, 1990), especially his notion of habitus, may be useful in order to understand why the adolescents fail to adopt a new and healthier lifestyle despite their best intentions. On the basis of the findings described in the articles and the previous chapter this section outlines the adolescents’ habitus in regard to their eating habits and habits of being physically active.

Habitus is a sociological concept used to understand and elaborate everyday practice. According to Bourdieu habitus equips the individual with an implicit
practical logical that regulates daily life in a structured and generative way, thus,
habitus ensures that the individual act alike in a range of different settings. This
logic is the product of previous experiences in response to objective structures
experienced from a specific position in society determined by the individual’s
amount of capital within the field. Although minor attention is given to
Bourdieu’s forms of capital and his concept of field in this chapter habitus does
not exist independently of these sociological ideas. Thus, an individual with a
high amount of symbolic capital holding a prestigious position within a specific
field will have a different habitus compared to the individual who has less
capital and an inferior position in the respective field.

To illustrate the adolescents’ habitus their incentive to change practice is of
interest: their prime motivation is to lose weight and they do not generally
associate the lifestyle necessary to lose weight with other advantages. For
instance, besides a means to lose weight the adolescents ascribe few positive
characteristics to physical activity. On the contrary, and as found by Zabinsky et
al (2003) and Deforche et al (2005), they do not enjoy being physically active,
and do not, for instance, view such behaviour as relaxing, convenient, social or
fun. Also, besides a means to lose weight they find a healthy diet boring and
tasteless. Similar findings have been reported by Hesketh et al (2005), Murtagh
et al (2006), and Davis et al (2008). On the contrary the adolescents prefer
unhealthy foods and may eat such products on a daily basis.

This study therefore indicates that one reason why obese adolescents are obese
is because they have developed a fondness, or habitus, for the lifestyle associated
with obesity, i.e. they prefer being sedentary and they find it natural to eat what
they like and when they like it. At the same time they have limited interest in
healthy food. Although not applying the concept of habitus, similar insights have
been suggested by Heading (2008). It is therefore suggested that the
adolescents’ habitus regarding food and exercise favours a lifestyle that may
generate obesity. Following Bourdieu the adolescents will make behavioural
choices that correspond with such a lifestyle. Also, to avoid the influence of
habitus the adolescents need to reflect upon their practice and actively make
choices that oppose their habitus.

However, the adolescents’ fondness for the lifestyle associated with obesity does
not explain much and it could be argued that to support obese individuals to
change practices it is vital to understand why they have developed this habitus, or, as Hastrup (2004) puts it, why a given practice makes sense for the people practising it. According to Hastrup, this calls for epistemological awareness in contrast to ontological certainty. In this case, ontological certainty refers to the fact that obese individuals in comparison to a non-obese control group may prefer a lifestyle associated with obesity while epistemological awareness refers to possible circumstances that have generated such preferences. To account for the development of the adolescents’ habitus, it is, following Bourdieu, of particular interest to focus on previous experiences experienced within the home environment. It is therefore suggested that the adolescents’ fondness for the lifestyle associated with obesity is linked to the home environments’ views and use of eating and physical activity.

The development of obese adolescents’ habitus
As illustrated in the previous chapter, the adolescents’ families had to a high degree similar tastes and preferences in regard to the practices associated with obesity. Thus, according to Bourdieu, they may have contributed to the adolescents’ habitus regarding the lifestyle associated with obesity. However, it is important to understand that habitus is not the product of causal incidents that can be, for instance, statistically defined, hence it is not possible to account for the exact development of the adolescents’ habitus within their homes. Therefore, the following is not to be seen as a finite description of the development of the adolescents’ habitus but only some aspects in this development. This section points to some factors from the home environment that the adolescents have experienced that may have contributed to their fondness for the lifestyle associated with obesity. According to Bourdieu the adolescent will internalize these and other subjective experiences into a matrix that, in combination with other factors, develops habitus.

Overall, the parents, and hence those in the home environment, did not generally perceive and practise eating and physical activity as a means to generate a positive family environment. For instance, within the families eating was primarily viewed, to put it simply, as a way to become full. For example, especially in the last round of data collection, the families did not on a regular basis gather and socialise when eating, and if they did, they often ate in front of the TV. In addition many parents viewed a good meal as a meal low in conflicts
that finished quickly. Furthermore, the parents rarely set restrictions in regard to for instance quantities of food, composition of food on the plate or otherwise explicitly tried to control their child’s eating. Also, eating in many families was not associated with a specific time or event, like breakfast, lunch and dinner, but spread out through the day. The adolescents and other family members therefore could eat during the entire day if they wanted to. Lastly, adolescent and parent rarely shopped for groceries or cooked together and the adolescents seldom helped with, for instance, the dishes, thus, there was a limited tradition within the families of socialising when, for instance, cooking or grocery shopping. Thus, eating in the adolescents’ families was an activity that primarily served a functional or nutritional purpose and was not generally practised for social reasons or because it simply gave pleasure. Besides these examples the families to a large extent associated healthy food with weight loss and not with, for instance, taste or variation in diet. Within the family therefore, these products were perceived as “healthy products”, e.g. food to eat when having a need to reduce weight and become healthy.

As with the eating habits the families did not generally view and practice physical activity as a practice that served a positive or practical purpose. For example, within the families physical activity was rarely used as a mode of transportation and if it was, it was because there was no other option. Likewise, the families rarely used physical activity as a social practice, for instance going for a walk or a bike-ride together or participated in activities that would involve being active. Many parents even expressed a surprised attitude towards slim and presumably healthy individuals that exercised regularly; some parents even ridiculed such habits as purposeless. On the contrary, the parents viewed physical activity as a practice useful when one was obese and therefore in need of reducing weight. Thus, within the adolescents’ families the prime purpose of being physically active was to reduce weight and become healthy. Hence, physical activity was not seen and practised as a practice that could be for instance convenient, social, relaxing or joyful.

In summary, within the adolescents’ homes eating and physical activity are not valued as social and integrative practices. Simply put, eating was viewed as a way to become full, and healthy eating and physical activity were viewed as practices done to reduce weight. By no means does this thesis imply that the
families’ practices regarding eating and physical activity are wrong in any sense but it is argued that the symbolic value the families attach to these activities is different compared to a family who, for instance, socialises when eating, enjoys going for a walk together and eats salads because they enjoy the taste.

The point regarding the adolescents’ habitus is that, in their upbringing, the adolescents have experienced that it is possible to eat according to preferred taste whenever the need or desire arises. In addition they have experienced that a major purpose of healthy eating and physical activity is to reduce weight and become healthy, thus they have not experienced that everyday healthy eating and physical activity are practices associated with meanings and pleasure besides weight loss. According to Bourdieu, the adolescents will internalize and embody these experiences and, it is argued, develop a habitus that reproduces similar dispositions and hence similar practices. Thus, the adolescents will develop a habitus that favours a sedentary lifestyle and at the same time outlines physical activity as an activity done with the intention of reducing weight. In addition the adolescents will develop a habitus that favours “unrestricted eating”, e.g. the ability to eat what is liked when the desire arises. At the same time “healthy food” will be outlined as food to eat when wanting to become healthy. Their habitus therefore will not outline healthy eating and physical activity as natural and legitimate practices but, on the contrary, outline them as annoying and strenuous practices that oppose their preferred way of living. As habitus works at a pre-reflexive level it is their preferred way of living that will dominate their practices. Hence the adolescents will live a sedentary life and “eat unrestrictedly”. To alter habitus and thereby oppose these preferences, the adolescents need to reflect upon their practices and actively contradict their habitus when facing a choice regarding these matters.

Bourdieu’s theory of practice is in many ways a refinement of former socialisation theories where habitus, simply put, links parental lifestyle and society’s structures with their child’s lifestyle. Although sociological concepts such as habitus are rarely applied within health science, a consistent body of research has found similar associations as outlined above, e.g. parents significantly influence their child’s eating and exercising habits (Davison et al 2002, Borra et al 2003, Kelly et al 2006, Cooke 2007, Zehle et al 2007, Scaglioni et al 2008, Burgess-Champoux et al 2009, Hart et al 2010, Jones et al 2010,
Anderson et al 2010, Beets et al 2010, Cleland et al 2011). However, the majority of these studies focus on specific incidents, or variables, as causal for the child’s unfavorable habits; for instance, exposure to vegetables, parental consumption of certain products, number of weekly breakfasts, number of weekly family dinners, family rules and restrictions in regard to certain products, parental co-participation when being physically active. The importance of such incidents is by no means overlooked. But the advantage of applying Bourdieu’s concept of habitus is that it takes the complexity of all possible variables regarding eating and physical activity into account. Hence, rather than reducing the adolescents’ practices in regard to eating and physical activity to a single, causal, incident it is suggested that these practices are a product of a complex interplay of different variables that mutually and in non-causal ways influence one another. Based on the interplay of different non-causal variables habitus equips the adolescents with an implicit practical logic that predisposes them to make sedentary choices and eat something they like in taste when they feel like it.

However, according to Bourdieu individuals’ (or families’) habitus cannot be seen in isolation but as part of a broader social space, where individuals in similar social positions have similar habitus. Thus, a full exploration of their habitus needs to address these other social influences.

**Habitus and social networks**

The study and its findings explored a period in the adolescents’ life where non-familial relations are important. The parents of course also had relations outside the home. Thus, both parents and adolescents belong to other social networks. According to Bourdieu individuals tend to socialise with individuals they resemble; hence, their friends and relatives may have similar habitus and therefore, dialectically influence and confirm a similar lifestyle. Although this study did not focus on non-familial acquaintances it is presumed, following Bourdieu, that the participating families’ social networks have similar views and practices regarding diet and physical activity. This presumption is supported by a growing body of research that has documented an association between obesity and social networks. Hammond (2010) for instance, when reviewing the literature, found that people who regularly socialise come to share norms in regard to body image and eating habits and thereby accept and behave according to such norms. Also, Christakis et al (2007) quantitatively followed
nearly 40,000 individuals for more than 30 years and found that the individuals’ weight is highly dependent on his/her social ties. Furthermore, they found that social distance is more important than geographical distance in the spread of norms and behaviours associated with obesity.

In summary therefore, it is suggested that, besides parental influence, their and their parents’ social networks have contributed to the adolescents’ habitus. Hence, when the adolescents and their parents socialise with for instance family and friends they indirectly and directly confirm and support the lived lifestyle, and hence habitus.

Nevertheless, as argued above, habitus is formed by a combination of subjective matters in response to objective structures. To understand why the adolescents have become obese it is necessary to relate their subjective experience with the obesogenic environment.

*The habitus of obese adolescents and the development of obesity*

As the adolescents and their parents were part of non-familial networks they also lived and participated in society, hence they were part of the obesogenic environment. The essence of the obesogenic environment is that everyday life can be lived without being physically active and, at the same time, cheap and fattening food is available everywhere (Swinburn et al 1999, Lake et al 2006, Jones et al 2007). Thus, the obesogenic environment presupposes that in order to stay slim one chooses to be active and eat a healthy diet.

So far it has been suggested that the adolescents had a habitus that made sedentary activities and unrestricted intake of primarily unhealthy foods natural and legitimate practices. In addition the adolescents, through their habitus, did not associate physical activity and healthy diet with many positive characteristics besides weight loss. Thus these matters were viewed as strenuous practices opposing their favoured way of living. However, following Bourdieu it is important to understand that the development of the adolescents’ habitus has only been possible because, and in simple terms, the obesogenic environment has allowed it to develop. For instance, as the obesogenic environment has made it possible to catch the bus to school, watch TV when at home and in general live a sedentary life, the adolescents made use of these possibilities. Also, as they had the possibility to eat throughout the entire day, decline vegetables, and on a daily basis eat junk food and drink sugary drinks, they did so. Thus, regardless
of geography and time of the day, when facing a choice where they could choose to be sedentary and eat the adolescents unconsciously and without much reflexive thinking choose such options. The reason why these practices are so pervasive in time and space is because habitus is generative. This means that although the adolescents in the obesogenic environment constantly encounter different situations and choices, the logic underlying their practice towards these choices is the same. Thus, following Bourdieu the adolescents’ habitus is to a high degree the product of the possibility provided by the obesogenic environment to live a sedentary life and eat an unhealthy diet. However, following Bourdieu there is no causal relation between for instance, amount of screen-time or passive transportation and habitus and hence the practice associated with obesity. On the contrary, the influence of these possibilities is according to Bourdieu, internalised into habitus as well as the habitual way of dealing with such conditions. Thus, it is not so much the actual possibility but rather the handling of this possibility that influences on habitus. For instance, by choosing – at an unconscious level – to be sedentary and eat unhealthily the adolescents both produce and reproduce their habitus and the preferences it expresses. In this sense, habitus is only developed when it is applied within society’s possibilities and limitations. Habitus therefore takes into account both the social influence the individual is exposed to and the objective conditions he/she encounters in life. Again, as with the aforementioned parental influence on the obese adolescents’ habitus, it makes little sense to quantify or causally explain the environment’s contribution to habitus.

One way to perceive the obese adolescents’ weight gain in their teen years is therefore to relate their habitus to their newly won independence with the possibilities the obesogenic environment has provided. Hence, as the adolescents matured and gained independence and to an increasing degree came to make independent choices they made these choices in accordance with their preferences as outlined by their habitus. Thus, as they preferred being sedentary and it is possible to live a sedentary life they made use of this possibility in daily life. And, as they preferred unhealthy food whenever in the mood and such products are available everywhere, they made use of this availability. The obese adolescents’ sedentary habits and tendency to eat unhealthy products therefore are neither a result of free will, nor determined by
the obesogenic environment, but created by a kind of interplay between the two.

Above it has been argued that Bourdieu’s theory of practice is one way to theoretically elaborate upon the adolescents’ everyday life in regard to their obesity. Bourdieu’s theory is complex and only minor parts of his theory have been adopted. It has been argued that the adolescents have a habitus that outlines a sedentary lifestyle and unrestricted eating as natural and fully legitimate. At the same time their habitus outlines “healthy eating” and physical activity as practices that are useful when wanting to be healthy and not practices carried out to achieve meaning and pleasure. Following Bourdieu this habitus is developed through parental upbringing and social network in response to objective structures outlined by the obesogenic environment. For instance, within their homes the adolescents have experienced that physical activity and “healthy eating” are practices associated with health and therefore not a natural element of everyday life. In addition the adolescents have not experienced that physical activity and meals are activities associated with joy and meaning besides losing weight and becoming full. These experiences have been, it has been hypothesised, supported by the adolescents’ and their parents’ social networks which, according to the literature (Christakis et al 2007, Hammond 2010) have the same views and practices regarding food, meals and physical activity. However, following Bourdieu habitus can only be formed when the objective structures in society are internalised. Thus, as the adolescents from their home environment and social networks have experienced that it is fully natural and legitimate to make use of the possibilities the obesogenic environment offers, for instance eating junk food and watch many hours TV at a daily basis, they come to internalise this use into their habitus. Hence they come to have a habitus that, for instance, makes it natural and legitimate to watch TV all day, eat junk food regularly and in general live a sedentary life.

**Why are obese adolescents unable to reduce weight?**

The study showed that the adolescents, contrary to their intention, failed to make healthier practices a natural part of their everyday life. It has been argued that this failure to some degree can be explained using Bourdieu’s concepts of habitus. However, habitus has been criticised for being too deterministic and unable to account for individual innovation and change (e.g. Jenkins 1982).
Such criticism may be appropriate but as some individuals are able to permanently alter their lifestyle their habitus generating such lifestyle is altered too. Hence, habitus, of course, can be modified. Bourdieu does not discuss a change of habitus in detail, but it could be argued that a change of habitus presupposes a thorough change of the individual’s environment. Simply put, in order to alter their practices related to eating and physical activity the obese adolescents need to be socialised into a habitus that enables these new practices. This argument is in line with much research within obesity management that has found that lasting lifestyle changes are linked to social support (Grignard et al 2003, Tyler 2004, Chen et al 2005, Barberia et al 2008). Nevertheless, a finding in this study is that obese adolescents deliberately avoid parental involvement when they attempt to adhere to a healthier lifestyle and reduce weight and this, it is argued, makes a change of habitus difficult. The parental preclusion was due to the negative feelings, like shame and embarrassment, the adolescents felt about being obese and not being able to reduce weight. This section first addresses the adolescents’ shame about being obese and not being able to reduce weight. Then their daily life living with shame within their family is outlined. Lastly consequences of this are addressed.

**Obesity, shame and stigma**

The findings showed that the adolescents’ obesity caused them emotional problems. This corresponds with literature exploring these aspects of obesity that consistently find that obese individuals to a higher degree suffer from, for instance, reduced quality of life, depressive symptoms and lower self-esteem compared to normal weight controls (Griolo et al 1994, Sarwer et al 1998, Kolotkin et al 2001, Puhl et al 2004, Sjöberg et al 2005, Williams et al 2005, Luppino et al 2010). These and other negative psychological characteristics have been linked to feelings of bodily shame (Polivy et al 2002), which, according to Skårderud (2007), is a severe perception that one has bodily attributes that others find unattractive. The experience of bodily shame, according to Skårderud, involves a state of self-consciousness and embarrassment that is evoked when others view the body shape and thereby see that the individual falls short of meeting society’s representation of the ideal body. Bodily shame is therefore caused when the individual experiences that he/she does not meet these standards. Thus, obese individuals’ bodily shame may be the result of a
discrepancy between on the one hand the preferred body defined by society and on the other hand their actual body. Following the theories of Erving Goffman (1986) deviation from society’s norms and values may give way to stigmatization. In that light, an individual having a body that fits society’s norms and values is regarded as normal whereas a person having a body that falls short of meeting these norms and values is categorized as deviant and therefore stigmatised. Thus, Goffman argues, stigma is a social process that links attributes with stereotype and thereby enables classification of individuals. Goffman operated with three groups of stigmatised individuals: individuals with bodily deviance, individuals with character flaws and individuals belonging to specific tribes perceived as deviant. Although Goffman did not focus on obese individuals they may fit into two of these categories; thus according to society’s norms and values (Lupton 1995, Lupton 2003), obese individuals both have an abnormal body and a flaw of character.

Therefore, one way to comprehend obese individuals’ bodily shame and impaired psychological and social well-being (Kolotkin et al 2001, Strauss et al 2003, Williams et al 2005, Luppino et al 2010), is to link it to the widespread, societal perception that obese individuals are perceived as, simply put, lazy gluttons who lack self-discipline (Neumark-Sztainer et al 1999, Sechrist et al 2005, Puhl et al 2008). These stereotypes are very prevalent and translate into practically all settings leaving obese individuals vulnerable to injustice and unfair treatment (Puhl et al 2009). In recent years, attention to obesity stigma has increased with a growing recognition of the pervasiveness of negative effects of stereotypes, prejudice, and discrimination due to obesity (Meyers et al 1999, Sobal 2004, Puhl et al 2007, Conradt et al 2008, Peronard et al 2008, Puhl et al 2009). Although many aspects of obesity stigma have been explored, these studies primarily focus on public arenas and few studies have investigated its impact and consequences in family life. Nevertheless in the family it has been found that parents may discriminate against their obese child in favour of a non-obese child, for instance in regard to willingness to pay for college education (Crandall 1995). Also, Neumark-Sztainer et al (2002) found that weight teasing within families of obese children and young people is common. Adams et al (1988) found that parents may verbalise negative stereotypes about obese individuals to their children and thereby create an understanding in the family.
that perceives obese individuals as the stereotypes indicate. Although not empirically tested Puhl et al (2007) has hypothesised that the home atmosphere within families of obese individuals may be characterised by a stigmatising attitude.

The present study supports Puhl et al’s hypothesis and illustrates that obesity stigma has a fundamental influence within families of obese adolescents. All adolescents participating in this study were highly ashamed of being obese and not being able to reduce weight. The adolescents’ shame was caused, as Skårderud (2007) and Goffman (1986) above suggested, by a perception that they did not meet society’s demands of the slim and well-trained body and personal responsibility in regard to being active and eating healthy foods (Lupton 1995, Lupton 2003). This perception was regularly confirmed and fortified, for instance by parents who criticised their child for being lazy, and by dieticians, teachers, doctors and exercise experts etc., who wanted to help the adolescents replace current bad habits with better ones. But also because the adolescents attributed their continual failure to lose weight internally and thereby increasingly came to view themselves as incompetent individuals. Similar findings have been documented by Rudman et al (2002) and Wang et al (2004) who found that obese individuals internalise the stereotypes associated with obesity and thereby stigmatise themselves and other obese individuals. Goffman in his work on stigma (1986) accounted for this matter and argued that stigmatised individuals come to view themselves with the eyes of a non-stigmatised individual. Hence, stigmatised individuals are very well aware that they do not meet society’s norms and values and, according to Goffman, they come to perceive themselves as deviant.

Thus, although the adolescents, using Bourdieu’s terminology, had a habitus that favoured a lifestyle associated with obesity they were well aware that this lifestyle conflicted with society’s norms and values regarding the “right” lifestyle. Bourdieu calls these processes symbolic violence, e.g. when individuals’ values and practices are the subject of one’s own and others’ devaluation. The point here is that the adolescents increasingly came to associate their way of living with a fundamental shame, which had major impact on their life.

*Living with shame*

The adolescents’ shame was evoked whenever their obesity, or the lifestyle
associated with their obesity, was brought into focus. Such attention, following Goffman, the adolescents felt, exposed their failure to adhere to society’s norms and values and thereby exposed their self-perceived incompetence. This corresponds with what Goffman has showed when analysing stigmatised individuals; when their deviance is on display they are reminded that they do not meet the legitimate norms and values in society and they become embarrassed and ashamed. To reduce these negative feelings stigmatised individuals, Goffman argues, try to avoid or prevent such shameful situations. 
The situation is likewise with the adolescents: they had a pervasive need to avoid bringing attention to their obesity and they did everything possible to meet this need. Thus, in everyday encounters with their parents they adopted preventive behavioural techniques that aimed to draw attention away from their obesity and the lifestyle associated with it. For instance, to hide the many hours a day they watched TV in their room they once in a while showed themselves for their parents or turned off their TV and opened the door. Likewise with their eating practices; to an increasing degree they felt uncomfortable eating with their parents and although they reduced their secret food shopping, they never ate too unhealthily in front of their parents. These and the previously given examples are very specific and do not grasp the pervasiveness of these strategies. It is important to understand that in their daily interaction with their parents the adolescents *always* tried to control the encounter in a direction that avoided exposure to the obesity: thereby, and with the words of Goffman (1956, 1959), coherence was ensured. The adolescents’ parents of course knew that their child disliked having their obesity exposed and as the parents did not want to emotionally hurt their child they also had preventive behavioural techniques that were intended to avoid making their child feel ashamed, or with Goffman’s word, they ensured coherence in the interaction. One parental technique was not to make radical changes in a healthier direction in the home diet as such change would draw attention to the adolescents’ obesity and his/her failure to adhere to a healthy diet. Again, the parents were as eager as the adolescents to prevent a shameful situation so the use of these strategies was just as pervasive as the adolescents’ use of them.
To elaborate upon the home-based avoidance of drawing attention to the adolescents’ obesity Goffman’s theories on face-to-face interaction are
applicable (1959). In an encounter, Goffman argues, individuals follow certain implicit rules that ensure coherence in the interaction. In particular, the individual will attempt to control the impression that others might make of him/her in a certain and appropriate direction. Thereby, Goffman argues, individuals do not lose face and their sense of self stays intact. Furthermore, as all parties to the encounter are interested in controlling their impression they are just as interested in making sure that the other individuals’ impressions stay intact. Thus, in an encounter, individuals both try to control both their own and also others’ impressions. If all succeed coherence is achieved. Inspired by his thoughts on face-to-face interaction Goffman addresses how the potentially embarrassed individual tries to avoid becoming embarrassed in a given social encounter (1956). To avoid being embarrassed the individual projects an acceptable self into the interaction and thereby downplays characteristics that are associated with the embarrassment. ‘Acceptable’, according to Goffman, refers to certain moral, mental and physiognomic standards defined by society and shared by its members. The other parties in the encounter follow the implicit rules of social interaction and accept and confirm this self, thereby helping the potentially embarrassed individual in not becoming embarrassed and losing face. If, however, coherence is not restored the embarrassed individual may reach a point where he/she, according to Goffman, abdicates his/her role as someone who tries to assure coherence in the encounter. When reaching that point the embarrassed individual may, for instance, burst into tears, leave or experience a blind rage.

As indicated, the adolescents in this study in their encounters with their parents were very cautious not to signal that they could not adhere to the society’s norms and values regarding healthy eating and regular physical activity (Lupton 1995, Lupton 2003). In line with Goffman’s argument they did this by deliberately projecting a non-obese self into their daily encounters with their parents. For instance, by turning off their TV when they hear their parents approaching they project a self that is in accordance with the societal discourse that emphasises an active lifestyle. Thereby they downplay the characteristics associated with obesity. Thus, although the obese adolescents cannot hide their obesity they can minimise attention to it and thereby reduce the possibility of being confronted with it. By following the rules of tactful, social conduct, the
parents also avoid displaying the adolescents’ inability to comply with such norms and values; thereby the parents accept and confirm the adolescents’ projected self. Thus, on a regular basis the adolescents and their parents tried to sustain coherence in the interaction by using different behavioural coping strategies that aimed to avoid being confronted with the shame associated with being obese. Hence, by projecting a non-obese self the adolescents, following Goffman, gave the impression that they could adhere to society’s norms and values. The process of keeping the impression of the adolescents’ self as non-obese has, it is argued, major impacts on obese adolescents’ life.

Three consequences of living with shame

So far it has in this section been argued that obese individuals can be perceived as deviant and stigmatised as they do not meet the preferred norms and values in society. Following Goffman the adolescents have internalised these norms and values and when, in everyday encounters, they are reminded that they fail to meet them they become embarrassed. To avoid this embarrassment obese adolescents and their parents adopt behavioural techniques that aim to prevent such embarrassment. This, however, is not without side effects. Three issues will be addressed.

First, they do not have “a backstage”. Backstage is a term from Goffman (1959) and is a space where the individual does not have to worry about appearing in accordance with acceptable norms and values. In backstage the individual can feel safe, relax and recover before entering frontstage where one’s self is at stake. In backstage therefore, one can joke, laugh or otherwise have a critical approach towards one’s self – a behaviour that is unthinkable in frontstage. Thus, although the adolescents’ obesity was a major and sad burden they had no one to talk to or find comfort in regarding their obesity – in fact, the researcher was the only person they had a backstage with. Although it will be addressed no further here, this lack of backstage, or loneliness, plays a major negative role in the adolescents’ lives and is an issue that needs more attention in future interventions.

Second, since in the adolescents’ homes there was an implicit understanding of projecting and accepting a non-obese self the adolescents could not address matters regarding weight loss. Thus, the adolescents could not discuss and plan in collaboration with their parents how to establish a supportive home
environment. Also, when attempting to reduce weight they could not involve their parents in these attempts. On the contrary, to ensure coherence in the interaction the adolescents could deliberately hide such attempts from their parents, for instance by eating normally in their company but dieting when alone. Thereby, attention was not brought to their obesity, and hence a shameful incident was avoided. A finding from this study therefore is that obese adolescents do not involve their parents in their attempts to reduce weight and therefore are solely responsible for making the lifestyle changes necessary for weight loss within their home environment. As mentioned above, social support is a crucial element in effective, behavioural induced weight loss. Thus, this factor is very unfortunate.

Third and last, although major behavioural energy was used to avoid bringing the adolescents’ obesity into focus, the adolescents’ obesity was frequently the centre of criticism and conflicts. Similar findings have been reported elsewhere (Chen et al 2005, Alm et al 2008, Edmunds 2008). These conflicts typically happened because the adolescents’ parents got annoyed with their child because, for instance, they believed their child watched too much TV or bought too much junk food. In these situations the parents would lose their temper and yell, saying he/she was lazy, immature, irresponsible and the like. Such criticism made the adolescents sad, angry and embarrassed. Often they reacted by crying, yelling and leaving the room, leaving little chance to restore coherence. When they gained control of their temper, the parents also got sad and regretted their outrage. Thus, when the adolescents’ obesity was brought into focus it was often due to a conflict and it created a negative atmosphere. This matter is directly comparable to Goffman’s thoughts on embarrassment (1956); at some point, Goffman argues, coherence is no longer an option and the embarrassed and ashamed individual reacts by bursting into tear or a blind rage.

Following the theory of Bourdieu a change of habitus requires, as mentioned above, the involvement of close social relations. As shown, the adolescents in this study deliberately deselected parental involvement in their attempts to reduce weight and were thereby solely responsible for initiating and maintaining the practices needed for weight loss. This reluctance to involve their parents was, it has been argued and following the theories of Goffman, a consequence of
the widespread stigmatisation of obese individuals. In short, according to Goffman stigmatised individuals get embarrassed when their deviance is on display and one way to cope with this embarrassment is to avoid situations where attention is brought to the deviance. Although other factors, including matters related to for instance genes or psychology, may contribute to the adolescents’ inability to reduce weight, such avoidance of involving those in one’s close social relations makes a change of habitus difficult and thereby hinders long term behavioural changes.

Below the implications of the above-sketched argument are outlined. Before this, however, limitations, matters related to reliability, validity and generalisability regarding the study’s specific methods are addressed.

**Reliability and validity**

Reliability and validity as scientific concepts are rooted within a positivistic tradition (Golafshani 2003); reliability refers to the quality of a particular measurement while validity is concerned with the study's success at measuring what the researchers set out to measure. However within a non-positivistic approach, like anthropological studies, it could be argued, that validity and reliability are inseparable as validity is assured if data is reliable and answers the aim. Therefore when applied in anthropological studies it is difficult to sustain such clear distinction between reliability and validity as seen in positivistic studies. Also, as anthropological research rarely focuses on measurable data, reliability may be regarded as the trustworthiness of the data collected, e.g. is data collected in a suitable and appropriate manner?

To enhance the trustworthiness of the collected data three matters in the study design are addressed: first, by combining participant observation and interviews the present study gained a more refined understanding of the participants compared to a situation where only one method had been used (Bernard 2005). The use of several methods to explore the same phenomena is in the literature referred to as triangulation. The different methods used complemented each other and could be used actively by the researcher, for instance in the interviews by asking to observed findings and inversely, when conducting participant observation by focusing on what the participants had said in the interviews. Second, as the researcher visited participants three times over almost two and a half years he became familiar with the participants which to a high degree has
contributed to the intimacy in the relations between the researcher and participants. Also, the longitudinal design made it possible to address matters that in the previous round were found and thereby test, detail and elaborate a given interpretation. Third, as the researcher has a degree in anthropology and has previously conducted qualitative investigations among obese adults and obese children (Lindelof 2005, Lindelof 2005a) he had both the relevant academic skills and previous experience within the field to conduct the present exploration. All three characteristics, e.g. poly-methodical approach, longitudinal design and the researcher's background, have contributed to the trustworthiness or reliability of the data collected and hence the study's validity. However, to extend upon matters related to validity Hastrup’s (2004) notion of epistemological awareness is fruitful. Contrary to the knowledge dominant within the positivistic paradigm and thus the majority of the knowledge within the scientific field of medicine, Hastrup argues that anthropological knowledge intends to suggest possible connections between social facts that may help understand a given phenomenon. This, according to Hastrup, demands that the researcher is “in touch” with reality and tries to figure out how parts and wholes are constructed and how the individual within these parts and wholes acts and makes sense of his/her world. Thus, the validity of an anthropological study lies in its ability to offer a sound argument that takes people's lives seriously. This argument is by no means definite and it is up to others to judge and further elaborate upon it. Validity in this sense therefore is assured if the argument delivered is usable in any possible way.

**Generalisability**

Qualitative studies form a weak basis for generalisability in a statistical sense. Flyvbjerg (2006) has explicitly dealt with case studies and their ability to be generalised. According to Flyvbjerg the tendency to view generalisability as primarily statistical or formalised is unfortunate, since non-statistical knowledge enters into the collective process of knowledge accumulation just as well and as much as knowledge generated quantitatively. Thus, statistical generalisation is only of many ways to generalise. He further argues that case studies can give good, in-depth examples that can be of great value within science and supplement large quantitative studies. It is therefore not the exact findings that may be generalised and transferred to a wider population but
rather the argument developed on the basis of the findings that can be generalised.

According to these assumptions the argument developed from this study may serve as an explanatory basis from which obese individuals’ practice within the obesogenic environment may be understood. More concretely it is suggested that the concept of habitus can be applied within the field of obesity. Thus, to understand why some individuals turn obese while others do not an analysis of social positions combined with the obesogenic environment is relevant. Social positions may be equated with socioeconomic status (SES). Therefore, this thesis application of habitus within the obesogenic environment is a fruitful way to address obese individuals practice as it both takes into account subjective experiences and objective conditions.

Furthermore, as obesity stigma is pervasive in society and, for instance, discrimination due to obesity is as prevalent as racial discrimination in the US (Puhl et al 2008a) it is assumed that the above mentioned thoughts on stigma, shame and behavioural strategies used to cope with these matters are relevant within the homes of obese children and young people in general. Although the impact and effect may vary among the homes it is hypothesised that few homes are completely unaffected by obesity stigma and that obesity stigma plays a negative role in obese individuals ability to reduce weight.

In summary it is therefore believed that the main arguments of this thesis can be generalised to the wider obese population.

**Suggestions in regard to the methods**

The hindsight gained from the study points to some adjustments in regards to methods that would have been fruitful to incorporate, if they had been known before commencement of the study. First, the study was initially presented to the families as primarily addressing the adolescents’ obesity and it is hypothesised that this created an implicit atmosphere that put attention on the adolescent and not on the family. For instance, as the parents believed the study addressed their child it was sometimes difficult to critically address the parents’ practices and the researcher, due to politeness and tactful conduct, could not be as direct toward the parents as he could toward the adolescents. This bias may have been reduced if the study to a higher degree had been presented as addressing the adolescent and the parents/family. Second, it might have been
fruitful to interview adolescents and parents together, especially in round three, where the adolescents had become more independent and more reflective and the researcher knew the family well. If, for instance, they had been interviewed together right after they were interviewed alone a dialogue between parent and child, facilitated by the researcher, could have gained interesting insights. The lack of these aspects does not invalid the findings but if the two suggestions had been integrated more attention could have been devoted to the family and hence the development of the adolescents’ habitus.
7 CONCLUSION

The aim of the thesis was to explore how obese adolescents’ and their parents’ experience the adolescents’ obesity and possible attempts to reduce weight in daily life.

It can be concluded that obese adolescents have an immense desire for weight loss and their parents have just as great a wish for their child to reduce weight. Nevertheless, through the teenage years, obese adolescents increase their weight. Both obese adolescents and their parents are well aware that the former live a way that perpetuates obesity. Obese adolescents frequently attempt to alter their lifestyle in a healthier direction but continually fail to make healthier practices permanent. One reason for obese teenagers’ weight gain is that the freedom achieved due to independence from parents is managed by, at a pre-reflexive level, making everyday choices that favour sedentary above active possibilities and eating preferred food whenever the desire arises. Preferred food is largely unhealthy and associated with obesity.

The tendency for obese adolescents to make sedentary choices is related to the effects of close social relations, in particular their parents, in combination with their interaction with their physical surroundings. These social and physical influential factors have in a practical and theoretical sense led young people to associate a sedentary life with meaning and pleasure and therefore it becomes the natural practice. In conclusion therefore, obese adolescents have not inherited and thereby developed an inclination to be active; on the contrary, physical activity is viewed as a strenuous practice primarily useful for losing weight. Obese adolescents’ taste for unhealthy food products and the tendency to eat when the desire arises is likewise a product of the effect of social experiences, in particular related to their parents, in response to objective societal structures. These factors have not led young people to associate eating with joy and meaning besides as a mean to get full. On the contrary they have experienced that it is possible and legitimate to eat according to preference when the desire arises. In conclusion therefore, obese adolescents have inherited and developed an inclination to eat what they like in taste whenever they want. Further the adolescents have developed an assumption of healthy
eating as something associated with health and practised as a means to reduce weight.

With reference to Bourdieu’s theory of practice it is concluded that obese adolescents have developed an implicit, practical logic, or habitus, that outlines sedentary practices and practices associated with unrestricted eating, e.g. eat what is liked, when desired. Habitus is the product of a non-causal interplay between subjective experiences, in particular parental upbringing, and objective structures, e.g. the opportunities provided by the obesogenic environment to live in a way that puts one at risk of becoming obese.

Obese adolescents’ habitus in regard to the practices associated with eating and physical activities opposes society’s norms and values regarding individual responsibility in relation to having a slim, attractive body. The inability to adhere to society’s norms and values makes obese adolescents ashamed of being obese and unable to alter their lifestyle. This shame increases through the teenage years and comes to be a fundamental part of their self-image. In everyday life, the shame makes obese adolescents and their parents adopt behavioural, preventive strategies that draw attention away from the adolescents’ obesity and thereby avoid stigmatisation and unpleasant situations. Consequently, within the homes of obese adolescents obesity is rarely the subject of non-negative attention and obese adolescents are solely responsible for implementing and sustaining the lifestyle changes necessary to reduce weight.

One perspective that arose from the investigation is that the management of obesity needs to address prevention, by making eating and physical activity meaningful and appreciated practices. This, however, calls for a different approach than currently applied within obesity treatment and prevention.
8 PERSPECTIVES

It would be convenient on the basis of this study to be able to single out factors that could support the obese individuals to reduce weight, when targeted through an intervention. However, the study did not find such causal individual factors available for intervention. On the contrary, through the application of Bourdieu’s theories on practice it was found that obese adolescents’ practices of eating and of being physically active are the product of multiple and interwoven experiences founded in family and home environment. On the basis of these experiences and, it has been argued, in response to encountered objective structures in society, the adolescents has developed a habitus that provides them with an implicit and unconsciously possessed practical logic. Regardless of time and space this logic outlines sedentary practices and practices associated with unrestricted eating as natural and fully legitimate. Again, this is one approach towards obesity and does not account for, for instance, factors related to genetics or psychology. Therefore the suggestions made in regard to preventing and treating obesity should, of course, be designed in accordance with other promising findings. However, the empirical findings elaborated with Bourdieu’s theory of practice indicate that, to support obese individuals to reduce weight, a change of habitus is needed. A change of habitus calls for a thorough change of the individuals’ surroundings and can therefore not be reduced to a few independent factors. In line with the assumption of the individual as a non-autonomous subject, perspectives on intervention that focus on the individual cannot be suggested.

A first issue in this chapter therefore addresses a non-individualistic approach to the treatment of obesity. This, however, opposes the dominant way of treating obesity. As mentioned in Chapter 1 a widely used approach when treating obese individuals is to teach the individual about better and healthier practices in regard to eating and physical activity. However the long-term effect of such an approach is modest and the great majority who lose weight will regain it after some time. This study indicates that a possible reason for the limited effect is that this approach does not alter habitus and therefore does not cause changes in the incentives and motives underlying individual practices.
Based on the data collected and elaborated by applying Bourdieu’s concept of habitus, this study suggests that to alter habitus it could be fruitful to develop a large-scale societal approach that aims to set the grounds for preferred and valued practices. Societal initiatives that take, for instance schools, public arenas, infrastructure, residential and recreational areas into account would contribute to the way the population thinks about and makes use of practices of physical activity and practices of eating. With time a societal approach will have the potential to increase the population’s inclination to be physically active and to eat in a reasonable way. Eating in a reasonable way means that it is not a matter of attaining a healthy diet in a strict sense but a matter of having a pragmatic attitude towards diet. Put simply, if eating junk food today, tomorrow’s diet must be healthier.

Further, this study indicates that such initiatives should not evolve solely around health but instead attempt to make valuable and preferred practices meaningful and joyful in life. For instance, the participants in this study did not value an active lifestyle and it is hypothesised that they therefore will not regularly use running-paths, exercise playgrounds and similar initiatives aiming to increase physical activity as a means to become healthy or lose weight. But, with time they may use playgrounds made for playing, barbeque-areas, local walking paths and recreational areas, attractive bike-riding paths etc. It is not argued that, for instance, barbeque-areas make individuals thinner but time spent there may limit screen viewing and increase social integration and thereby set the scene for more outdoor play, and hence, over time, contribute to a more active life. Consequently, the initiatives established to reduce obesity cannot solely be made by health professionals but should integrate a host of different disciplines and stakeholders, e.g. architects, aesthetes, philosophers, anthropologists, gardeners, urban planners, engineers.

Based on these ideas the researcher developed a “meal pyramid” (Fig. 5). The meal pyramid illustrates that to eat according to the traditional food pyramid (placed in the top of the meal pyramid) it is necessary to be able to reflect on eating practices. In short, in order to prioritise and choose to eat in reasonable way (or according to other preferences such as organic, Italian, unhealthily, vegetarian or the like) the individual needs to have learned to value eating and associate such practice with something more than just getting full or as a means
to counteract boredom, loneliness or sadness. The meal pyramid thereby shows that nutritional insight has little chance of leading to healthier food habits if the individual finds limited meaning and pleasure in eating.

The findings from this study therefore indicate that obesity cannot be managed by perceiving it primarily as a medical problem. On the contrary, obesity is to a not insignificant degree the product of the way society has influenced upon peoples’ everyday life the last 50 years or so. Therefore, a significant perspective from this thesis is that the handling of obesity is far more complex than just addressing factors related to diet and physical activity.

Another issue to be addressed is closely connected with the above and regards obesity stigma. An important finding in this study is the impact and negative consequences of obesity stigma within obese adolescents’ homes. More attention is needed on these matters and it could profitably be addressed in, for instance, weight loss programmes. Thus, more attention could be devoted to support the families to openly, and non-judgementally deal with their child’s obesity. A home environment where matters related to blame, shame and guilt is reduced would, it is hypothesised, contribute to increased quality of life and may, as indicated in this study, increase social support in regard to weight loss attempts. However a thorough reduction of obesity stigma calls for a societal approach. Hence, as long as the preferred treatment of obesity is individual prescriptions that keep failing to succeed, the stereotype, and thereby the foundation of obesity stigma, of obese individuals as irresponsible and lacking will power is supported. Therefore, by continuing to emphasise individual responsibility in regard to obesity obese individuals will continue to be seen as lazy gluttons. By shifting to

Fig. 5. The meal pyramid. The meal pyramid illustrates that, in order to eat according to the food pyramid, individuals need to value and find meaning in eating. This can, for example, be achieved by focusing on pleasure and social activities related to eating.
a societal rather than an individual approach less attention would be placed on
the individual and his/her inability to comply with society’s’ norms and values.
Overall, based on this thesis it is believed that obesity prevalences can only be
reduced if it is acknowledged that obesity to a high degree is a social
phenomenon as opposed to a medical problem. Thus a final issue addresses the
unfortunate in the positivistic paradigm’s hegemony in regard to both research
and treatment related to obesity. In short, the adolescents in this study had
become obese because they ate too unhealthily and were too sedentary – to help
them reduce weight and prevent others from becoming obese it is urgent that
these practices are dealt with by a scientific discipline that has the appropriate
ontological, epistemological and methodological conditions to understand and
address practice.

Lastly, based on this thesis a number of relevant areas of research could be
singled out: first it could be scientifically interesting to address matters related
to stigma and the family. Besides further knowledge on the subject a
randomised controlled study that aims to support families to develop a non-
stigmatising home environment could be launched. This may be a fruitful way to
improve social support in regard to weight loss attempts within the homes of
obese children and young people. Besides randomised studies far more research
is needed on matters addressing practice associated with obesity and possible
factors contributing to such practice. For instance, if connections between the
obesogenic environment and individuals’ practice of physical activity and
dieting were better understood possible ways to counteract the environment
could be singled out and subsequently addressed. However, as Figure 1 indicates
this calls for a shift in focus of the research that addresses obesity.
Subsequently, another suggestion in regards to research addresses the
environment and societal changes. As mentioned, it was in this study found that
obesity is not caused by a single variable but instead the product of a host of
different and interwoven factors. To address those scientifically, a given
gerographical area could be selected and initiatives as outlined above could be
developed. The area selected for intervention could be compared with a control
area and the population within these areas could recurrently be monitored in
regards to both inclination towards practices and actual practices – such
monitoring would involve both quantitative and qualitative studies. Over time, it is hypothesised, the area targeted for intervention may have a population that is more fond of being active and to a higher degree can reflect on their dieting practices compared to the control area. This may lead to a thinner population. Such study, however, calls for a multi-disciplinary approach, a long time frame, and has to be situated in the community.
SUMMARY

Dansk resumé

Fokus i undersøgelsen er teenageres fedme og den dagligdag de og deres forældre oplever med fedmen og eventuelle forsøg på at tabe sig.

Prevalensen af overvægt og fedme er steget globalt siden 1960erne. En forklaring på dette kan være, at samfundet har ændret sig i en retning, hvor mad er let tilgængeligt og bevægelse er unødvendiggjort. Der er begrænset viden om, hvad der er betydelige for, hvordan mennesker undgår fedme ved at kontrollere sin brug af madubuddet og tilvælge bevægelse.

Formålet var at undersøge, hvordan fede teenagerer og deres forældre i deres dagligdag lever med teenagerens fedme og eventuelle vægttabsforsøg. Øget viden herom forventes at kunne kvalificere behandling og forebyggelse af fedme.


Resultatet over tid viste, at selvom teenagerne ønskede at tabe sig tog allé på nær én på i vægt i den periode undersøgelsen varede. For problemstillingen viste tre temaer viste sig særligt betydningsfulde: mad, bevægelse og skam og stigma. Teenagerne spiste over hele døgnet og havde en positiv præference for ”usund mad” som f.eks. slik, chips, junk food, sodavand, hvidt brød. Omvendt brød de sig ikke om ”sund mad” som f.eks. frugt, grønt, og groft brød og de associerede sådanne produkter med sundhed og vægttab. Forsøg på at spise sundere blev jævnligt prøvet, men motivationen mistedes efter kort tid. Mad blev i hjemmet ikke anskuet som en social og integrerende aktivitet, men havde som primært formål at stille sulten. Sund mad blev af forældrene set som et middel til at tabe sig, hvorfor sådanne produkter i hjemmene primært tjente et sundhedsmæssigt formål.
Bevægelse blev ikke tillagt mange positive karakteristika udover vægttab. "Rigtig" bevægelse blev sidestillet med hård motion i f.eks. motionscenter. At dyrke motion blev jævnligt forsøgt, men motivationen mistedes efter kort tid. I hjemmene blev bevægelse ikke anskuet og anvendt som en social eller funktionel aktivitet, der indgik i den almindelige dagligdag, men blev primært set som et middel til at tabe sig.

Manglende evne til at dyrke regelmæssig motion og spise sundere udløste en følelse af skam hos teenagerne. For ikke at blive konfronteret med skammen benyttede de sig af strategier, der reducerede opmærksomheden på deres fedme i hjemmene. Forældrene havde lignende strategier og undgik at bringe opmærksomhed på deres barns fedme. I hjemmene var der derfor minimal positiv opmærksomhed på teenagernes fedme. Som konsekvens heraf havde teenagerne begrænsede muligheder i at involvere forældrene i deres vægttabsforsøg.


Et perspektiv fra undersøgelsen er, at håndteringen af fedmeproblematikken i højere grad må tage udgangspunkt i de rammer, betingelser og opvækstvilkår der er, hvor mennesker lever. Dette kræver, at medicinens traditionelle tilgang til fedmeproblematikken må overvejes.
English Summary

The focus of the study is adolescents’ obesity and daily life as experienced by them and their parents’ in relation to the teenagers’ obesity and attempts to reduce weight.

The prevalence of overweight/obesity (BMI>25) has risen globally since the 1960s. One explanation could be that society has changed towards the widespread availability of food coupled with less need to move and be active in daily life. Current knowledge is limited regarding the significant factors involved in how people avoid obesity by controlling their intake of food and opt for exercise.

The aim was to explore how obese adolescents’ and their parents’ live their daily lives with the adolescents’ obesity and attempts to reduce weight. A development of knowledge in this area is expected to inform treatment and prevention of obesity.

A longitudinal, anthropologically-inspired approach was employed. Fifteen teenagers and their parents were included in the study. Data collection was carried out in three annual rounds, in the form of participant observation and interviews. The first round took place both at a weight loss camp for obese teenagers and by meeting parents in their homes. The second and third rounds took place in the participants’ homes. The data were analysed using a method inspired by Ricoeur and was carried out on three levels: naive reading, structural analysis and critical interpretation and discussion.

The findings showed over time that despite the great desire teenagers had to lose weight, all but one gained weight. Three themes emerged as particularly significant: food, exercise and shame and stigma.

The teenagers ate throughout the day and had a positive preference for 'unhealthy food', such as for example, sweets, crisps, junk food, sugary drinks and white bread. However they did not generally favour 'healthy food' such as fruits, vegetables, wholegrain bread and other such products associated with health and weight loss. Attempts to eat healthier were regularly started but they lost motivation after a short time. At home eating was not regarded as a social and integrating activity, and its primary aim was to satisfy hunger. Healthy food was seen by the parents as a means to lose weight and such products were used by the families primarily with this aim. Exercise was not attributed many
positive characteristics beyond weight loss. 'Correct' exercise was considered to be hard physical training, for example at a gym. Exercising was regularly attempted but motivation was lost after a short time. At home exercise was not regarded and not used as a social or functional activity that was included in daily life but as a means of losing weight.

The lack of ability to take regular exercise and eat healthier brought about a sense of shame in the teenagers. In order to avoid being confronted with the shame they used behavioural strategies that reduced the attention given to their obesity at home. The parents similarly used strategies and avoided drawing attention to their child's obesity. Thus at home there was very little positive attention given to the teenager’s weight condition. As a consequence the parents were not involved in the teenagers’ weight loss attempts.

The study showed that the teenagers’ upbringing was characterised by the notion that healthy food and exercise were not a natural and meaningful part of daily life, but on the contrary were considered to be negative duties that were necessary for weight loss. Based on this, the teenagers had developed an implicit, practical logic or habitus that favoured sedentary choices and where preferred food could be eaten whenever desired. This habitus became embodied and operated on a pre-reflexive level. In line with increased independence from parents the opportunity to live in accordance with this habitus also increased. This can explain the teenagers’ weight increase during their teenage years. This praxis is predisposed to be contrary to the requirements of society to take responsibility for one’s own body and health. This led to a feeling of shame and had a negative impact on the teenagers’ ability to lose weight as the parents were not involved in their weight loss attempts.

One perspective that emerged from the study is that the management of the obesity issue must to a greater extent be based on the actual parameters, conditions and kind of upbringing experienced in real situations where people live. The traditional approach of the medical community towards obesity must therefore be reconsidered.
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## Appendices

### Appendix 1

Eating – findings from round one to round three

<table>
<thead>
<tr>
<th>Units of meaning — what they say</th>
<th>Units of significance — what it speaks</th>
<th>Subthemes</th>
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<tbody>
<tr>
<td><strong>THEME: The adolescents have unhealthy food habits</strong></td>
<td>Attempts to avoid buying food when alone. Keep buying junk food although wanting to reduce their intake</td>
<td>Reduce solitary food purchases, especially “non-food” (e.g. sweets, chips, cake)</td>
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<tr>
<td>“When I was younger it was every day, you know every day I had sweets, or chips, or cake, or cheese burger, fries and a coke. Mostly I buy a burger menu these days, maybe two-three times a week” (round three)</td>
<td>Junk food bought alone serves another purpose than earlier – now it is as a supplement to the home diet</td>
<td>View junk food as a natural and legitimate daily dietary source</td>
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<td>“If I had all the money I have spent on such ridicules (sweets, chips, cake etc) food today I would be rich. ... Think about the money I have wasted” (round three)</td>
<td>View their past eating habits as childish (e.g. waste of money, compare it with junkies’ need for drugs)</td>
<td>Increase of eating unhealthy food at home when alone</td>
</tr>
<tr>
<td>“A few weeks ago I bought some crisps, I ate them and afterwards I couldn’t believe I used to do it every day” (round three)</td>
<td>Feel a need to eat unhealthy food at home</td>
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<td>“When I think back I behaved stupidly ... Every day I had something and I ate it as if I was a junkie (e.g. hiding the urge to eat)” (round three)</td>
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<tr>
<td>“Before, I was afraid that my mother would yell at me when I took something I was not allowed to, she still does but I don’t care now. ... If there is something (“unhealthy” food in the house) I have to eat it, I can’t resist it” (round three)</td>
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<td>“I know I shouldn’t do it (eat food at home that is saved for special occasions) and I always feel guilty ... but, well I guess I can’t explain why I do it anyway” (round three)</td>
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<tr>
<td>“After maybe two or three days (eating healthily) I just get so sick and tired of apples and dark bread and stuff like that (round three)</td>
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</table>
THEME: The adolescents are ashamed of this behaviour and want to change it

“When I was younger I always had some chewing gum to take before coming home so my mother didn’t notice I just had a burger or something. Now I don’t care. … I know she wishes I didn’t, and I try not to, but it is hard” (round three)

“I’m not proud of it (unhealthy eating habits) and I don’t brag about it to them (parents) and sometimes my mother finds a sweets bag or an empty soda. She doesn’t say anything and I don’t either, so … it’s not like before (hiding unhealthy eating habits)” (round three)

“I used to have all these little strategies to signal that I had not eaten anything. Now I don’t care” (round three)

“I have tried so many times (to eat healthier) and I can’t, it’s my own fault … I am incompetent, I guess” (round three)

THEME: The parents believe the home is an environment where healthy food is prioritised

“I (mother) have come to the conclusion that I won’t accept that we (the family) do not have anything (unhealthy food) for visitors or just for us (parents). She (adolescent) needs to grow up (learn to control her eating habits). … Of course I put it away” (round three)

“She (adolescent) is so fixated on eating that I have been forced to hide even packets of biscuits in the garage, she is terrible… whenever I’m not home, I tell you (researcher) she vacuums the house for food” (round three)

“It is up to him now. I (mother) can’t do any more. He has to find an inner motivation” (round two)

Not concerned about parents’ reaction if they find out about solitary eating habits
Does not hide eating habits
Shame is not associated with the specific situation where the food is eaten but is a general condition of living as an obese adolescent
Reduce eating in secret
Shame has shifted from being associated with a specific situation to an overall condition of life

The home environment is healthy in regard to food
Difficult to do anything more than already done in regard to supporting child to reduce weight, it is the child that needs to be motivated
Supportive home environment
Hide unhealthy products
**THEME: Parents blame their child for its eating habits**

> “Three years ago he was a child and ok, you cannot expect that a child can do such thing (eat healthier), but he has just turned 18... I can't understand why he doesn’t do something (alter his eating habits)” (round three)

> “I really thought that he (adolescent), when he got older would stop being so irresponsible. ... I can yell at him one night, roaring thunder and the next day he buys a coke and a burger. I can’t understand why he does it, he is killing himself and he knows it and he doesn’t care” (round three)

> “I have stopped interfering, she (adolescent) has to want to do it (change habits)” (round two)

> “I (mother) keep thinking, could we (parents) have done something differently? Of cause some minor things “yes”, but it is him (adolescent) that put stuff in his mouth. I don’t force it in him” (round three)

| Disappointed in their child as he/she does not change eating habits | Perceive their child as gluttonous | Blame their child for not being able to alter eating habits |
Appendix 2

Theme: Home meal environment

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<tr>
<th>Units of meaning — what they say</th>
<th>Units of significance — what it speaks</th>
<th>Subthemes</th>
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<tbody>
<tr>
<td>“Maybe once a week we all eat together. It’s not like I don’t want to but we (mother and two children) practically always fight” (Mother: round two)</td>
<td>Unpleasant mood when eating together</td>
<td>Do not eat together</td>
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<td>“A typical meal? ... Yesterday we (parents) sat here (on the sofa) and watched the news (in TV), he watches “The Simpsons” (in TV) in his room. That’s very typical” (Mother: round two)</td>
<td>The family eats in separate rooms due to conflicts and the adolescents’ resistance to eating together</td>
<td>The parents wish to eat together, the adolescents try to avoid it due to a feeling of being watched</td>
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<td>“I keep hoping that we can eat together and have normal conversations, you know, like normal families. But he (adolescent) just does not want to and if I force it through (eating together) he gets moody and then the good atmosphere is ruined and it doesn’t matter” (Mother: round three)</td>
<td>Socialising at meals is not practised but is seen as important by the parents</td>
<td>Meals are not associated with a specific time</td>
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<td>“To avoid fights we (family) don’t spend much time or energy on meals. I know it is sad but it is the way it is” (Mother: round three)</td>
<td>The meal is not restricted to specific times</td>
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<td>“We are all so busy and really, if we were to plan on eating together... now that would be stressful! We eat when we want to” (Father: round three)</td>
<td>The adolescents prefer not to eat together as they sense they are being “watched” and judged</td>
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<td>“I’m pretty sure when you (researcher) started to come here we were better at eating together. Now we don’t” (Mother: round three)</td>
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<tr>
<td>“Of course I enjoy going out to eat ... candle light and tablecloths and everything. ... But here (home) I guess a good meal is when we (mother, adolescent, one sibling) enjoy ourselves” (Mother: round three)</td>
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<td>“On weekdays I try to focus on the main meals, but it’s hard because they (children) just go and eat whenever they like. At weekends then we just eat when we are hungry” (Mother: round three)</td>
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<td>“I don’t eat breakfast (at home), I buy something for lunch and when I get home (after school) I make some food and eat while I watch TV, then it’s dinner and then in the evening I make something again, maybe pasta or something” (Adolescent: round three)</td>
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<tr>
<td>“I guess I eat pretty much through the entire day, I always have something ready (to eat)” (Adolescent: round three)</td>
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<tr>
<td>“Of course I eat the usual three times a day... but I don’t find it that important, for instance last night I made some toast and had a soda just before going to bed. ... So, well I had two dinners” (Adolescent: round three)</td>
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<td>“I know my parents would like it better if we ate together, but I just feel they keep expecting that I only should eat salad and healthy stuff and I really hate it when they see me as fat and useless” (Adolescent: round three)</td>
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<tr>
<td>“When we have dinner together and don’t watch TV it’s never pleasant... it’s like they (parents) watch me and try to control me” (Adolescent: round three)</td>
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Appendix 3

Theme: Parents’ and the families’ view and practice of physical activity

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<th>Units of meaning — what they say</th>
<th>Units of significance — what it speaks</th>
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<tr>
<td>“If you knew how much I have told him (adolescent) that he has to be more active in order not to get diabetes or bad knees and stuff – but he doesn’t care” (Mother: round one)</td>
<td>Do not use physical activity as transportation or as socialisation</td>
<td>The parents are sedentary</td>
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<td>“He (adolescent) cycles sometimes but I think it is because I tell him to do so. He is a member of the gym. But he does not use it”. (Mother: round one)</td>
<td>View physical activity as serving the purpose of generating weight loss, hence non-obese individuals do not have a need to be physically active</td>
<td>Physical activity is a means to lose weight</td>
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<tr>
<td>“We don’t (use physical activity). That’s why we have a car!” (Father: round two)</td>
<td>Believe physical activity primarily belongs in specific arenas, like the gym</td>
<td>Physical activity is equated with hard exercise</td>
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<tr>
<td>“It’s not like I don’t like being active. I just don’t do it much. ... it’s also hard to find the time to go the gym” (Mother: round two)</td>
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<td>“I guess we’re not the kind of family who goes walking in the woods or bike-riding holidays or the like” (Mother: round three)</td>
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<td>“I’m fat too and I try to exercise, but to be honest I only do it to lose weight, I’m just as lazy as X (adolescent)” (Father: round three)</td>
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<td>“Honestly, I think this whole healthiness-thing is too far out. Every day I see slim, beautiful women running just around the corner. ... Some are even too thin. ... For me it makes no sense. Why are they doing it?” (Mother: round three)</td>
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<tr>
<td>“I have offered to drive him (adolescent) to the gym and pick him up, but he doesn’t accept the offer” (Father: round three)</td>
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<tr>
<td>“I won’t have her saying that I won’t support her (e.g. by not paying the gym) but I feel like a fool and you know I am, I pay for nothing (because her daughter does not use the gym)” (Mother: round three)</td>
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<tr>
<td>“I have stopped asking if she wants to go (to the gym), but inside I’m so sad because she can’t see that she has to do something now if she’s not going to be overweight the rest of her life” (Mother: round three)</td>
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