Social Science & Medicine 119 (2014) 114–122

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

"Don't eat that, you'll get fat!" Exploring how parents and children conceptualise and frame messages about the causes and consequences of obesity

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ARTICLE INFO

Article history:
Received 6 May 2014
Received in revised form
8 August 2014
Accepted 19 August 2014
Available online 19 August 2014

Keywords:
Obesity
Weight
Health
Children
Parents
Family
Discourses
Communication

ABSTRACT

Family interactions about weight and health take place against the backdrop of the wider social discourse relating to the *obesity epidemic*. Parents (and children) negotiate complex and often contradictory messages in constructing a set of beliefs and practices around obesity and weight management. Despite this, very little research attention has been given to the nature of family-unit discourse on the subject of body weight and it's potential influence on the weight-related behaviours of family members. This includes the broad influence that dominant socio-cultural discourses have on family conceptualisations of weight and health. Using in-depth qualitative interviews with 150 family 'groups' comprised of at least one parent and one child in Victoria and South Australia, we explored how parents and children conceptualise and discuss issues of weight- and health-related lifestyle behaviours. Data were analysed using Attride-Stirling's (2001) thematic network approach. Three thematic clusters emerged from the analysis. First, both parents and children perceived that weight was the primary indicator of health. However, parents focused on the negative physical implications of overweight while children focused on the negative social implications. Second, weight and lifestyle choices were highly moralised. Parents saw it as their responsibility to communicate to children the 'dangers' of fatness. Children reported that parents typically used negatively-framed messages and scare tactics rather than positively-framed messages to encourage healthy behaviours. Third was the perception among parents and children that if you were thin, then eating habits and exercise were less important, and that activity could provide an antidote to food choices. Results suggest that both parents and children are internalising messages relating to obesity and weight management that focus on personal responsibility and blame attribution. These views reflect the broader societal discourse, and their consolidation at the family level is likely to increase their potency and make them resistant to change.

1. Background

The prevalence of adult overweight and obesity is increasing across the developed and developing world, with about two thirds of North American, British and Australian adults categorised as being overweight or obese (World Health Organisation, 2013a). Childhood obesity, while showing a plateau over the last decade in many countries, remains unacceptably high (Olds et al., 2011). Overweight and obesity are associated with increased likelihood of many diseases, including diabetes, cardiovascular disease, arthritis and some cancers (World Health Organisation, 2013a,b). Furthermore, there is uneven spread across the population, with obesity being disproportionately high amongst low socio-economic and rural populations in Australia (AIHW, 2013).

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http://dx.doi.org/10.1016/j.socscimed.2014.08.024
0277-9536/

There is widespread recognition that obesity is an urgent issue for public health prevention initiatives (National Preventative Taskforce, 2010). Some researchers argue that the notion of an *obesity epidemic* arises partly from largely uncontested biomedical data and partly from a socially constructed sense of panic, risk and urgency, coupled with a set of social and cultural values about bodies and body practices (Bordo, 2003; Gard and Wright, 2005; Campos et al., 2006; Monaghan, 2005; Monaghan et al., 2013; Moffat, 2010). Information about the causes and consequences of obesity plays out on a socio-cultural stage, where a narrative is constructed by a range of players with different interests (e.g. biomedical researchers, commercial interests, government agencies, healthcare providers) (Gard and Wright, 2005; Saguy and Almeling, 2008). Medically-based discourses predominantly frame obesity as an issue of personal responsibility – arising from poor individual choices – that individuals and families can 'solve' by losing weight and/or making appropriate food and lifestyle choices (Campos, 2004; Gard and Wright, 2005; Murray, 2008; Rich and Evans, 2005; Saguy and Riley, 2005; Thomas et al., 2008).

In an attempt to prevent and reduce rates of obesity, governments around the world have introduced various public communications initiatives which aim to increase awareness of the dangers of intra-abdominal fat and the associated increased risks of chronic disease. These communications strategies have aimed to encourage behavioural changes, particularly in relation to food consumption and physical activity. While these strategies clearly play an important role in a *comprehensive* public health approach to obesity (alongside education, regulation of industry tactics and environmental change) to improving the health of populations (National Preventative Taskforce, 2010), some state such campaigns are problematic because they mix the *behaviours* that are associated with overweight and obesity with the *fact of* being obese (Katz et al., 2012; Lupton, 2014; Thomas et al., 2010). Others argue that messages that are framed as simple 'eat less/exercise more' equations ignore the powerful structural and market forces that drive individual and population weight gain, and further entrench social inequalities and moral judgements about those who appear to be failing to engage in 'healthy behaviours' (Gard and Wright, 2005; Saguy and Almeling, 2008; Herndon, 2005; Bell and McNaughton, 2007; Thomas et al., 2008). This includes how messages about personal responsibility and healthy behaviours may act to marginalise other kinds of discourses, including those that would highlight the importance of social structure in terms of gender, ethnicity, social class and place (Bell and McNaughton, 2007; Ristovski-Slijepcevic et al., 2010a, 2010b, 2008).

Public health initiatives and policies which aim to address childhood obesity locate the family as a primary site for intervention (Ristovski-Slijepcevic et al., 2010a). Understanding how information about weight and health are understood and communicated within the family unit is particularly important given that many lifestyle behaviours are influenced within the home (Sallis and Nader, 1988). Parents are the primary source of health-related information for children and adolescents (Shonkoff and Phillips, 2000), and therefore have significant influence over their children's exposure to positive or negative information related to health and weight (Neumark-Sztainer et al., 2010). Family interactions about weight and health take place against the backdrop of the wider social discourse relating to the obesity epidemic (Gard and Wright, 2005). Parents (and children) negotiate complex and often contradictory messages in constructing a set of beliefs and practices around obesity and weight management (Rail et al., 2010; Ristovski-Slijepcevic et al., 2010a). Research shows that different groups of parents may react differently to these messages. For example, some mothers perceive that it is their role and responsibility to promote healthy eating beliefs and practices among their children by conforming to official dietary guidelines (Ristovski-Slijepcevic et al., 2010a), while others distance themselves from personal responsibility messages because they do not 'fit' with their perceived role of providing for the collective needs of the family (Warin et al., 2008). Some studies also suggest that parents are reluctant to discuss weight with their children because of a fear of creating tension in the home or anxiety in their children about an issue that they will eventually 'grow out of' (Borra et al., 2003, p.724). However, surprisingly little research has examined how parents and children are influenced by messages about obesity, either at the population level or in other places of socialisation such as the family home (Neumark-Sztainer et al., 2010). This includes how lay perceptions about the relationships between (over)weight and health are formed, the nature of weight-related communications within the home environment, and the factors that may influence and characterise such discussions.

The aim of this study was to explore how *parents and their children* conceptualise and discuss issues of weight- and health-related lifestyle behaviours within the family environment. We conducted in-depth qualitative interviews with 150 family 'groups' comprised of at least one parent and one child (aged 9–18 years) to provide insight into the following research issues:

1. How do parents and children conceptualise the issue of overweight and obesity?
2. What broader socio-cultural factors may influence how health-related messages are framed within family unit discourses?
3. What role do healthy lifestyle behaviours (eating healthily and exercising) play in the lives of parents and children?

2. Methodology

2.1. Recruitment and sampling strategy

Two market research companies recruited the family groups from metropolitan Melbourne (Victoria) and Adelaide (South Australia) in Australia. Purposive sampling was used to recruit 75 families from each state using Socio-Economic Indicators for Areas Index of Relative Social Disadvantage (IRSD) quotas to broadly represent the population distribution of metropolitan families. If a parent agreed to be contacted by the research team, the recruitment company provided their contact details and the researchers then contacted the parent to provide additional information about the study via parent and child Participant Information Sheets. If they agreed to participate, an appointment was made for the interview. Written informed consent was obtained from the parent on behalf of the family group before the interview commenced.

Individuals not fluent in English were excluded from the study. For ethical reasons, children who had a history of eating disorders were also excluded. Ethics approvals were received from two University Human Research Ethics Committees, and each family group was provided with a $100 grocery voucher as compensation for the time spent participating in the study. Confidentiality was assured and all identifying data were removed from the transcripts.

2.2. Data collection

We conducted face-to-face, semi-structured interviews with parents and children. Digitally recorded interviews were conducted in family homes (July 2011–July 2012) by trained researchers. The interviews lasted approximately 45–120 min. Pairs of researchers attended the interviews, with one conducting the interview and the other taking notes about the family dynamics during the interviews.