CHILDREN'S EXPERIENCE OF THEIR OBESITY

by

MOYNENE COOKE

Submitted in partial fulfilment of the requirements for the Degree of

MASTER OF DIACONIOLOGIAE
(DIRECTION: PLAY THERAPY)

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: MRS. I.F. JACOBS

November 2009

I declare that **Children's Experience of their Obesity** is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

_____

Moynene Cooke (3676-913-4)

PROOF READING CERTIFICATION

Hereby I declare that I have edited and proof read the thesis *Children's experience of their obesity* by Moynene Cooke for the degree M.Diac. I am a freelance language practitioner.

Dora-Marí Janse van Vuuren, B.A. (Languages)
27 November 2009

ACKNOWLEDGEMENTS

A sincere thank you is due to the following people who have contributed to the completion of my thesis:

My Heavenly Father for His unconditional blessing over my life.

My supervisor, Mrs. I.F. Jacobs for facilitating and supporting my process.

My mentor, Dr. A.F. Louw for his support and encouragement.

My fiancé, Werner, for his endless love, support, encouragement and inspiration.

My family and friends for their endless support and encouragement throughout the years.

Mrs. H.J. Blom for her thoughts and insights on childhood obesity.

Mr. W. van Heerden for his thoughts and insights on childhood obesity.

Mrs D.M. Janse van Vuuren for proof reading and editing my thesis.

A special thank you to all the respondents who took part in the interviews and made this research possible by sharing their stories and experiences.

ABSTRACT

This study takes the form of exploratory and descriptive research in which children in middle childhoods' experience of their obesity was explored and described. A case study research design was used in a qualitative approach and data was gathered through semi-structured interviews. The data analysis spiral of Cresswell was implemented in order to facilitate the research process. Empirical findings present the experiences obese children in middle childhood undergo with regard to different areas of their development. The researcher drew upon literature relating to obesity and middle childhood development in order to analyse and verify collected data in pursuit of describing children's experience of their obesity. Emotional hideaway amongst obese children, the role of the family in an obese child's life and the reason why obese children make the wrong food choices are some of the topics not addressed in the limited scope of this project. The possibility of exploring these final thoughts provides opportunity for future research.

KEY CONCEPTS

Obesity
Middle Childhood
Subjective Experience

TABLE OF CONTENTS

CHAPTER 2

OBESITY IN MIDDLE CHILDHOOD

CHAPTER 3

EMPIRICAL FINDINGS AND LITERATURE CONTROL

CHAPTER 1

OVERVIEW AND RATIONALE OF THE RESEARCH

1.1 INTRODUCTION AND RATIONALE

Obesity is seen as an imbalance between energy intake and expenditure such that excess energy is stored in fat cells, which increase or enlarge in number (Goedecke, Jennings & Lambert, [sa]:65). Sullivan (2004:3) also defines obesity as an excess of body fat and mentions that the level of obesity can be calculated arithmetically by the use of the Body Mass Index (hereafter referred to as BMI). If the BMI is 25 or larger, a person will be seen as being overweight, whereas in the instance of obesity the BMI of a particular person will be 30 or above. For the purpose of this study the words “overweight” and “obese” were used interchangeably, as both scientific and popular literature do (Dalton, 2004:14). This is done even though overweight connotes a milder degree of excess fat than obesity.

Kruger, Puoane, Senekal and Van der Merwe (2005:491) state that the obesity phenomenon is on the increase and it is currently estimated that more than one billion adults are overweight, whereas at least 300 million are obese. Van der Merwe (2006) who also heads South Africa's first Obesity Clinic situated in Pretoria, mentions that obesity is one of the modern world's biggest killers. In this regard Caelers (2006:4) states that in the United States, some 24 percent of adults are obese, as are nearly 13 percent of children. Britain is not far behind with almost one-fifth (18 percent) of people being classified as obese, but at 7 percent, Germany had the lowest number of those who fell into the obese category. The United States has always been held up as an example of a country that other countries don't want to emulate in terms of overweight and obesity issues, but it now appears that South Africa finds itself in the same category (Van der Merwe, 2006).

In parallel with the worldwide increase in obesity, Kruger *et al.* (2005:491) also mention that obesity in children is rising. According to Caelers (2006:4) the South African Medical Journal reported that nearly five percent of girls aged six to thirteen

were obese, and for boys of the same age group, two percent were obese. This phenomenon can also be depicted in the National Household Food Consumption Survey that reported that 17.1% of South African children between the ages of one and nine living in urban areas are overweight (Goedecke *et al*., [sa]:67). Overweight and obesity are therefore found to be independent risk factors for increased morbidity and mortality throughout the life cycle (Deckelbaum & Williams, 2001:241; Goedecke *et al*., [sa]:67). Deckelbaum and Williams (2001:239) postulate that obesity in childhood tracks over into adulthood and for that reason childhood obesity is a major contributor to the adult obesity epidemic.

The worldwide increase in obesity levels, especially amongst children, gave rise to this study focussing on children in middle childhood and their subjective experience with regards to their own obesity. The study focussed on the subjective experience as defined in the DBS-STN Glossary ([sa]). Subjective refers to relating towards, proceeding from, or taking place in an individual's mind and emotions. This study was subjective due to the fact that data gained from the semi-structured interviews originated from, or was influenced by the obese children's personal interests, prejudices and emotions. The study is consequently based on the personal opinions of children in middle childhood with regards to their own experiences and not based on the interpretations of the researcher.

Middle childhood was chosen due to the characteristics found during this stage. Huston and Ripke (2006:7) characterise middle childhood as the period when biological, social and intellectual changes occur and new cognitive capabilities develop. During this developmental period children's social environments offer them new opportunities for socialisation and for gaining new learning experiences. Huston and Ripke (2006:7–9) state that middle childhood development prepares the child for the subsequent adjustments and challenges of adolescence. In middle childhood, children should master developmental tasks, with specific attention given to tasks that can be influenced by obesity, namely extension of social participation, the acquisition of greater self-knowledge and the further development of moral judgement and behaviour (Huston & Ripke, 2006:7-9).

This study allowed the respondents to give a voice to their own experience surrounding this problem, and consequently give parents and caregivers insight into this phenomenon and an in-depth knowledge on their children's reality.

1.2 PROBLEM STATEMENT

1.2.1 Identifying a Research Theme

Whitley (2002:91) states that the initial step in the planning of the research study is that of identifying a research theme, therefore choosing a topic. Accordingly two factors influence the choice of topic, firstly the researcher's interests and secondly the feasibility of the study.

With reference to the researcher's interests, Whitley (2002:91) states that a choice of topic grows naturally from the researcher's background because personal and professional backgrounds give rise to different interests. This background knowledge takes on two forms, namely the informal and formal background.

1.2.1.1 Informal Background

Whitley (2002:90) mentions that informal background relies on a researcher's personal experience, therefore taking into consideration what life experiences have impacted on the chosen topic. The choice of this study was determined by the researcher's personal experience of being in contact with obese children and seeing the children's discomfort. This led the researcher to suppose that exploring the experience of obesity in children could lead to an individual-, familial- and societal awareness of this problem and in time to a decrease in this phenomenon.

1.2.1.2 Formal Background

Formal background according to Whitley (2002:90) refers to knowledge of theory and research results and provides a scientific basis for carrying out research. Developing formal background involves the process of literature reviewing, which in turn allows for a general understanding of the chosen topic. The feasibility of the

current study was known once a literature overview had been undertaken and it was established that the research topic met the necessary requirements needed to conduct the research (Whitley, 2002:90-92; Strydom & Delport, 2005:331).

The feasibility of the proposed study was also based on consultation with experts in a field that pertains to the theme of the intended research study. The following experts were consulted:

- In the field of psychology, Mrs. H.J. Blom, a Counselling Psychologist, was consulted. Blom is currently in private practice and associated with Vista Clinic, dealing in specialised psychiatric disorders. Blom has a passion herself in the field of eating disorders. According to her obesity is on the rise in children, and she therefore believes that the study is feasible. Blom mentions that in the same way individuals become addicted to substances, they are capable of addiction to eating disorders and in the occurrence of obesity it may be that food becomes a comforter. She is also of opinion that children are less active than in the past, parents lead busier lifestyles which increase unhealthy eating habits and that parents should teach their children healthy lifestyle habits from a young age.

- Mr. W. van Heerden was consulted on the prevalence of obesity amongst children in South Africa. Van Heerden is a Biokineticist and currently working at the University of Pretoria's High Performance Centre (UPHPC). He is of opinion that the study is feasible as children are becoming more obese and states that obese children might have difficulty in social coping, may have a lacking support system and may necessitate a lifestyle change. Van Heerden mentions however that the question should be asked with regards to how they see their obesity, as all children do not regard it as negative. The curbing of obesity and overweight at a younger age is easier than when it becomes a problem extending into adolescence and adulthood and therefore more attention should be given to this problem whilst clients are still young.

Literature according to several authors (Deckelbaum & Williams, 2001:239-242; Obesity epidemic …, 2004; Kruger *et al*., 2005:491-495; Goedecke *et al*., [sa]:65-67) reveal that the overall prevalence of obesity (BMI>30) in South Africa is high, with more than 20% of men and women being classified as obese. This becomes a major public health concern in that obesity is not limited to the adult South African population but has also been well documented in adolescents and young people. Goedecke *et al*. ([sa]:67) postulates that childhood obesity is an increasing problem worldwide with 22 million children under the age of five years being classified as overweight, who are in turn likely to grow into overweight or obese adults. Moran (1999:861) furthermore mentions that obesity can have a negative impact on the self-esteem of children and adolescents which may have implications for long-term happiness and success later in life. Knowing the experience of the obese child could aid in the understanding of this fast growing epidemic of obesity, and in turn might help parents, caregivers, teachers and all other involved parties in combating obesity before it tracks over into adulthood.

A great deal of research has been conducted on the topic of obesity, however the researcher is of opinion based on reviewing numerous articles, that articles focused on childhood obesity as a global problem and none up to date, were found to reflect on the experience of children enduring this phenomena (Deckelbaum & Williams, 2001:239-242; Kruger *et al*., 2005:491-495; Goedecke *et al*., [sa]:65-67). Therefore the experience of children with regards to their obesity can only enrich the sources that are available up to date.

1.2.2 Research Question

According to Whitley (2002:93-95), a research question is based on the refining of a broad topic into a more specific research question on which data can be collected. A good research question is based on three characteristics, namely how well grounded the question is in the current knowledge base, how researchable the question is and lastly how important the question is. The importance of the question is measured by the amount of information that the answer to the research question can provide.

The focus of the research, and therefore the research theme, was on exploring and describing children in their middle childhood year's experience of their obesity. The research question that arose, was stated as follows: **How do children in middle childhood experience their obesity?**

1.3 GOAL AND OBJECTIVES

Research goals are essential in providing clarity of the intended outcomes of research (De Vos, 2002:404). The Webster third international dictionary (in Fouché & De Vos, 2005:104) defines both goal and objective as "… the end towards which effort or ambition is directed".

The main goal of this research was to explore and describe the experience children in middle childhood have of their obesity. The following objectives were identified for the research study:

- To conduct a literature review in order to form a conceptual framework of obesity in middle childhood.

- To conduct an empirical study by collecting data through the use of semi-structured interviews in order to explore children in middle childhoods' experience of their obesity.

- To analyse and verify the collected data with literature in order to describe the children's experience.

- To draw conclusions on the completion of the aforementioned objectives and to make recommendations to health professionals working in the field of childhood obesity and to families in order to make them aware of the way children in middle childhood experience their obesity.

1.4 RESEARCH APPROACH

1.4.1 Qualitative Research Approach

A qualitative research approach was used for the intended study. Whitley (2002:32) defines qualitative data as data that consists of non-numerical information, such as descriptions of behaviour or the content of people's responses to interview questions. Neill (2006) broadly defines qualitative research as "... any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification".

The benefits of using a qualitative approach in researching obesity are based on the following characteristics as mentioned in Whitley (2002:34) on this approach:

- *Qualitative research studies behaviour in its natural context and tries to maximise ecological validity.* The experience of obesity was studied as it naturally occurs and this in turn maximised ecological validity.

- *In qualitative research, the researcher is an inseparable part of the research process. His experience as well as that of the participant is important.* In the intended study the researcher became part of the process by making use of a semi-structured interview schedule to gain qualitative data from the respondents rather than making use of questionnaires. The interview process gave respondents the opportunity to share their experiences with the researcher personally, whereas the experience of the researcher also allowed for relevant data to be collected in order to reach the aims of the intended study.

- *Data are open ended in qualitative research.* Descriptions of the experience of obesity were based on the response to the questions on the interview schedule.

- *The variables studied and methods to be used emerge from the researcher's experience in the research context and allow for modification as the research situation changes. This, in turn, leads to a high degree of naturalism*. The

semi-structured interviews allowed for modification to take place in the setting as the situation changed. The questioning followed its own course as more questions arose from the answers that respondents provided.

Whitley (2002:34) states that a qualitative approach focuses on understanding how people experience and interpret certain phenomena in their lives. The focus is on both similarities and differences in individual experiences, and on both similarities and differences in the way in which people interpret the experiences. This research focussed on the similarities and differences in the experiences of obesity that children in middle childhood have, as well as the similarities and differences in their interpretations of the effects that their obesity have on them. In conclusion this study portrayed qualitative research in that the researcher did make use of descriptions on the experience of obesity, in order to gain insight into this complex phenomenon.

1.4.2 Type of Research

Applied research was conducted to find a solution to a problem that is affecting some aspect of society, in this instance obesity in middle childhood. According to Whitley (2002:30), the results of applied research are intended to be immediately useful in solving a problem, thereby improving the condition of society. It usually focuses on behaviour in only one or a few situations rather than on general principles of behaviour that would apply to a variety of situations. Applied research is usually conducted in a natural setting and consequently studies variables in context (Whitley, 2002:30). The proposed research aimed at exploring children in middle childhood's experience of their obesity and as a result the studies' outcome intended to be immediately useful in understanding the obesity problem.

According to Fouché and De Vos (2005:106), the objectives of research can be exploratory, descriptive and explanatory in nature. The goal of this research study draws on both exploratory and descriptive research. Fouché and De Vos (2005:106) state that exploratory research is carried out to gain insight in a situation. They also mention that exploratory research could be based on a lack of information about a new area of interest or be used in order to get familiar with a situation so that a

problem can be formulated or a hypothesis developed. In this study, the researcher wished to gain insight in the experiences that obese children have.

Descriptive research presents a picture of the specific details of a situation, social setting or relationship (Fouché & De Vos, 2005:106). In qualitative research Rubin and Babbie (2001:125) state that description is more likely to refer to an intensive examination of an occurrence and its deeper meaning. Consequently this leads to a thicker description of an occurrence, which in this instance was that of children in middle childhood's experience of their obesity. Yin in Whitley (2002:272) states that descriptive purposes include providing a narrative, detailed description of the events that take place in a situation. This formed part of this research study in that a narrative was given as to how obesity is experienced by children in the middle childhood.

In the current research the theme of obesity in middle childhood was explored, focussing on the experiences of the children. The experience of obesity as well as obesity itself was described amongst middle childhood.

1.4.3 Research Design

The research design implemented to explore the phenomena was a case study. According to Creswell in Fouché (2005:272) a case study can be regarded as an exploration or in-depth analysis of a 'bounded system', a system bounded by time and place, or only one of the previous. Whitley (2002:37) notes that a case study is an in-depth, usually long-term, examination of a single instance of a phenomenon. This method is used either for descriptive or hypothesis testing purposes. For the purpose of this study a case study was used for descriptive purposes, in that a description of the experience of obesity was studied. An intrinsic case study design was used in that, according to Mark (in Fouché, 2005:272), the researcher did not aim to further her understanding of a broad social issue but rather the case being studied, namely that of obesity.

The place of theory and the literature review is also important in the case study. Creswell (in Delport & Fouché, 2005:265) positions the case study strategy in the

middle of the continuum. Theory might be completely absent from the study, with the focus on description of the case. In this study theory was used to guide the study before data collection (explanatory way) and afterwards as a literature control.

1.5 RESEARCH METHODOLOGY

1.5.1 Research Procedure

The first step in the qualitative approach is selecting a paradigm and considering the place of theory and literature in the research process. When selecting a paradigm Creswell (in Fouche & Delport, 2005:262) state that qualitative researchers approach their studies with a certain set of assumptions, which in turn form the paradigm.

The paradigm in which the researcher worked, was that of the ego psychological theory of Erik Erikson. Meyer and Viljoen (2002:187–211) state that Erikson asserts that personality development takes place in eight stages, ranging from birth to old age. At each stage a certain aspect of personality emerges as the main point of development, while other aspects develop below the surface. Each developmental stage is characterised by a developmental crisis whereby the individual needs to choose between two opposing developmental possibilities.

In the stage of middle childhood, which Erikson (in Meyer and Viljoen, 2002:187–211) also calls the school stage, the two opposing possibilities is that of industry versus inferiority. This stage ranges from ages six to twelve, and children develop a sense of industry as they learn to handle the tools of their culture. The danger of this stage as stated in Meyer, Moore and Viljoen (2002:187–211) is that children may fail to acquire the skills and tools needed to reach a sense of proficiency or competence and may feel inferior.

During the data analysis and interpretation of this research study, the researcher considered that certain aspects of their development was important to the child in middle childhood due to the above mentioned theory. The child in middle childhood

wants to reach competence and not to feel inferior. This was taken into consideration when data was interpreted and themes and categories were generated. These feelings of inferiority came to the foreground in the experiences of the respondents who participated in the research study.

1.5.2 Universe, Population, Demarcation of Sampling and Sampling Technique

Arkava and Lane (in Strydom, 2005:193) define universe as all potential subjects who possess the attributes in which the researcher is interested. Population, on the other hand, is a term which sets boundaries to the study unit; consequently it refers to individuals in the universe who possess specific characteristics. The universe therefore represents all children in middle childhood who are obese and who reside in Gauteng. For the purpose of this research study, the population referred to obese children, aged eleven and residing in the East of Pretoria.

Sampling was used for the feasibility of the study, in that complete coverage is seldom possible because the whole population cannot be reached (Whitley 2002:390-391; Strydom & Delport, 2005:327-328). Kerlinger (in Strydom, 2005:193) is of opinion that sampling means "… taking a section of a population or universe as representative of that population or universe". The sample taken is considered to be representative and generalisable, and it is assumed that what was observed can be observed in any other group from the population. The term *sample* always implies the simultaneous existence of a population or universe of which the sample is a smaller section according to Gravetter and Forzano (2003:465).

Non-probability sampling was used in that the odds of selecting a particular individual were not known, and so the researcher did not know the population size or the members of the population (Gravetter & Forzano, 2003:118). Purposive sampling was undertaken in the drawing of the sample. Singleton *et al.* (in Strydom, 2005:202) postulates that purposive sampling is completely based on the judgement of the researcher, in that the sample is comprised of fundamentals that contain the most characteristics or representative attributes of the population.

Respondents had to meet the following criteria to partake in this study and form part of the sample group:

- Be obese or overweight;
- Be eleven years old;
- Be Afrikaans or English speaking;
- Be any gender;
- Reside in the East of Pretoria and
- Be willing to participate and feel comfortable about participation.

The researcher had no maximum sample size in mind, as the size depended on the amount of interviews that were held before a point of saturation was reached. For this study the researcher decided on a minimum sample size of five respondents. The sample consisted of willing obese respondents aged 11, who responded to adverts placed in local school bulletins (refer to Addendum I). The aims of the research were revealed to the potential respondents and the children who expressed a willingness to participate and whose parents gave permission, were screened to see whether they met the necessary criteria.

According to Sullivan (2004:9) scientific approaches to define obesity amongst children include using growth charts as well as body mass index charts. However, she also mentions that a less scientific approach exists, which can be based on a child's appearance. This approach includes asking questions such as for example, whether a child has unnecessary rolls of fat on his or her body. In this study the researcher mentioned in the advert (refer to Addendum I) that respondents had to be overweight or obese to participate and therefore screened the respondents as being overweight or obese once meeting them and considered if they could participate in the study. The children originated from the urban areas in the East of Pretoria due to the fact that Kruger *et al*. (2005:492) cites that the highest prevalence of overweight was found to be amongst urban children (20.1%). The sample consisted of only female respondents due to the fact that only females responded to the advertisements placed regarding participation. The researcher

consequently used this as an opportunity to draw conclusions and make comparisons based on the same gender.

1.5.3 Data Collection

According to Whitley (2002:321-323) and Greeff (2005:286) interviewing is the predominant mode of data or information collection in qualitative research. In this process the researcher and participant are both actively involved in shaping meaning. Qualitative studies typically make use of unstructured or semi-structured interviews. For the purpose of this study the researcher made use of a semi-structured interview schedule (refer to Addendum II) with five respondents, until saturation of information was gained. Saturation, as defined by Van der Heyden (2006), essentially means that no new information is being learned from new data that is collected in a specific research context.

Whitley (2002:323) defines a semi-structured interview as follows:

> "A semi-structured interview follows an interview guide that specifies the topics and issues to be covered and may include some specific questions but there is no specified order in which the topics must be covered. This makes data collection more systematic and allows the interview to be flexible and somewhat conversational. Possible negative aspects of this type of interviewing can be that some topics may be skipped. "

A pilot study was undertaken prior to the formal research being conducted. A pilot study, as defined by Whitley (2002:403-404), refers to an initial piece of research conducted with a sample of research respondents. The number of respondents may vary and is left at the discretion of the researcher. Pilot studies have several purposes, however, with regards to this study, it served as a final test of research procedures prior to beginning data collection. The pilot study assisted in giving suggestions on how to improve clarity of the instructions, tested whether respondents interpreted things as intended and helped in developing probes (Whitley, 2002:403-404). The pilot study also helped in giving the researcher an

indication of how much time is required for the research. The pilot study comprised of individuals of the same age and gender as the respondents.

Relationship building took place prior to the interviews in order to inform the respondents on the process, to communicate information with regards to ethical practices, answer questions and sign consent forms (refer to Addendum III). Interviews were then held with the respondents individually. The researcher had a general purpose in mind, and therefore there was a preset group of questions posed to the respondents. The repetition in investigation of the same phenomenon during the semi-structured interviews allowed for greater depth obtained from the interviewing process as mentioned in De Vos (2005:361-365).

Data collection was enhanced by researcher observations and the use of a data recorder, for which permission was obtained from respondents. Smit (in Greeff, 2005:298) mentions that a recording device allows for a much fuller record than notes, as it allows for the researcher to concentrate on the way the interview is proceeding. Respondents in this research had the right to ask for the tape recording after the interviews if they so wished. The researcher also made use of field notes, which aided in remembering and exploring the process of the interview. Greeff (2005:298) mentions that field notes are a written account of the things a researcher hears, sees, experiences and thinks about in the course of the interview.

1.5.4 Data Analysis

Creswell (in De Vos, 2005:334) believes that the process of data analysis and interpretation can best be presented by a spiral image, called a data analysis spiral. Data analysis aids the process of literature control and according to this spiral image, the researcher moves in analytical circles rather than a fixed linear approach, to analyse data. Creswell's analytical spiral has been integrated with the processes of Marshall and Rossmann (in De Vos, 2005:334) to form a set of guidelines given as follows:

Guidelines	Implementation of the guidelines
• *Planning for the recording of data*	This included planning before the commencement of data collection. The researcher planned when and where interviews would take place.
• *Data collection and preliminary analysis*	Data was obtained from semi-structured interviews. Interviews were recorded and field notes utilised to enhance the data collected.
• *Managing or organising the data*	Once the interviews were completed, the data was transcribed from the recordings. These transcribes were organised by storing it on a computer.
• *Reading and writing memos*	Transcripts were read several times in order for the researcher to familiarise herself with the given data on the experience of obesity. All information not applicable to the aims of this study was cut from the transcripts.
• *Generating categories, themes and patterns*	Recurring themes were generated from the recorded data. The researcher made notes on recurring themes and so formed categories to which the themes could be assigned.
• *Coding the data*	Data was coded according to a recurring theme. The researcher made use of different colours in order to highlight and code information.
• *Testing the emergent understandings*	This stage allowed for the researcher to challenge findings amongst the data. This stage also incorporated the evaluation of data for its usefulness.
• *Searching for alternative explanations*	As themes and categories on obesity arose from the study, the researcher challenged the themes and categories by searching for any other plausible explanation for the findings.

• *Representing, visualising (writing the report)*	In this final stage the researcher presented the data on obesity in a suitable, understandable form.

TABLE 1.1 GUIDELINES FOR DATA ANALYSIS BASED ON CRESSWELL, MARSHALL AND ROSSMANN (in De Vos, 2005:334)

According to Lincoln and Guba (in De Vos, 2002:351-352) the four constructs needed for validity of qualitative research, are credibility, transferability, dependability and confirmability. The constructs will be discussed hereafter and a summary of the way they were reached in this study will be given in Chapter 4.

- *Credibility:* Credibility demonstrates that a qualitative study was conducted in such a way that the subject was accurately identified and described (De Vos, 2002:351).
- *Transferability:* Transferability is an alternative to external validity or generalisability to other settings. Transferability is the degree to which the findings of this inquiry can apply or transfer beyond the bounds of this research, therefore the applicability in other contexts (De Vos, 2002:351).
- *Dependability:* According to De Vos (2002:352), dependability refers to the researcher's attempt to account for changes in and around the phenomena being studied.
- *Confirmability:* Confirmability is linked to the question of objectivity. Lincoln and Guba (in De Vos, 2002:351-352) state that the criterion for a qualitative study is simply summed up in the question: "Does the data help confirm the general findings and lead to the implications?"

1.6 ETHICAL ASPECTS

Williams, Tutty and Grinell (1995:30) mention that because human beings are the objects of study, this will bring ethical problems to the fore. For researchers in social sciences, ethical issues are pervasive and complex, since data should never be obtained at the expense of human beings.

According to Whitley (2002:62), research in the behavioural sciences is guided by three general ethical principles, namely respect for persons, beneficence and justice. As the primary responsibility for the ethical conduct of research lies with the researcher, the researcher implemented ethical consideration across three stages of the research process, namely the planning stage, during data collection and following data collection.

1.6.1 Planning Stage

Whitley (2002:62) states that ethical considerations during the planning stage of research should be based on the following:

- *The risk of harm and/or deprivation of the research should not outweigh possible benefits:* The likelihood of possible risks to the respondents was evaluated before the research. The researcher was of opinion that no possible harm and risk could come to the respondents, but she did, however, decide to implement a strategy if any harm would possibly come to a respondent. The researcher informed respondents of the possibility of free follow-up therapy if needed.

- *Participation is voluntary:* A principle was designed to protect the autonomy of potential respondents by giving them the choice of participating or not. The freedom of choice had two branches, namely freedom of will to participate and freedom to withdraw from the research at any time. Respondents in the research study were informed that they are allowed to withdraw at any time during the study.

- *The principle of informed consent*: This allows respondents to receive information regarding the questions the researcher will ask of them, what will happen during the research and the risks and benefits of participation. Before collection of the data, respondents were informed about the goal and objectives of the study and of the procedure that was to be followed (refer to

Addendum III). This was done so that the respondents could make an informed decision about participating.

- *Deception:* Deception seems to be a frequently used tactic in research in the behavioural sciences, however, due to ethical considerations, deception was not used in this research study. Respondents knew that the study was aimed at gaining a better understanding of their experiences and that the findings could possibly be utilised in developing future intervention programmes.

1.6.2 During Data Collection

Whitley (2002:77) postulates that there are ethical considerations during data collection and this includes the following:

- *Avoidance of harm:* Steps were taken for the event of adverse or negative effects, namely that the study would be suspended until an informed decision could be made whether to continue with the specific respondent or not. The researcher contacted all respondents in a few weeks after the interviews, in order to establish whether any negative effects or harm was experienced. No negative or adverse effects came to the foreground during this research study and consequently no respondent was referred for professional help.

- *Withdrawal of consent:* This may take place at any time during the research process. Respondents had the right and free will to withdraw at any stage and this was taken up with them during the planning stage.

1.6.3 Following Data Collection

Whitley (2002:81-82) states that ethical considerations that follow data collection includes alleviating *adverse effects* if needed, as well as *debriefing*. During the research no debriefing was implemented as there was no need for it. The researcher did however have individual discussions with respondents and their parents during which certain aspects that came to the foreground during the semi-

structured interviews, such as the development of self-esteem, bullying, peer and family relations were discussed. The researcher was of opinion, based on an ethical viewpoint, that parents, with the permission of the respondents, should be made aware of some of the aspects that came to the foreground.

1.7 DEFINITION OF KEY CONCEPTS

1.7.1 Middle Childhood:

Meyer (1998:16) defines the life stage of middle childhood as ranging from the age of approximately six years to the beginning of puberty at age 12. In Meyer and Viljoen (2002:200), Erikson defines middle childhood as "School Age" and this is the development period ranging from ages six to twelve. In this stage, children learn to master industry (*acquiring necessary skills needed to function in society)* and gain competence. Success becomes important and helps the child to avoid feelings of inferiority.

The researcher decided to work with this age group as the socialising stage of children become important. As acceptance and not feeling inferior plays an important role, the researcher is of opinion that not achieving competence in this stage could possibly lead to negative development for the child.

1.7.2 Obesity:

According to Sullivan (2004:3), obesity is defined as an excess of body fat. Obesity can also be defined as the excessive accumulation of body fat and as a deadly disease which is of global concern, according to Hume (2000:131).

According to Beecher, Hagen and Tessmer (2006:35-46) excessive body weight has been shown to predispose individuals to various diseases, particularly cardiovascular diseases, diabetes mellitus type 2, sleep apnea and osteoarthritis. Obesity is both an individual clinical condition and is increasingly viewed as a serious public health problem.

1.7.3 Subjective Experience:

According to Dictionary.net ([sa]) *subjective* can be defined as pertaining to, or derived from one's own consciousness. Clare (2000:12) states that each individuals' emotions are unique, and if an experience bears any connection to their own life, they feel it according to their subjective perceptions. She furthermore states that emotions are the basis of subjective experiences in life.

The boundaries of an experience can be expansive and can include the sensorial, the symbolic, the temporal and the meaningful (Nathan Glossary [sa]). With regards to experience, Clare (2000:37) states that emotions are the messengers of experience, and if they are not recognised, individuals are missing the richness of most of the experiences of their own lives.

For the purpose of this study *experience* referred to the personal opinion of the respondents, with regard to their feelings and emotions gained through their own involvement in their obesity.

1.8 CONCLUSION

In this chapter attention was given to the methodology and work procedure of this research study. In Chapter 2 the researcher will present a literature review in order to form a conceptual framework regarding obesity and the child in middle childhood.

CHAPTER 2

OBESITY IN MIDDLE CHILDHOOD

2.1 INTRODUCTION

As obesity amongst children are on the rise and are observed at a much higher rate in societies today than previously, gaining more information on this phenomenon should be a priority. According to Moran (1999: 871-873), the evaluation of obesity in childhood is important for several reasons. Firstly it can possibly offer the best hope for preventing disease progression and associated morbidities into adulthood. Secondly, while genetic and hormonal causes of obesity are rare, they do warrant consideration in obese children. Lastly, directed sessions emphasizing healthy eating and exercise habits for children and their families may have lasting effects on the lifestyle of the obese child (Moran, 1999:871-873). Moran only mentions children in the broader sense of the word. However, the researcher will focus on the child in middle childhood.

The researcher aims to gain more clarity on the impact obesity has on children in middle childhood by focussing on the children's own experience of obesity in this study. The aim of this chapter will be to focus on the concepts of obesity as well as the child in middle childhood. Understanding these concepts as the researcher wishes to use them is of importance to ensure that the meaning of the concepts is understood in the context of the study.

2.2 OBESITY

2.2.1 Defining Obesity

Cole and Roland-Cachera (2002:3) define obesity as an excess of body fat, however they are of opinion that it is not only the amount of body fat but also the distribution of body fat in the body that is important. According to Sullivan (2004:3) the height and build of the child affects whether he or she is considered obese at a

given weight. Children are consequently considered obese when they are significantly over the ideal body weight for their height.

2.2.2 The Scale of the Obesity Problem

Sullivan (2004:x-xi) states that according to the international obesity task force, some 22 million of the world's under-fives are overweight or obese and that the problem is not only confined to the western world as many believe. In Zambia and Morocco it is estimated that 15 to 20 percent of four-year-olds are obese whereas in Chile, Peru and Mexico, obesity rates are more than 25 percent among children aged between four and ten. In the United Kingdom, studies estimate that the number of overweight children has increased by 25 percent since 1995, with an average of 17 percent of these overweight children classified as obese. In Australia figures are healthier, with six percent of children classified as obese whereas in New Zealand a national study in 2003 found that almost one in three children aged five to 14 were overweight or obese (Sullivan, 2004:x-xi).

Costain (2001) mentions that obesity rates amongst six-year-olds doubled in recent years to 8 percent and trebled to around 17 percent among 15 year olds. In addition Caelers (2005:10) estimates that by 2020 half of the girls and a third of all boys in the world will be overweight if current trends continue. These statistics are disturbing and imply that in a family with three children, one of the children is destined to be overweight. Sullivan (2004:x-xi) also mentions that a quarter of South African children between the ages of 12 and 18 are classified as being overweight or obese.

These alarming statistics illustrate just how many nations are on the verge of an obesity epidemic and it could be believed that some nations are already in the midst of it. Obesity is not just a condition that characterises the way children look; it's a serious threat to their health as well.

2.2.3 Possible Reasons for Obesity in Children

Sullivan (2004:26-36) states that poor diet, overeating and a lack of exercise are main reasons that children gain weight. Rolland-Cachera and Bellisle (2002:69) agree that nutrition is a major determinant of body size. According to the Heart and Stroke foundation of South Africa …, ([sa]) childhood obesity is linked primarily to unhealthy eating habits, but also to the fact that children are less active than in the past. Sullivan (2004:26-36) furthermore mentions that children should be encouraged to lead a healthy lifestyle while still young. She states that it is important to understand how societies are also to blame for the lifestyle changes that led to the surge of obesity in both children and adults. Sullivan (2004:26-36) further emphasizes that no child sets out to be obese nor do the majority of parents simply allow the problem to occur. The reality of obesity is that obese children come from all types of backgrounds, classes and ethnic origins.

2.2.3.1 A Child's Diet and Eating Habits

According to Sullivan (2004:26), eating habits that are put into place until a child is six or seven years of age, can help to establish healthy eating patterns in a child or at least implant a very basic understanding of which foods are healthy. Sullivan mentions that it is not lack of education or even apathy that steer most parents in the wrong direction, it's usually exhaustion on their behalf.

The following factors in a child's diet can lead to overweight or obesity, namely:

- *A diet based on junk:* Sullivan (2004:27-36) states that foods that are high in salt, sugar and fat contribute to obesity and these appear to be the foundation in the diets of many small children. Children are eating energy-dense food and not getting enough nutrient-dense food such as fruit and vegetables and therefore children's diet is at least partly to blame for the rise in overweight and obesity. The end result is, not surprisingly, unhealthy children with vitamin and mineral deficiencies as well as weight problems (Sullivan, 2004:27-36). Rolland-Cachera and Bellisle (2002:85-86) mention

that obese children do not have an excessive appetite for sweet foods, but rather for high fat foods.

- *Empty tummies:* According to Sullivan (2004:28), children who don't eat breakfast seem to suffer from poor concentration and when they become hungry they seek out snacks, which are generally unhealthy. In addition, according to a 2003 study published by the American Journal of Epidemiology, those who skip breakfast have a 4.5 time greater risk of becoming obese than those who eat regularly (Sullivan, 2004:28). Rolland-Cachera and Bellisle (2002:85) also found that obese children eat less in the mornings and more later in the day. Sullivan (2004:28) furthermore states that in today's culture, children are often rushed from activity to activity without a proper meal or parents return home too late to provide a proper meal. Young children are making their own food choices and eat whenever they like, often alone and in front of the television. Today's society has somewhat to do with the decline in good eating habits as the number of families who regularly eat dinner together has diminished and only one third of families are estimated to eat together daily. This implies that parents can influence their children's eating by controlling mealtime routines. Regular family meals are related to healthier eating habits and a higher intake of nutritious foods (Sullivan, 2004:28).

- *Unhealthy snacking, a soft drink culture as well as eating too much fat:* According to Sullivan (2004:31-36) unhealthy snacking, a soft drink culture and high fat diets, all contribute to the problems of the modern child's diet. Changing eating habits for instance and the trend of eating at restaurants and buying take away foods furthermore contributes to this epidemic of childhood obesity. (Deckelbaum & Williams, 2001:240; Kruger *et al*., 2005:492-494.) Rolland-Cachera and Bellisle (2002:85) also cite that some behavioural traits, for example snacking, bingeing, late day or night eating that are persistent in some individuals, facilitate the development of obesity. Draper (2004) also mentions that food indulgence was a reaction both automatic and habitual. Individuals seemed to eat uncontrollably as life confronted them with its daily

dose of conflict and as time passed the weight mounted slowly but surely (Draper, 2004).

- *Psychological factors:* These factors include mainly two aspects, namely parents either expressing their love in terms of food or exerting control over their children by means of food (Deckelbaum & Williams, 2001:240; Kruger *et al*., 2005:492-494).

2.2.3.2 High Birth Weight

Obesity: Complications in kids … ([sa]) postulates that high birth weight in excess of 4kg and parental obesity are risk factors associated with obesity which could place a child at a disposition. It therefore seems that the interaction between genetic and environmental factors play a role in obesity, in that children with obese parents and a "fat prone" genetic makeup who are always overfed, will be more likely to become obese, than those who have no genetic tendency and are not overfed.

2.2.3.3 Ethnicity

Many SA kids obese … ([sa]) claimed that ethnicity was found to play a role in obesity as it has been noted that certain population groups are more inclined to gain weight than others when they are exposed to a high fat western diet. In South Africa for example rural children who become city dwellers, substitute grains, fruit and so forth for high-energy snack foods and cooldrinks.

2.2.3.4 Lack of Physical Activity

According to Schutz and Maffeis (2002:99) there is a significant relationship between inactive behaviour in pre-obese children and subsequent weight gain over time. With regards to this, several authors (Deckelbaum & Williams, 2001:242; Kruger *et al*., 2005:492-494; Goedecke *et al*., [sa]:71-72) state that the lack of physical activity cause children to expend much less energy than ever before. It seems that watching television and playing computer games contribute immensely to the inactivity of children, however, the lack of safe playing areas and the discarding of sport and physical education at schools should also not be overlooked.

2.2.3.5 Emotional Origin

Sullivan (2004:48) states that there is a great deal of evidence that emotional health underpins at least part of the trend towards obesity, and this is something that parents simply may not have considered relevant. Like adults, children often rely on food fixes to deal with emotions. They may eat more when they are feeling sad, stressed or bored and they are more likely to do so if this pattern was demonstrated to them via their parents.

According to Draper (2004) the link between obesity and emotions is tight, yet frequently undefined. Draper (2004) states that he has reviewed several books which speak about the issues of rejection, fear, anger, depression, stress, loneliness, other emotional disturbances and its ties to overeating. The details of the relationships between emotions and overeating differ, but the themes were similar. Themes included aspects such as situations where feelings of distress reached a point at which eating became a suitable and temporary relief from their pain. Eating and its preparation seemed to provide the troubled person with a distraction, a reward, gratification, comfort or a sense of being loved. Several authors (Kruger *et al*., 2005:494-495; Goedecke *et al*., [sa]:67-70) mention that psychological problems such as negative self-esteem, withdrawal from interaction with peers, depression, anxiety and feelings of chronic rejection are characteristic of obese children.

Sullivan (2004:48) is of the opinion that the problem of obesity seems to be twofold. Children who put on weight for a variety of reasons may begin to lose their self-esteem and this loss of self-esteem may lead to eating more and to weight gain. Hill and Lissau (2002:117) mention that girls who had a higher BMI reported lower self-worth, reduced self-competence in areas of physical appearance, friendships and behavioural manners. Furthermore Sullivan (2004:48) mentions that children with a short-term weight problem may find that they are recipients to all sorts of negative stereotypes, which can be both confusing and destructive and can consequently lead to more weight gain. It is evident that children who feel bad about themselves have little self-esteem and therefore care little about what they look like, or have the self-respect necessary to monitor their own health (Sullivan, 2004:48).

Sullivan (2004:48-55) states the following factors as emotional contributors to the obesity epidemic amongst children and adolescents:

- *Using food to satisfy emotions:*

  Parents use food to satisfy children's emotional needs or to promote good behaviour and this may in fact promote obesity through interfering with the children's ability to regulate their own food intake. Food can take on emotional significance when used to comfort or reward children. This type of habit is very difficult to shift and can cause weight to spiral out of control (Sullivan, 2004:48-55).

- *Loneliness:*

  Because of family structure and employment changes over the past couple of decades, children frequently experience disrupted family life and less 'quality time' with parents. For a number of children and adolescents, this phenomenon badly affects psychological development, eating style, physical activity and weight status, and may contribute to loneliness. Children sit and eat in front of the television and often do so alone without the company or interaction of parents (Sullivan, 2004:48-55).

- *Depression:*

  Sullivan (2004:48-55) mentions that depression is a growing problem in children and yet according to some research, may go unnoticed and untreated. According to Pesic (2006) it is, however, unclear what the relationship between childhood obesity and childhood depression is in that it is not yet clear if depression caused obesity or if obesity caused depression.

  Pesic (2006) recognises that obesity amongst children can be traumatic as it may cause social stigma and lead to withdrawal in socialising with peers. Obese children may develop a poor self-image and be of the opinion that they are not good enough. As society views obesity as something negative, obese children may stop interacting with children their age and tend to shy away from peers. Obese children prefer to stay at home rather than spending time with their friends. This may already be an early sign of depression.

Pesic (2006), therefore, states that depression can be a cause of obesity. Children suffering from depression stay at home more often and watch television as they have difficulty relating with other children. They become 'couch-potatoes' and have the tendency to eat more than necessary. If this continues, these children will gain weight above the ideal weight for their age and over time become obese. Sullivan (2004:48-55) also mentions that depression can affect weight gain in the following ways: Firstly, self-image is affected during an episode of depression and children lose interest in taking care of themselves, or may develop a poor body image. Overeating, comfort eating, destructive behaviour and apathy are common characteristics of depression. Even short-term depression can lead to a rise in weight that set children on a course for increased weight gain and the negative feelings that accompany this. Chronic obesity (lasting from childhood to adulthood) is associated with psychiatric disorders such as oppositional defiant disorder and depression. Depression affects the way a child looks, feels, thinks and behaves (Sullivan 2004:48-55).

- *Stress:*

  According to Sullivan (2004:56), stress is a strong risk factor for overweight. Children eat to relieve feelings of discomfort and distress, particularly when they don't understand the emotions they are experiencing or don't know how to deal with them. Comfort foods seem to calm the body's chronic stress, whereas brain systems affected by stress play a role in disorders of both mood and weight regulation.

It is clear that children's diets as well as emotional factors are found to play a role in the origin of obesity, and therefore the development of obesity amongst children in middle childhood. Once obesity has become part of a child's life, there are certain implications on their physical health, mental health and the social spheres of their lives. Data from a number of studies provided strong evidence that overweight and obesity in children predict overweight later in life, and therefore obesity in the middle childhood is of importance due to the awareness that it causes possible long-term problems (Deckelbaum & Williams, 2001:240; Kruger *et al*., 2005:492-494).

2.2.4 Health Implications

Obesity among South African children is of concern for the present and future of South Africa and this can be found particularly in relation to possible consequences for the country's health care system and the cost of health care. Obesity major health …, ([sa]) states that South Africa can not allow its children to become progressively obese, as this could in turn result in a recipe for an unhealthy nation, with dismal consequences.

Implications of this epidemic include co-morbidities (Deckelbaum & Williams, 2001:241; Kruger *et al*., 2005:494-495; Goedecke *et al*., [sa]:67-70) and co-morbidities of childhood obesity include biochemical, physiological, behavioural and psychological factors. Zwiauer, Caroli, Malecka-Tendera and Poskitt (2002:131-145) found the adverse effects of obesity in children to be growth problems, hormonal problems, orthopaedic problems, gastrointestinal problems, respiratory and sleep problems, neurological problems, immunological problems and metabolic problems.

2.2.4.1 Physical Consequences

Physical consequences include cardiovascular risk factors, such as high blood pressure, high cholesterol levels as well as orthopaedic problems and diabetes mellitus (type 2) (Deckelbaum & Williams, 2001:241; Kruger *et al*., 2005:494-495). Table to Grave … (2005), in addition, cites the following physical consequences of obesity, namely glucose intolerance and insulin resistance, fatty degeneration of the liver, gallstones, sleep apnoea, menstrual abnormalities, impaired balance, metabolic syndrome, arthritis and cancer. Kruger *et al*. (2005:492) furthermore mentions that as many as 19% of children are stunted because of insufficient food intake.

2.2.4.2 Emotional Consequences

Sullivan (2004:26-36) states that overweight and obese children are often the target of abuse, typically because they are assumed to be lazy and lacking self-restraint. According to Table to Grave … (2005), emotional consequences also include low

self-esteem, negative body image and depression. Also included are psychological problems such as negative self-esteem, withdrawal from interaction with peers, depression, anxiety and feelings of chronic rejection (Deckelbaum & Williams, 2001:241; Kruger *et al*., 2005:494-495; Goedecke *et al*., [sa]:67-70). Body shape discontent is clearly evident in obese children as mentioned by Hill and Lissau (2002:115), who state that preadolescent as well as adolescent girls express a tendency for a slimmer figure.

The researcher aims to discover the experiences that children in middle childhood have with regards to their obesity. As a result, the researcher aims to gain information on the possible emotional consequences that obese children describe for themselves.

2.2.4.3 Social Consequences

According to Hill (2005) a person's quality of life, as well as social acceptances are influenced through obesity. Table to Grave … (2005) mentions that social consequences include stigmatisation, negative stereotyping, discrimination, teasing, bullying and social marginalisation. Saunders (2003), in addition, declared that previous research pointed out inconsistencies in friendship nominations amongst overweight and obese children, in that overweight children claim more friendships than they actually have. The study also found that overweight children, on the one hand, were more likely to be socially isolated. On the other hand it was found that being more social could however also open overweight children up to more teasing. In this regard Hill and Lissau (2002:111) mention that previous weight-related teasing and the degree to which it caused upset correlated with current levels of body dissatisfaction and eating disturbances in college-age women. Weight-related teasing, according to Hill and Lissau (2002:111), seems to be more prevalent amongst girls as it was found that girls are less accepting of overweight same sex peers.

Reflecting on the above information, the researcher deemed the consequences of childhood obesity to be of great importance to the child and his/her future health and

well-being in all realms of their humanness. The researcher consequently supposes that knowledge on children's experience of obesity is important in gaining an accurate understanding of the phenomenon from a child's viewpoint.

2.3 MIDDLE CHILDHOOD

2.3.1 Defining Middle Childhood

Meyer (1998:16) defines the life stage of middle childhood as ranging from the age of approximately six years to the beginning of puberty at age 12 years (refer to 1.7.1). Although middle childhood, according to Louw, van Ede and Ferns (1998:322) is characterised as a period of relative calmness in respect of physical development, it is in actual fact an important period in a child's cognitive, social, emotional and self-concept development. Children in middle childhood's interaction with peers and socialisation are of utmost importance as this interaction and socialisation impacts directly on the child's social, emotional and self-concept development. As their social environment offers them new opportunities for socialisation and for gaining new learning experiences, the development that takes place in this phase prepares the child well for the subsequent adjustments and challenges of adolescence.

Huston and Ripke (2006:7) characterise middle childhood as the period when biological, social and intellectual changes occur and new cognitive capabilities develop. Freud (in Meyer & van Ede 1998:47) named this age period the latent stage, because of the fact that no new erogeneous zones appear and this stage is dominated by the child's identification with the parent of the same sex.

Encarta ([sa]) states that during middle childhood, children acquire heightened capacities for judgment, reasoning, social understanding, emotional management and self-awareness. At the same time, the social world of children in the middle childhood broadens beyond the family to include the school, neighbourhood, peer group and other influences. Children begin to perceive themselves in multiple roles and relationships besides those of the family, even though family relationships remain central.

In the following discussions aspects with regards to physical development, cognitive development, self-development, emotional development and social development in middle childhood will be discussed.

2.3.2 Physical Development in Middle Childhood

Brightfutures ... ([sa]) defines middle childhood's physical development as a slow, steady growth which occurs until the onset of puberty. Louw *et al.* (1998:322-323) also mention that physical development in middle childhood is characterised by a gradual growth rather than rapid growth. Brightfutures ... ([sa]) states that children have growth spurts, which are usually accompanied by an increase in appetite and food intake. Body shape remains relatively constant during middle childhood, however during the ages 9 to 11 years in girls and 10 to 12 years in boys, the percentage of body fat increases in preparation for the growth spurt that occurs during adolescence. This body fat increase occurs earlier in girls than in boys, and the amount of increase is greater in girls which may cause them to appear "chubby". Louw *et al.* (1998:323) confirm this in that they mention that from approximately 10 to 11 years, girls' height and weight increase much more rapidly than that of boys.

During middle childhood, children may become overly concerned about their physical appearance and girls especially may become concerned that they are overweight. Boys, on the other hand, may become concerned about their stature and muscle size and strength (according to Brightfutures ..., [sa]). Huston and Ripke (2006:9) state that hormonal changes with regards to puberty begin in this stage, and consequently body changes associated with the first stages of puberty begin towards the end of middle childhood. The researcher is of opinion that obese children reach puberty earlier than their peers due to their higher body weight and consequently may feel inferior towards their peers, as stated in Beecher *et al.* (2006:51) where it is mentioned that obesity is linked to early development in obese girls due to a higher body fat content. This feeling of inferiority might be due to obese children looking different and may also be a result of the physical consequences (refer to 2.2.4.1) that they may experience. This may lead obese

children to not gain the necessary competence which Erikson, as referred to in 1.5.1, states to be important during this phase of development.

2.3.3 Cognitive Development in Middle Childhood

Eccles (1999: 33-36) declares that a crucial shift occurs between ages 7 and 11 in the cognitive abilities of children. While they have made dramatic developments just prior to this phase, they now begin to master the abilities to reason, to reflect on themselves and to take the perspective of other people. While these thinking skills become strengthened and refined throughout their later life, the beginnings of these skills occur during this phase (Eccles, 1999:33-36). Piaget (in Galotti, 2004:468) was of opinion that children are active participants in their development and that children construct their own mental structures through interaction with their environment. Piaget described different stages of cognitive development, amongst others the stage of concrete operations which ranges from age 7 until 11 or 12. During this stage children's thinking becomes mature and their thinking is limited to actual or imagined concrete things. Children have difficulty thinking in abstract terms and their thinking is less systematic (Galotti, 2004:476-477).

Louw *et al.* (1998:326) also mention that children spend more time in school at this life stage and consequently develop their cognitive skills to a great extent. Equally, the child's memory, creativity and language abilities are enhanced and improved during the middle childhood years. The researcher is of opinion that as children master the abilities of self-reflection and take the perspective of other people, children might now for the first time realise their obesity and that they look different to their peers. This realisation may shape decision making as well as the way they think about themselves and may directly influence how competent they perceive themselves versus feelings of inferiority as described by Erikson (refer to 1.5.1).

2.3.4 Self-development in Middle Childhood

Self-development refers to terms such as self-concept and self-esteem, therefore referring to the development of the self. Huston and Ripke (2006:9) mention that children in middle childhood form identities, they form a sense of who they are and where they fit in the bigger scheme of things.

Emotional and Social Development in Middle Childhood … ([sa]) mentions that during the middle childhood years, children develop a much more refined me-self or self-concept, organising their observations of behaviours and internal states into general dispositions. Louw *et al*. (1998:344), however, state that middle childhood is a sensitive period for the development of the self-concept due to specific kinds of experiences having significant consequences for self-concept development. According to Papalia and Olds (in Louw *et al*., 1998:344) and Emotional and Social Development in Middle Childhood … ([sa]), children begin to define themselves in terms of psychological terms, in that they develop a concept of who they are (real self) versus whom they would like to be (ideal self). They further begin to make social comparisons, in that they judge their appearances, abilities and behaviour in relation to those of others and consequently make self-assessments. Children in middle childhood, in other words, are able to form concepts of what they do well and what not, for example whether they are smart or popular (Huston & Ripke, 2006:9).

Cognitive development, according to Emotional and Social Development in Middle Childhood … ([sa]), affects the structure of the self-concept and hence the changing content of self-concept is a product of both cognitive capacities and feedback from others. Perspective-taking skills also emerge during middle childhood years due to the fact that children become better at "reading" messages they receive from others and incorporating them into their self-definitions. Although parents remain influential, between the ages of eight and 15 peers become more important. In this regard Huston and Ripke (2006:9) further mention that although families and parents still play an important role during this stage, children's increasing independence from their parents is associated with their ability to regulate themselves as they reach the end of middle childhood.

Emotional and Social Development in Middle Childhood … ([sa]) declares that middle childhood is also characterised by a hierarchically structured self-esteem. Classrooms, playgrounds and peer groups are key contexts in which children learn to evaluate their own competence. By age seven to eight, children have formed three separate self-esteems, namely academics, physical and social, that become more refined with age. Self-esteem, however, can drop during the first few years of primary school. Most children appraise their characteristics and competencies

realistically while maintaining an attitude of self-acceptance and self-respect. From the fourth to the sixth grade, self-esteem rises for the majority of children. Children with high social self-esteem are consistently better liked by their peers, and academic self-esteem predicts school achievement (Emotional and Social Development in Middle Childhood …, [sa]).

The researcher is of opinion that since children in middle childhood begins to make social comparisons, judging their appearances, abilities and behaviour in relation to those of others, developing the self is an important aspect in the maturation of the middle childhood child. The researcher supposes that an obese child will have more trouble in developing their self due to the fact that their social comparisons might be harsher. Negative facets of this stage could include things such as learned helplessness and low self-esteem (refer to 1.5.1) as a negative developmental outcome of Erikson's theory.

2.3.5 Emotional Development

LaFreniere (2000:238) mentions that children in middle childhood advances in emotional understanding as they become more aware of emotions in everyday life. In middle childhood children understand that an individual may experience conflicting emotions as a single reaction and children learn the rules for management of emotions that are prescribed by their culture. According to Emotional and Social Development in Middle Childhood … ([sa]) the self-conscious emotions of pride and guilt become clearly integrated by personal responsibility in middle childhood. Shame is often felt when violation of a standard is not under a person's control and may also be experienced after violation of standards if the self-as-a-whole is blamed for it. Pride, on the other hand, motivates children to take on further challenges, and guilt prompts them to compensate and strive for self-improvement as well.

Children in middle childhood understand psychological dispositions and this allows them to explain emotion by making references to internal states rather than to physical events (Emotional and Social Development in Middle Childhood … ([sa]). They are also more aware of the diversity of emotional experiences whereas

cognitive and social experiences also contribute to a rise in empathy. Children come up with more ways to handle emotionally arousing situations as they make rapid gains in emotional self-regulation during middle childhood. According to LaFreniere (2000:28), emotional management includes four abilities: firstly the knowledge concerning appropriate situations for expressing emotion, secondly the ability to control emotions, thirdly the motivation to control emotions and lastly the level of cognitive understandings.

When the development of emotional self-regulation has gone along well, school-age children acquire a sense of emotional self-efficacy, in other words a feeling of being in control of their emotional experience. This sense of self-efficacy can be related to gaining competence during this stage as described in Erikson's theory (refer to 1.5.1). Emotionally well-regulated children are generally upbeat in mood, more empathic and pro-social, and better liked by their peers (Emotional and Social Development in Middle Childhood … ([sa]). The researcher is of the opinion that an obese child in this life stage may experience problems with emotional regulation and this could lead to stigmatisation or to inferiority as described by Erikson's theory (refer to 1.5.1). The stigmatisations could include things such as other children not experiencing them as upbeat or pro-social, which in turn could lead to rejection by their peers.

2.3.6 Social Development in Middle Childhood

Social development, as defined by Craig (2000:1), is concerned with the development of social interactions, how they originate, how they change over the lifespan and how they contribute to individual development. According to Emotional and Social Development in Middle Childhood … ([sa]) the society of peers become an increasingly important context for development in middle childhood. Friendships in middle childhood become a mutually agreed on relationship, in which children like each other's personal qualities and respond to one another's needs and desires. Once a friendship is formed, trust becomes its defining feature and consequently violations of trust are viewed as serious breaches of friendship. Friendships seem to remain fairly stable over middle childhood. According to Hartup (2000:69) children

make friends on the basis of common interests and common activities, and children were more likely to be friends with children who cooperated with them than for any other reason.

Eccles (1999:33-36) mentions that the child in middle childhood begins to spend more time with their peers and away from parents. Eccles further states that members of these peer groups begin to take responsibility for managing group dynamics, nurturing each other and sometimes establishing group hierarchies. As they get older, children begin to contribute to the happiness of others in their group and there is the beginning of a “we” feeling. Their friendship groups reflect more children's own personal qualities and achievements (Eccles, 1999:33-36).

Emotional and Social Development in Middle Childhood … ([sa]) mentions that a peer group is composed of peers who form a social unit by generating shared values and standards of behaviour and a social structure of leaders and followers. The “peer culture” of a peer group typically consists of a particular vocabulary, dress code and particular gathering places during leisure hours. The group provides a context in which children practice cooperation, leadership and follower-ship, and develop a sense of loyalty to collective goals. Children who participate in formal groups gain in social and moral understanding. Peer acceptance is a powerful predictor of current as well as later psychological adjustment. Rejected children are unhappy, alienated, poorly achieving children with a low sense of self-esteem. Rejection is also strongly associated with poor school performance, dropping out, antisocial behaviour and delinquency in young adulthood (Emotional and Social Development in Middle Childhood …, [sa]).

Hartup (2000:67) furthermore mentions that children who have friends are more socially competent and less troubled, they are overall more sociable, cooperative, unselfish, self-confident and less lonely. Contained in the understanding of others and having positive peer relations, the researcher states that obese children might have difficulty in their peer relations due to the fact that they may be rejected by their peers. In this regard Emotional and Social Development in Middle Childhood … ([sa]) cites that most interventions to help rejected children involve coaching, modelling and reinforcement of positive social skills. Often rejected children are poor

students, and intensive academic tutoring has been shown to improve both their school achievement and social acceptance.

2.4 CONCLUSION

Reflecting on the above information, the researcher deems the consequences of childhood obesity to be of great importance to the child and their future health and well-being in all realms of their humanness. The researcher consequently supposes that knowledge of the child's obesity experience is important in gaining an accurate understanding of the phenomenon from a child's viewpoint, as well as aiding the declination of childhood obesity in the future. The researcher mentions, based on reviewing the above information, that if obesity had an effect on the mastering of the above developmental tasks of the middle childhood, it could have a negative impact on the development of the child. This, in turn, leads to stagnation in developing as social, emotional, cognitive and moral beings.

CHAPTER 3

EMPIRICAL FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

In this chapter the researcher will present empirical findings based on research regarding obese children's experience of their own obesity. As mentioned previously (refer to 1.2.1.2) the researcher found that there is a great deal of research on the topic of obesity, but a limited amount of research that focus on the experience obese children have of their own obesity. The researcher therefore focussed on gaining information based on obese children's own experiences of their obesity.

3.2 EMPIRICAL FINDINGS

Empirical findings in the current research process were collected by means of a sample group of five respondents. The respondents were 11 year old, female and obese and data was gained through semi-structured interviews (refer to 1.5.3) with each of the respondents. Only five respondents were interviewed, as only five respondents replied to the advert placed regarding the research (refer to 1.5.2).

The exploratory research on the experience of the obese child resulted in key themes being identified by the researcher. The researcher will present each theme individually and then describe these themes in relation to the literature gained through the research. Hence the empirical findings will be presented in the context of a comprehensive literature control. In the researchers' view, the experiences represented in this study cannot only be limited to the obese respondents found in this study. On revision of the empirical findings the researcher is of opinion that the experiences noted in this research can be generalised to most obese children; however the researcher by no means wishes to create the illusion that all obese children have the same experiences. The following table illustrates the identified themes, sub-themes and categories:

THEME	SUB-THEMES	CATEGORIES
THEME 1: EXPERIENCE ON THE ORIGIN OF OBESITY A recollection of reasons that in the respondents experience, led to their obesity.	• Respondent's diet as origin • Emotional origin • Physical origin	
THEME 2: ASPECTS OF DEVELOPMENT INFLUENCED BY OBESITY Respondents give detailed discussions on the experience of their obesity and how it influences all spheres of their development.	• Self-development	Self-concept Social self-concept Self-esteem Self-efficacy
	• Emotional development	Feelings of abnormality Anger Sadness Jealousy Regret Hopelessness
	• Cognitive development	
	• Social development	Friendship Family
	• Physical development	Sport

TABLE 3.1 IDENTIFIED THEMES, SUBTHEMES AND CATEGORIES IN EMPIRICAL FINDINGS

3.2 THEME 1: EXPERIENCE ON THE ORIGIN OF OBESITY

The growing problem of childhood obesity is of great concern in society today and consequently experts are even starting to call it a chronic disease, as stated in Dalton (2004:3). Understanding the interplay of causes and taking action to reverse the epidemic of childhood obesity should therefore be a priority to all. According to Beecher *et al.* (2006:15-17) the greatest concern regarding childhood obesity is that of the physical and emotional impact on the child. With regards to the emotional impact Dalton (2004:3) remarks that obese children are seemingly in pain and suffering due to the merciless torment of discriminating societies. Obesity furthermore also leads to children having a much higher risk for chronic diseases later in life (Dalton, 2004:3). Parents, according to Beecher *et al.* (2006:17), however, seem not to be worried that their children are becoming too heavy.

In order to explore obese children's experience of their own obesity the researcher considered it important to ask the respondents, what in their experience, they thought were possible causes of their obesity. The respondents were able to reflect on their weight and give probable causes. The following sub-themes were identified as causal factors in terms of their obesity.

3.2.1 Respondent's Diet as Origin

Dalton (2004:45) cites that the word "obese", originates from the Latin word "obesus" which directly means "grown fat by eating". The term's origin correctly suggests that overeating is the major cause of the epidemic of obesity. The researcher found that the respondents all had awareness with regards to their eating habits and that their weight was a problem due to their diet. They were aware of the major role their eating habits played in their obesity, and also of which aspects of their diet led them to being obese.

Several authors (Sullivan, 2004:26-26; Dalton, 2004:45; Beecher *et al.*, 2006:24) mention with regards to eating habits of obese children, that diets based on junk food as well as unhealthy snacking were found to be among the reasons that children were obese. Respondents mention that they ate too much junk food, which

included sweets and soft drinks and according to them healthy food generally did not taste as good to them as junk food. In this regard respondents mentioned the following: “I believe I am obese because I can’t say no to sweets and junk food” also, “… I feel as if I’m losing out if my friends eat junk food especially during break, and although I know I shouldn’t, I do too”. Another respondent stated that she is allowed to eat whatever she wants, “... so why would I not choose takeaways, it tastes much better than healthy food. I also wonder why anyone would want to drink water if there is soda available”.

With regards to the last comment, respondents admitted that, in general, they did not drink enough water and believed that this also caused them to eat more. As Beecher *et al.* (2006:279) mentions, rather than allowing an obese child to drink sugar-sweetened drinks, they should be encouraged to drink low fat milk and lots of water. The human body actually needs and uses some elements contained in water. The researcher found in this remark that respondents had awareness about what they should be eating and drinking with regards to their diet, but for specific reasons chose to do the opposite.

The discussion of the respondents’ weight problems seemed to give rise to an increased awareness of their weight and eating habits at a deeper level, as was found with some of the responses. One respondent mentioned that, “I believe I eat too much over all and this leads me to persistently eat even though I feel full”. Another respondent pointed out, “… I feel I could have done something before it got to this point. I could have not eaten the extra piece …, not eaten the ice-cream, and especially eaten less, only until I felt full”.

From the empirical findings it seems clear that a child’s diet and eating habits did contribute to obesity as was previously mentioned in 2.2.3. It was further clear that the respondents were knowledgeable with regards to what it required to change their eating habits. Examples of this include distinguishing between eating when hungry versus eating when bored, making healthier food choices, not eating too many sweets and sugary foods. However this was not enough for them to eat less, change their diet and consequently lose weight successfully.

3.2.2 Emotional Origin

According to the empirical findings there seems to be a link between emotions and overeating, which in the respondents' case led to obesity. All respondents mentioned that they ate more:

- *When at home, due to boredom:* One respondent mentioned that: "… when I get home in the afternoon and my work is finished, I sit in front of the TV and before I know it, I'm eating something". Another respondent added that, "… eating when I have nothing to do, makes me feel that I'm actually doing something and then I don't feel so bored".

  Food indulgence was found to be habitual in many respondents due to boredom, and not knowing what to do with their time. This aspect is confirmed by Beecher *et al.* (2006:22) when they mention that watching television for the whole day is boring and therefore children look for anything else to do whilst watching television. Eating is by far the easiest activity to partake in when an individuals mind is numb, as in the case of watching television.

- *Due to being unhappy with themselves about their weight:* In this regard one respondent mentioned, "I am angry about my weight, and very sad and unhappy about it. When I feel like this I eat even more". Another respondent said, "I feel depressed about my weight, and then I think that as I already look this way, could it hurt to just keep on eating".

- *Due to feeling frustrated and sad for not being able to lose weight:* The following two remarks by respondents summarise these feelings of frustration and sadness. One respondent mentioned that: "I try losing weight and nothing works, before I can help myself I rather just eat again, at least eating is something I can do well". Another respondent remarked that: "… I exercise and my weight doesn't change. I sometimes feel that my weight is something I cannot escape, even that maybe I am meant to look this way. When I feel like this I just go straight back to eating".

> One respondent remarked that exercising did help her lose weight, but as soon as she loses weight she immediately thinks: "... now I can have something sweet just to congratulate myself on my weight loss. I then have a chocolate or something sweet, so in actual fact I am not only losing weight, I am just gaining it back straight away".

The literature reviewed supports the above mentioned research findings. Dalton (2004:84), for instance, mentions that as children get older and move into adolescence, they may begin to turn to food for reasons having more to do with psychological needs than with their appetite. The obese person also eats in response to emotional distress and therefore according to Draper (2004) gain weight, as food then turns into their emotional defence against their distress. Butor (2004:128) states that from clinical experience it is known that obese children eat even when they are not hungry, due to them feeling emotionally upset, stressed or frustrated. Eating and digestion may produce feelings of physical satisfaction which balance the negative feelings. In this regard one respondent stated that: "I feel dumb, hopeless, sad and quite depressed about my weight, however when I eat I feel satisfied and forget about the feelings I had".

3.2.3 Physical Origin

For the purpose of this study, the focus of the physical origin of obesity is placed on the inactivity of the obese child. Research findings indicated that respondents exercised less because of difficulty using their muscles and also experiencing that their body movements were limited. Obesity therefore seems to play a major role in how active respondents were on a physical level as well as with the fact that they on a physically level had difficulty in keeping up with peers. In this regard Gunther (2004:145) mentions associations between obesity in children and specific deformities of feet, knee and hip joints. He is therefore of the opinion that, considering the adverse effects of elevated body weight on the musculoskeletal system, increased efforts must be given to lower the prevalence rates of overweight and obesity in children, adolescents and adults.

Respondents all felt that on a physical level they could not measure up to skinny or "normal-weight people" (as they refer to it), and what they were able to do with regards to exercise and sport. One respondent clarifies this by mentioning "… I would love to be able to partake in the sports my friends do, but I just can't. I am too big and clumsy for it, and instead of being laughed at, I rather just don't do it". Another respondent states that, "I love sport and I love watching sport, I just know that I can't participate at the same level as my friends, and then I rather just don't participate. Have you ever seen a fat kid winning a 50 or 100 meter race …"

Little or no exercise consequently led to respondents being inactive which can also lead to obesity. This is confirmed by Sullivan (2004:63) when she states that: "… physical fitness is a vital part of maintaining weight and preventing obesity. If your child is not getting enough exercise, there is no doubt that their weight will be affected". Beecher *et al*. (2006:22) also indicates that the tell-tale sign of an inactive lifestyle is sitting around doing nothing, and that this can lead to weight gain due to physical activity being lowered (Tauber & Jouret, 2004:91).

In this regard a respondent mentioned, "… I rather just watch sport on TV and dream that it is me partaking and winning. I will never be able to do it in real life, but at least in my dreams I can be the winner".

Research findings revealed a vicious cycle with regard to the link between exercise and obesity. On the one side respondents were inactive due to them being obese; and on the other, they were obese because of a lack of physical activity. The respondents' feedback link with the viewpoint of Beecher *et al*. (2006:21) in that if an obese child sees other children playing a game that they can't partake in, it might just be that they feel like the odd one out, even though they might want to join them. This, in turn, may lead to the obese children consoling themselves with a snack.

3.3 THEME 2: ASPECTS OF DEVELOPMENT INFLUENCED BY OBESITY

As children develop through different stages of their lives; they reach and attain certain developmental goals which allow them to move along with their development. In Meyer and Viljoen (2002:200), Erikson defines "school age" as the

developmental period ranging from ages six to twelve. In this stage, children learn to master industry (*acquiring necessary skills needed to function in society)* and gain competence. Competence being a sense of proficiency, which if not reached, leads to inferiority.

Although middle childhood is a stage of relative calmness in respect of physical development, other developments such as cognitive, social, emotional and self-concept, however, are of importance (refer to 2.3.1). According to Beecher *et al.* (226:55), children in middle childhood are still discovering who they are, what they are capable of and how they view themselves. Problems during the formative years can affect the way children feel about themselves for the rest of their lives. From the empirical findings it seems as if the following aspects of the respondent's development are influenced by their experience of obesity.

3.3.1 Self-development

Self-development will be discussed in terms of the following categories, namely self-concept, social self-concept, self-esteem as well as self-efficacy, as all of these relate to the self and its development.

3.3.1.1 Self-concept

According to Baron and Byrne (2003:162) the self-concept can be defined as an organised collection of beliefs and self-perceptions that an individual has of him or herself. It is a framework that determines how individuals process information about themselves, and how they protect their self-image from threatening information.

From the empirical findings it seemed as if the respondents had a negative self-concept development with regards to their weight. All respondents reflected on their own weight and consequently saw themselves as more obese than they actually were. The researcher gained this information by using a weight scale (refer to Addendum IV) ranging from underweight to obesity. The respondents had to place themselves where they thought they were situated with regards to their own weight.

Respondents also had to place themselves where they thought others saw them on the chart, as well as where they would like to be. The respondents alleged that others saw them as less obese than they saw themselves. Lastly, when placing themselves where they would like to be in weight range, all respondents chose a weight range which they identify as a healthy "normal" weight range for themselves. Respondents define this range as a weight they saw as neutral, consequently a weight range they define as being in the middle between skinny and obese.

3.3.1.2 Social Self-concept

Respondents in this research based their view of obesity mostly on comparisons with their peers regarding clothes size and how they thought clothes influenced being pretty and acceptable in peer relations. The clothes they could wear as well as the size of the clothes played a crucial role in the way they thought about themselves. As one respondent commented: "I am not supposed to look this way, I feel stupid and ugly. I am not one of the popular girls and no one even notices me".

Comparing themselves to their peers links with information regarding the social self-concept as referred to by Baron and Byrne (2003:166). They state that the social self is made up of a persons' collective identity, which involves interpersonal relationships as well as the aspects of identity that can be derived from membership to a larger group. The respondents' social self is therefore influenced by the comparisons they make between them and their peers. Obese children may often feel ostracized from their peers which causes a "dark cloud" in their lives as cited by Beecher *et al.* (2006:69). Feeling as if an individual cannot escape from this dark cloud may even cause the problem to deteriorate in that low self-esteem may become a friend of obesity, causing the obese child to turn to nurturing foods in times of distraught emotions and experiences.

As discussed in 2.3.4, cognitive development also affects the structure of the self-concept and hence the changing content of self-concept is a product of both cognitive capacities and feedback from others. Cognitively it seems as if respondents had a clouded vision in relation to how obese they thought they were.

This thought pattern influenced the way they thought about themselves when they, for example, mention that "… I am not pretty" and "… I am stupid in comparison to the others". Research also showed that respondents felt they had to change their personality at times to be more acceptable to others, and this led to them feeling that they had to be two different people. Respondents therefore echoed a feeling that the original "me" was not good enough. In this regard one respondent mentioned that:

> "I feel I have to be someone else to be more acceptable and to fit in. I have to constantly change, change my personality, how I dress and how I act to fit in with friends and people that I hang out with. In the beginning I act like others and later become who I really am, but changing is not easy. People get to know someone else before they begin to get to know me. I have to be someone that I am not. I know that if I change to someone else, I loose a bit of myself. Losing a bit of myself makes me feel that it is so unnecessary because I know I don't have to do it, but I think I have to".

3.3.1.3 Self-esteem

According to Harter (in Muris, 2007:112), the development and maintenance of self-esteem is influenced by two factors, namely perceived competence in areas of performance for instance in athletics, school, social relationships and physical appearance. The higher children judge their abilities in these areas, the higher their self-esteem. The second is that of social support, where self-esteem is boosted by approval and support of others. This links with Erikson's viewpoint about this developmental period, and how important it is to master the industry by gaining competence (refer to 1.7.1).

In this research study empirical findings demonstrated that respondents had lower self-esteem and these findings can be verified with a 2000 National Longitudinal Survey of Youth (Dalton, 2004:41) that reported lower self-esteem in obese youth. In this regard respondents cited, "… I am not accepted as other children are at school, I am not popular so they don't even know I exist", also "I am just not able to

see myself as I see the other popular children. They are up there and I am down here, our lives will never meet". Another respondent mentioned that "… although people tell me I am pretty and special, I will never believe it. How can I? I do look in the mirror in the mornings".

According to Beecher *et al.* (2006:19), low self-esteem can be a major role player in obese children's view of themselves, consequently influencing their self-concept. Feeling like an outcast in a peer social setting leads to children not succeeding in the social settings, which in turn causes low self-esteem in many instances. Children can tolerate many things, but feeling different, looking different and moving different to their peers is a negative development for their self-esteem (Beecher *et al.*, 2006:19).

3.3.1.4 Self-efficacy

Self-efficacy as defined by Bandura (in Muris, 2007:114) is the perceived ability to produce a desired action, and consequently refers to competence that an individual has in his or her own abilities. Respondents' viewed their competence level as low with reference to their physical abilities (refer to 3.2.3). For example, one respondent mentioned "… I am not as good at sports as my friends and can't participate in the sports that they can". Respondents also viewed their competence as low with regards to their socialising abilities (refer to 3.3.1.2) in that they lack in being popular and being liked by popular peers. One ability that two of the respondents did mention as a positive remark had to do with their academic ability. One of the respondents mentioned that: "… I may not look good on the outside but there is nothing wrong with my brain. I am third in my class". Another respondent in this regard mentioned that "I give lots of attention to my schoolwork as that keeps me busy, and helps me not to eat so much when I am home. I feel it helps because I get high grade averages in most subjects".

3.3.2 Emotional Development

According to Sroufe (2000:xii-xiii) it is not possible to fully understand human development without understanding emotion. Emotional life draws upon perception, cognition and social experiences. Emotional development includes the appearance of specific affects, their changing appearance and eliciting conditions; as well as individual differences in developmental changes of emotional control and regulation. Finally it includes growth and understanding of the meaning of emotions in self and other and the rules concerning the expression and containment of emotions (Sroufe, 2000:xii-xiii).

Empirical findings showed that the emotional experiences respondents had, did at times lead to negative emotional development. Empirical findings further showed that the respondents experienced the following emotions with regards to being obese:

3.3.2.1 Feelings of Abnormality

From the empirical research it is clear that respondents felt that they were abnormal and different. Their feeling of being abnormal, however, was solely based on their view that they were treated differently by others, for instance their peers, parents and family. One respondent made the following remark with regards to this by commenting that:

> "… it feels different, abnormal and even weird. Abnormal in that people treat you differently because of your weight, even though they don't have to. I still have a heart and liver just as other people do. People treat you differently in for example, walking down the street they will say hello to your skinny friends first and then only to you. Maybe they think obese people should come last in the life-chain".

To further explain the respondents' feeling of being abnormal, another respondent mentioned that: "... when you make new friends they are weird towards you until they learn to know you better". Another respondent shares how she compares being

obese to being an alien by commenting that: “I have wondered many times why my obesity makes me feel like an alien, and maybe that aliens do exist because then I would be one of them”. As this is not an aspect that was mentioned in the literature consulted, the researcher is of opinion that obese children experience more than what popular literature discuss. As the researcher mentioned in 1.2.1.2, a great deal of literature have been produced on the topic of obesity, however the focus was on obesity as a global problem and not on the experiences that obese children endure.

3.3.2.2. Anger

Mandel and Anshel (2004), state that anger is a normal and healthy emotion felt by all people. When it gets out of control, however, it becomes destructive in children and can lead to difficulties with family, with peers, and with school performance. Anger can be caused by both internal and external events (Baron & Byrne, 2003:437-442). For example, children could become angry because they feel that their grades in school are not good enough (internal) or they could become angry because they were pushed by a sibling (external).

Emotions of anger amongst respondents were twofold in that respondents experienced anger firstly towards themselves (internal) and secondly towards others (external). Respondents feel anger towards themselves, given that they:

- don’t try harder to loose weight and therefore don’t succeed at weight loss;
- eat too much over all and
- eat too much junk food and sugary foods.

Respondents mainly deal with this anger by turning on themselves. Their internal dialogue (Stelter, 2009) reflects discussions based on feelings that “… I am the problem, there is something wrong with me,” or “… I am a failure and I am not good enough,” instead of separating themselves from the problem, which is their weight. In addition respondents also experienced anger towards others in that:

- They feel they are treated differently by peers that are not their friends (refer 3.3.2.1).

- They feel that their parents treat siblings different to them.
- They feel anger because of the judgements of others. In this regard one respondent mentioned that: “I get very angry when I feel that I am judged because of how I look”.
- They feel anger towards some teachers or coaches because they feel that they are purposely left out of certain activities or sports based on their weight.

Concerning this external anger, respondents mention that they mainly hold it all inside, rather than to show emotion about their feelings. A remark by one of the respondents explains how the respondent chose to deal with her anger towards others by mentioning that, “... sometimes I feel like I am going to explode because of the anger I feel towards the people that look down on me”. Another respondent commented that “… if I show my emotions they win because then they can see that they get to me”.

Research findings showed that respondents do not deal with all the emotions they experience and consequently emotional development may be hindered. As Clare (2000:12) mentions: releasing all negative thoughts, feelings and emotions are crucial for anyone in order to be able to realise their full potential. By holding on to these negative experiences, an individual is creating a limitation for him or herself. Obese children may create limitations for themselves by holding on to and not dealing with the emotions that they experience.

3.3.2.3 Sadness

Sadness was the emotion most recorded and talked about by all the respondents. Together with sadness, the feeling of unhappiness reigned in the respondents’ experience of being obese. Respondents mentioned feeling unhappy mainly due to circumstances in which they feel “different to others” and that they “… do not look or act the same as others”. One respondent noted: “I have this feeling of sadness that goes with me wherever I go. Feeling sad has almost become like a friend, it is mostly there, except when I am all alone and don’t have to look in the mirror”. The 2000 National Longitudinal Survey of children (in Dalton, 2004:41) also found that

obese children had increased rates of sadness and loneliness compared to normal-weight children. Reasons for the increased rates given in this survey were due to teasing and the embarrassment of the obese youth.

When respondents try to loose weight but don't succeed, there is also a high degree of reported sadness. Respondents also experience sadness when peers and people make remarks about their weight. Respondents state that peers tease them and don't include them in activities and socialising, for example parties. One respondent made the following comment with regards to being teased by peers: "… nothing feels worse than when peers tease me, and I already feel bad about myself. They won't know the pain that I already feel, but I can't explain it because I probably brought it on myself".

Another respondent refers to the degree of sadness that she experiences with regards to being obese by mentioning that, "… I try to be happy but it doesn't work. Sometimes I can fool others but deep in myself I know how sad I really am. I feel unhappy, sad and even depressed at times". As previously remarked in 2.2.3.5, Sullivan (2004:51-52) is of the opinion that feeling depressed influences obesity in that a person's self-image is affected during an episode of depression. Due to this, children may lose interest in taking care of themselves or may develop a poor body image. Overeating, comfort eating, destructive behaviours and apathy are common characteristics of depression. Gaining weight may therefore also be a negative outcome of a depressive episode.

3.3.2.4 Jealousy

The empirical findings have revealed that respondents experience jealousy towards other peers because they don't look like "the popular, normal, skinny people". It seems as if the respondents mostly experienced jealousy towards their friends when they are shopping for clothes. One respondent remarked that: "… I can't wear what I want but my friends can". Jealousy towards popular peers and friends were also experienced when peers didn't talk to the respondents because they (the

respondents) weren't popular. In this regard one respondent cited that "... when popular peers talk to my friends and not to me, I feel jealous".

Respondents also mention jealousy towards their peers who have the interest of boys. In this regard one respondent mentioned that "… boys don't like me or even look at me, they do however look at the skinny, popular girls". The respondents are therefore of the opinion that it is due to their unpopularity that they do not have interrelationships with the opposite gender. Beecher *et al.* (2006:67) states that as children start to reach adolescence the opposite sex becomes the main reason why they bother at all to show up at school. Watching peers become involved in relationships, making plans for the weekend and so forth can be emotionally devastating for the obese child when not asked to join. As peer relations become important at this developmental stage, it is important for children to reach competence in these relations, or inferiority may take place, as previously discussed with regards to Erikson's developmental theory (refer to 3.3).

Jealousy overall seems to have a negative effect and influence on how the respondents viewed themselves. The researcher supposes that this "negative viewing of themselves" could possibly lead to low self-esteem and consequently overeating.

3.3.2.5 Regret

According to Muller ([sa]) regret is a powerful emotion and it recognises the difference between the way things are, and how it might have been if a person had made a different choice. Clare (2000:17) furthermore defines regret as the "fear of having lost something worth keeping".

Wikipedia ([sa]) mentions regret of inaction, and this type of regret seems to be the case with respondents in this research project. Respondents mostly cited feelings of regret because they didn't succeed in weight loss or maintaining their weight. One respondent mentioned that: "I tried but gave up because it was too hard. Now I am sorry because it's just becoming harder. I wish I did something about it when I was

younger". Together with this, respondents in general seem to regret the fact that they have allowed the "weight to pile up" without putting more effort into trying to loose the weight.

With regards to the empirical findings, the researcher is of the belief that respondents experienced sincere feelings of regret, which consequently progressed to feelings of hopelessness.

3.3.2.6 Hopelessness

Individuals who suffer from hopelessness may become victims of their negative reasoning and as a result they wouldn't try out the possibilities that could have positive outcomes for their problems. Hopelessness, as defined by Macmillandictionary.com ([sa]), refers to a situation seeming unlikely to succeed or be improved. Two aspects, according to Sullivan (224:170), that can cause overwhelming feelings of hopelessness in some obese children, are social isolation and low self-esteem. In this research, respondents mentioned feelings which closely relate to hopelessness in social isolation (refer to 3.3.3.1) and low self-esteem (refer to 3.3.1.2). As stated in 3.3.2.3, when children lose hope that their lives will improve, they may well be on their way to depression. It also seems as if these feelings many times lead them not wanting to proceed in weight loss. In this regard one respondent commented that: "I just don't feel like fighting against it anymore, because nothing helps". The researcher is of the opinion that respondents could overcome hopelessness, feelings of not thinking that a situation will improve or that they will succeed in weight loss, by reaching self-love and self-acceptance.

Despite the feelings of hopelessness described by the respondents, there was a certain amount of resilience that the respondents portrayed. Resilience, as defined by thefreedictionary.com ([sa]), refers to the ability to recover quickly from illness, change, or misfortune. Resilience was found in respondents, as they mentioned "… I try to stay positive about my weight-loss struggle, and sometimes that gives me some hope". Another respondent also mentioned "... although I feel like giving up at

times and the situation seems hopeless, I don't want to give up and try to have some hope". This ability to recover was found in obese children.

3.3.3 Social Development

As stated by Damon (in Craig, 2000:1), there are two functions of social development. The first of these functions is socialisation, the process whereby individuals learn to establish and maintain relationships, become accepted members of society, get along with others and regulate their own behaviour. The second function is that of individuation which refers to the process of defining oneself as unique and distinct from others. Developing socially therefore means that individuals need to define themselves and then find a social network that will support, appreciate and recognise the individual's uniqueness. As Baron and Byrne (2003:358) cite, individuals' tendencies to conform to social norms stem in part from their desire to be liked and accepted by others. Consequently conformity to a group may stem from the fear of not being accepted in the social group.

According to Bagwell (2004:37), children's relationships with their peers and friends contribute to their social an emotional development. As stated by Pretorius (1998:131), children have social needs that can only be met through interaction and socialising with others during their developmental phases. Relations give way to future happiness, self-fulfilment and competence, an important concept in middle childhood.

Respondents mentioned the following emotions and experiences with regards to their obesity and its influence on their social fields:

- *Judged:* Respondents seem to feel that they are judged by others due to their weight. In this regard one respondent shared that "… we are all human beings with feelings and emotions. I am judged on how I look on the outside, but the real person is overlooked based on physical appearance". Another respondent remarked that "… I wish people would really look at me, look past

my weight and see that I am actually just like them, maybe just a bit bigger or rounder".

- *Rejected:* From the empirical findings it was evident that respondents did not want to be rejected based on how they look. In this regard one respondent commented that, "… I want to be who I am and accepted for that". Another respondent stated truthfully that, "I am not going to change because you reject me; I want to change because you love me".

- *Humiliated:* Respondents feel that weight is just a number. As one respondent cited "... my weight is just a number and should not be measured in order to allow others to judge or humiliate me". Respondents measure themselves mainly against their peers, in terms of their weight and clothing size.

- *Unfairly treated*: Respondents lastly mentioned that they would appreciate a fair chance in all aspects of their lives and hoped that others would allow this. They felt unfairly treated and that they were not given a fair chance.

In light of the fact that interaction in social groups is of importance for social development, the researcher believes it important to mention how the respondents experienced the influence their weight had on their social interactions in the groups. The following social groups, namely friends and family, came to light during the empirical research and will subsequently be discussed in the area of social development.

3.3.3.1 Friendship

Commencing in childhood, most children start to establish casual friendships with peers who share common interests. Baron and Byrne (2003:311) point out that people in general have a biological need to establish relationships, however many find it difficult to achieve that goal. The result of this is loneliness, an emotional and cognitive reaction to having fewer and less satisfying relationships than an individual

desires. The consequences of loneliness may include spending leisure time in solidarity and feeling left out. Loneliness accompanied by negative emotions may include feelings of depression, anxiety, pessimism, self-blame and shyness.

The research findings showed that respondents experience their friendships to be influenced due to their obesity. The following was reported in this regard:

- Respondents felt that they could not partake in certain social activities and consequently this led to them not being part of all the social activities their friends participated in. A respondent mentioned that: “I wish sometimes that I could just do everything my friends did, or that I could have more confidence to be able to do things my friends do. I don’t want to go to swimming parties, or dances at school, because I just don’t look like them, and can’t dress the way they do”.

- Respondents experienced that it was more difficult to form new friendships. One respondent made the following comment in this regard: “… when I meet new peers, it feels as if these peers feel embarrassed to have me as a friend”.

- Respondents further mentioned that they did not fit in well with the popular children at school. The popular children seemed to not mingle with the respondents who participated in the study. One respondent mentioned that: “... they (*the popular children)* don’t even talk to me, they do talk about me though, and laugh behind my back, but they will never lower themselves to talk to me”.

- Respondents felt that people didn’t see them for who they are, and that they are being judged by people who do not really know them.

- Respondents further felt that their peers didn’t like them, that they were seen as worthless and also that their peers looked down on them and teased them.

- Respondents also experienced feelings of not being good enough. One respondent mentioned feelings of "… not good enough being who I am" when in the company of other peers that weren't her friends. As Feldman ([sa]) mentions, children begin to compare themselves with others to determine the value of their own personal accomplishments. Generally, school-aged children compare themselves to others who are similar to them along certain dimensions. Respondents mostly compared themselves to their peers in order to value themselves. This, however, seems to have a negative impact on the respondent's self-concept and self-esteem as they experienced emotions such as anger, sadness or jealousy (refer to 3.3.2).

Sullivan also (2004:170) found that obese children had smaller social networks than non-obese peers. They also seem to be more prone to bullying and social withdrawal.

- Bullying, according to Beecher *et al.* (2006:58), is a form of abuse. Overt bullying includes physical or verbal abuse or other physical acts of intimidation whereas relational bullying involves shutting the victim out of social groups and/or spreading rumours about the child. These authors further mention that obese children may often feel isolated from their peers who, as studies have shown, perceive them to be less intelligent, lazy and less hygienic. Relational bullying, in other words, takes the form of a passive aggressive situation in which the child is left out of the group and feels isolated. It is not as obvious as the other form of bullying, but every bit as damaging to the self-esteem of the obese child (Beecher *et al.,* 2006:58).

  Baron and Byrne (2003:458), on the other hand, define bullying as a pattern of behaviour in which one individual is chosen by one or more others as the target of repeated aggression. Victims of bullying seem to be less effective in dealing with stress and may respond to the stress with aggressiveness or by engaging in self-destructive behaviour such as overeating. According to Sullivan (2004:171), a study published in Paediatrics in 2002, found that the social and psychological ramifications induced by the bullying-victimisation

process may hinder the social development of the obese child. This is because children are reliant on peers for social support, identity building and self-esteem.

Bullying perpetuates weight problems in that it isolates the obese child and consequently the only things left to do is watching television and eating. In the research relational bullying did take place in the form of isolation and judgement by peers. Respondents mentioned being ignored, treated differently, judged and teased by fellow peers, which led to feelings of shame, embarrassment and low self-esteem.

Respondents did, however, also state that they had a small amount of true friends and that these friendships were solid. Respondents remarked that in their solid friendships they not only felt safe but they also felt that they could be who they really were. One respondent mentioned that "... when I am with my close friends, I feel accepted, almost normal. I don't feel judged by them, but rather I judge myself, as I am not like them". Bagwell (2004:38) cites that friendships serve at least three functions, namely that they are the contexts for the acquisition of social and emotional skills and competencies. Also, friends are emotional and cognitive resources for one another, providing validation of self-worth. Finally that friendship may serve as precursors to future relationships in adolescence and adulthood. The friendships of the respondents did consist of the above-mentioned functions and therefore respondents experienced these friendships as positive.

Bagwell (2004:38) furthermore mentions that there is convincing empirical evidence to support the assumption that friendship and peer acceptance contribute uniquely to positive social and emotional adjustment, therefore having more mutual friends and low peer rejection are independently related to a more positive self-concept. In the empirical findings of this study it was, however, evident that being accepted by peers was difficult for the respondents. Questions can therefore arise regarding how positive the social and emotional adjustment of the obese child is.

3.3.3.2 Family

Beecher *et al.* (2006:73) cites that "… family is the first group setting in which people explore who they are; and no matter how old they get, they fall into the same roles they played as children". Huston and Ripke (2006:10) also state that at the centre of children's worlds, the family remains the core. Cognitive as well as emotional support from the family matters for the child in middle childhood. According to Beecher *et al*. (2006:70), researchers have found that obese children who had unconditional support at home were happier than obese children who did not have this type of support. Children, whose families picked on them for being obese, were the ones who had the lowest self-esteem. Dalton (2004:61) mentions that to understand an obese child, it should, however, be remembered that each of them (the obese children) accumulated their extra weight while living in a family who wittingly or unwittingly, encouraged overeating or inactivity.

Although the family systems of the respondents are a support structure to them, there were certain experiences that the respondents had with regards to their family interactions which they felt were due to their weight. Respondents mentioned that members of the family seemed to treat them differently, because of their weight (refer to 3.3.2.2). A respondent cited: "They treat me differently, for example if they buy presents I won't get chocolates. It seems they always make an exception for me because of my weight and it makes me feel bad, even like an outcast". Another said: "I feel sad when I am treated different to my sibling, as they complain about my weight but then they buy my sister chocolates". Beecher *et al.* (2006:72-73) mentions that buying treats for skinny siblings and hiding it from the obese child causes more problems. It makes the obese child feel more of an outcast and although parents are supportive in every other way, making this differentiation between children can have an effect on the way obese children view their place in the family.

Respondents also experienced that their family always have to make exceptions for them because of their weight. A respondent remarked "… we do not eat out as often as before, so they are changing the eating habits of the whole family to consider me".

Respondents did not just have certain experience with regards to the interactions in their families but they also seem to have conflicting experiences with regards to family relationships. A respondent for instance mentioned "… I am tired of hearing about my weight all the time". Another mentioned that: "... my relationships with my parents are influenced because things are said about my weight a lot, and I am not really listening to them anymore. When they talk to me about something I don't want them to talk to me about, it's sort of negative and I get angry at them". Another respondent mentioned feeling as if "… everyone else gets along better with each other than they do with me".

On the other hand respondents still reported having good relationships with their parents by mentioning that they do get along well with their parents when their weight is not brought up. A respondent remarked: "I love my parents very much, and I know they love me". Another respondent mentioned "… my parents are my best friends and even though I don't get along with my parents at times, we still have a good relationship" and lastly a respondent revealed that: "… mostly I feel my parents accept me and love me for who I am".

From the empirical findings it seems as if friendships as well as family relations are influenced by the respondents' obesity. It seems clear that many underlying issues with regards to weight are not dealt with in the family. The researcher is of opinion that, for example, ignoring the problem, or wrongly dealing with it, such as treating siblings differently or only complaining about the child's weight, may cause problems in future.

3.3.4 Cognitive Development

According to Huston and Ripke (2006:9) children between the ages of 5 and 12 develop new cognitive skills that allow them to think more flexibly and logically and also allow them to partake in self-reflection. In light of the fact that Erikson (refer to 1.5.1) characterised this stage as "industry", the attention is directed at gaining socially valued competencies and learning how to co-operate with peers and adults. Huston and Ripke (2006:9) state that cognitive changes are linked to the

interactions of children and their physical and social environment. The cognitive changes that take place in the development of children are an important part of development. As mentioned in 2.3.4.1, cognitive development also affects the structure of the self-concept and is of importance to the development of the obese child.

Zilmer and Spiers (2001:235) mention that in the age group 7 to 12 years, concrete operations take place in the brain and thoughts. Children begin to think logically, however it is mostly centred on the here and now. This may have a direct influence on the obese child in that focussing on the here and now may lead to focussing on their weight at hand and not seeing the possible future outcomes. Examples of this might include them not realising that their weight will not influence how successful they will be in future, or that their weight is not the most important aspect of them. Evidence that children begin to think more logically, could be seen in this study as one respondent pointed out that, “I know something needs to be done otherwise I will become more obese as I grow older”. Respondents also felt that the decisions they made were influenced by their weight, as they would purposely have to choose different things than others would. A respondent for example remarked that, “I rather wear pants than a skirt,” or “… I try to eat a salad instead of a burger”.

Respondents in this research all acknowledged that as they became older their weight became a bigger issue, as they realised that, as one respondent mentioned “… I am different to others”. The researcher is of opinion that this is due to the cognitive change of self-reflection becoming part of middle childhood. Partaking in social activities and social groups heightened this realisation that they were different, as they compared themselves to their peers. After a process of asking the respondents to think about themselves and forget their weight, in order to focus on positive traits, the researcher found that respondents could name but a few good characteristics about themselves in general, and this supports the view of the researcher that being obese possibly leads the child to finding the problem in themselves (refer to 3.3.2.2) and not seeing their weight as the problem.

As respondents mainly mentioned changes with regards to their self-reflection and decision-making during their cognitive development, the researcher is of opinion that

changing the cognitive message of the obese child may lead to changes in the self-concept. And consequently the researcher considers that reinforcing positive cognitive messages will help the obese child to develop a more positive self-concept.

3.3.5 Physical Development

According to Louw *et al.* (1998:322), physical development in middle childhood is characterised by rapid growth in arms and legs in comparison to the body. There is, however, a slower and more gradual growth rate during this period than in comparison with early childhood and adolescence. During this phase the brain reaches adult size, which gives a good indication to why cognitive changes occur (Louw *et al.,* 1998:322-323). Not only do obese children deal with emotional and social issues, they are also at risk for developing serious, high risk ailments as mentioned in Beecher *et al.* (2006:36). Physical development will be discussed in terms of sport, as this is the only aspect that the respondents mentioned with regards to physical development.

3.3.5.1 Sport

Chiarelli, Blasetti and Verrotti (2004:112) state that physical activity is likely to protect individuals from developing obesity. Chiarelli *et al.* (2004:120) mention that the type of exercise should be chosen carefully as it is crucial for the real resolution of the obesity. It must be chosen for a particular situation and should be slowly progressive. The most recommended exercise for the obese child is swimming, because it involves almost all of the muscle groups.

Respondents were all of view that physically it was more difficult for them to partake in sports. Respondents felt restricted in terms of what kind of sport they could participate in. This feeling of restriction had origins in two categories. Firstly respondents felt restricted by coaches, in what coaches thought they could do, could not do and allowed them to do, as this had a direct impact on what respondents participated in. Secondly respondents felt restricted by themselves, as

they knew their body form and what they were capable of participating in. One respondent mentioned:

> "I am overlooked by coaches when they pick teams, I think that they don't believe I could possibly make a good player or athlete and consequently they don't choose me. They may be right, but I just wish they would at least give me a chance. Maybe if someone gave me a chance, I could realise for myself that maybe I can't do this or that … right now, however, I just have to believe it because of how other people treat me".

Respondents mentioned that problems with their joints also did not allow for them to partake in all the sports their friends could. Having problems with their joints, according to Beecher *et al.* (2006:41), is a common problem amongst obese children as they bear extra weight on their joints.

All respondents did, however, participate in one sport that fell outside of school curriculum sport, such as karate and horse riding. It was interesting to note that respondents found it easier to participate in sports in which they could be themselves, and not worry about being teased by school peers about their weight. One respondent mentioned that: "… I love horse riding; I feel free and don't have to look over my shoulder like at school, for who is laughing at me. Horse riding allows me to be me, without having to be in competition as at school". Another respondent mentioned that "… in karate my size does not matter and may even count for me, as long as I am fit and conquering stages, my weight does not matter to anyone". According to Louw *et al.* (1998:326) children in middle childhood who can run fast or play some school sport well are usually popular amongst their friends. Usually this popularity can enhance the self-esteem of these children. Obese children, however, hardly participate in school sports and therefore their self-esteem is not enhanced as other children's are. The researcher, therefore, draws a conclusion that no matter what an individual weighs; success can still be achieved on the sporting front, if the right sport for an individual is found.

As Van Heerden mentioned (refer to 1.2.1.2), the question should be asked with regards to how obese children see their obesity, as all children do not regard their

obesity as a negative event. Most of the respondents' experiences in the study could be described as negative, although at times they seemed to portray an accepting attitude.

3.5 CONCLUSION

The empirical findings indicate that obese children experience a wide range of influences in all spheres of their development. Their experiences can be found mainly in the emotional aspects of their existence. The respondents gave a thorough account of their emotions and experiences. Obese children face many challenges as found in this research, and it will aid society to give more attention to these children and assist in their needs as well. As this epidemic of obesity is reaching levels of despair, all parties involved in an obese child's life have to participate in alleviating this problem. A thorough summary with regards to the empirical findings and research conclusions of this chapter will be discussed in Chapter 4.

CHAPTER 4

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The empirical findings presented in Chapter 3 have shown how children in middle childhood experience their obesity. The findings also showed which aspects of the obese child's life are influenced by their experience of obesity. The aim of this chapter is to revisit the proposed aim and objectives of the study and to establish whether these were met in such a way that the research question was adequately answered. The researcher will also provide conclusions and recommendations on the research findings and make suggestions for future research.

4.2 AIM OF THE RESEARCH STUDY

The broad aim of the research study was to conduct applied research in order to explore and describe children in middle childhood's experience of their obesity.

The aim of the study was met by carrying out the following procedures: The researcher conducted a literature review in order to form a conceptual framework for the study. From the knowledge base that was created through the conceptual framework, the researcher formulated questions that was used in a semi-structured interview schedule (refer to Addendum II) with five respondents. The questions were formulated in such a way that they explored children in middle childhood's experience of their obesity. Thereafter data from the interviews were analysed and themes were identified. The themes were explored in relation to literature and were discussed in Chapter 3.

4.3 OBJECTIVES OF THE STUDY

The researcher defined four key objectives for the research in order to meet the overall aim of the study, namely:

- To conduct a literature review in order to form a conceptual framework of obesity in middle childhood.

The researcher did a thorough literature review to form a conceptual framework of obesity in middle childhood. This information is set out in Chapters 1 and 2, and consequently this objective was met.

- To conduct an empirical study by collecting data through the use of semi-structured interviews in order to explore the experience children in middle childhood have of their obesity.

The researcher recruited 5 respondents through purposive, non probability sampling. The criteria that the respondents had to meet in order to partake in the study, was that they had to be obese or overweight, age eleven, any gender, Afrikaans or English speaking, reside in the East of Pretoria and, lastly, had to be willing to participate and feel comfortable about participation. Data was collected by means of a semi-structured interview schedule (refer to Addendum II) and field notes. The interviews were further audio recorded in order to allow for a fuller record than notes, and for the researcher to concentrate on the way the interview proceeded.

The main focus of the interview schedule was to give obese children the opportunity to describe the experiences of their obesity on all levels of their development, and also to gain an understanding into the way obese children viewed themselves.

- To analyse and verify the collected data with literature in order to describe the children's experiences.

The researcher used Creswell's analytical spiral, as discussed in 1.5.4, to analyse data. The researcher conducted a literature control in order to verify the data gained from the interviews, as set out in Chapter 3. The main themes, sub themes and

categories that were identified, can be found in Table 4.1 below. This objective was, consequently, achieved.

THEME	SUB-THEMES	CATEGORIES
THEME 1: EXPERIENCE ON THE ORIGIN OF OBESITY A recollection of reasons that in the respondents experience, led to their obesity.	• Respondent's diet as origin • Emotional origin • Physical origin	
THEME 2: ASPECTS OF DEVELOPMENT INFLUENCED BY OBESITY Respondents give detailed discussions on the experience of their obesity and how it influences all spheres of their development.	• Self-development • Emotional development • Cognitive development • Social development • Physical development	Self-concept Social self-concept Self-esteem Self-efficacy Feelings of abnormality Anger Sadness Jealousy Regret Hopelessness Friendship Family Sport

TABLE 4.1 DEFINING TWO 2 MAJOR THEMES, 8 SUBTHEMES AND CATEGORIES PRESENTED IN THE EMPIRICAL FINDINGS

- To draw conclusions on the completion of the aforementioned objectives and to make health professionals and families aware of the experiences that obese children in middle childhood undergo.

The fourth aim will be discussed in this chapter, where the researcher will draw conclusions and make recommendations based on the empirical findings.

The aims and objectives for this study were therefore successfully achieved.

4.4 RESEARCH QUESTION

Due to the research being qualitative, exploratory and descriptive in nature, the following research question was formulated: **How do children in middle childhood experience their obesity?**

The research question was answered through the processes of collecting empirical evidence and sourcing literature which supported the empirical findings. The researcher was able to identify the following experiences of the obese child through the research study: Firstly the respondent's experiences with regards to the origin of their obesity were found in 3 aspects, namely their diet, emotional factors and lack of physical activity. Respondents described that their diet and wrong eating habits contributed to their obesity, as well as different emotional aspects. For example frustration and sadness caused them to overindulge in food. Due to inactivity and difficulty partaking in sports, they also experienced their inactivity to be a cause of their obesity.

Respondents secondly discussed which aspects of their development were influenced by their obesity and the experiences that they have with regard to this. They mentioned experiences in their self, emotional, physical, social and physical development.

Respondents experienced that their self-development was impacted, in that their self-concept, social self-concept, self-esteem and self-efficacy were all influenced by their obesity. Respondents also mentioned the following emotional experiences with regards to being obese, namely feeling abnormal, sad, jealous, regretful and hopeless.

Respondents' social development was influenced by the experience of their obesity in that they reported feeling judged, humiliated, rejected, unfairly treated and not

being good enough. Cases of bullying were also reported. Respondents also discussed how their relationships in their friendships and family were influenced by their obesity.

With regard to their experiences they also mentioned that cognitive changes did take place regarding their decision making, logical thinking as well as their abilities of self-reflection now that they were older. Lastly the respondents' experiences with regards to their physical development were based on being able to participate in sport or not.

.

The researcher is of the opinion that the research has been successful in exploring and describing the experience of the obese children.

4.5 VALIDITY OF THE RESEARCH

The validity of the qualitative research was reached in that the four constructs, as defined and discussed in 1.5.4, were reached. Credibility through the study focussing on the experience of children in middle childhood of their obesity, and the research results are presented as being believed to be credible. Transferability to other settings was present due to the researcher using more than one case in order to enhance the usefulness of the study. The researcher was of opinion that the results that were collected are representative of the total population and will be applicable outside of the boundaries of this study, namely in obese children globally. In the study dependability was reached in that findings of the research may be relevant for a period of time, and then no more. It is based on the principle that individuals' social worlds are always in the process of being constructed. Lastly confirmability was reached. Given the specific focus by the researcher on understanding the selected population and its experiences through in-depth exploration, the researcher is of the opinion is that it is accurate to state that the results are objective and confirmable.

4.6 SUMMARY AND CONCLUSIONS

The researcher will present the summation and conclusions in a way that clearly states what the experiences of obese children were.

4.6.1 The Experience on the Origin of Obesity

The respondents all stated that their wrong eating habits were the main cause of their obesity. They furthermore mentioned that their obesity also had an emotional origin, in that they used food to satisfy a deeper emotional need. Empirical findings also showed that the respondents experienced that they were physically more inactive than their peers, and this in turn led to them not losing weight or being fit and healthy. Empirical findings revealed that respondents found themselves in a vicious cycle, a cycle in which their obesity made it difficult for them to be active, whereas their inactivity again led to them not losing weight. The researcher concludes that obese children have an awareness regarding the origin of their obesity; however this knowledge does not lead to direct change.

4.6.2 Aspect of Development Influenced By Obesity

Empirical findings clearly illustrated that different developmental spheres were influenced by the respondents' obesity. The developmental spheres were as follows:

- Self-development

The empirical findings highlighted that the respondents experienced themselves as bigger, larger and more obese than they thought others saw them. The respondents reflected a negative social self-concept in comparing themselves to their peers, as they were of the opinion that they were not as acceptable socially, due to their weight. The experience of the respondents also influenced their self-esteem, in that they did not perceive themselves as competent in their abilities.

- Emotional development

The empirical findings indicated that the respondents experienced a variety of emotions due to their obesity. Findings indicated feelings of abnormality, anger at themselves as well as others, sadness and unhappiness, jealousy towards their non-obese peers, regret and lastly hopelessness. These emotions were described in great detail by the respondents.

- Social development

Empirical findings showed that respondents experienced an influence on their social fields due to their obesity. Social interactions are of great importance for the social development of children in middle childhood. The researcher found in the research that respondents described their experiences with regards to the social sphere of their lives in the greatest of detail. Respondents stated that they felt judged and rejected and the findings further illustrated that respondents experienced the following with regards to friendships: They felt left out of social activities, had more difficulty in forming new friendships, peers teased them and they were looked down on by "popular peers". Some also mentioned being relationally bullied by peers and over all experienced feelings of "not-being-good-enough".

Empirical findings indicated that the family of the respondents also had an important role to play in their experiences. The respondents mentioned that they experienced that their families treated them differently than their siblings; they felt that they were always the ones for whom exceptions had to be made. Lastly findings illustrated that the respondents had conflicting experiences with regards to family relationships. Examples of these conflicting experiences are that relationships with their parents are influenced because things are constantly being said about their weight and that respondents felt that the rest of the family gets along better with each other than with them.

- Cognitive development

Empirical findings showed that respondents were aware that on a cognitive level their weight influenced their decision-making abilities, how they compared themselves to others and also reinforced their own negative feelings about

themselves. Findings suggested that the respondents would, for instance, make decisions based on their weight instead of on their primary need. They would, for example, want to wear a dress, but due to their weight, they always wear pants instead. Another example is that they would rather eat a hamburger but choose salad instead. Respondents mentioned that they would deny themselves that which they would have wanted, because of the perceptions that they have with regard to what others think of them.

- Physical development

Empirical findings indicated that respondents find it difficult to partake in sports. They also found themselves to be restricted by both the coaches and themselves with regards to what sports they could participate in. However, the findings indicated that respondents did participate in at least one sport that fell outside of the school curriculum sports. These are sports such as karate and horse riding. Respondents found it easier to participate in these sports due to the experience that they could be themselves and not worry about being teased by school peers about their weight.

Empirical findings illustrated that obese children experienced a vast amount of experiences in their self-development, emotional development, social development, cognitive development and physical development. The researcher concludes that obesity seems to impact children in a far more comprehensive manner. This problem, therefore, needs to be addressed in order to allow children in middle childhood the opportunity to achieve industry instead of inferiority.

4.7 RECOMMENDATIONS

In the researcher's view there is significant evidence to suggest that the experience of obese children cannot go ignored if the best interests of the children are to be protected. In light of the empirical findings and the literature review it becomes apparent that attention should be given to obesity among children, with regards to their experiences and the outcome that these experiences have on the lives of obese children. With regards to the research findings, the literature review and consultations with experts regarding the feasibility of this study, the researcher wants to make the following recommendations.

- Parents should not overlook their children's weight as "baby-fat"; they should seek professional help before the problem gets out of hand. As Van Heerden mentioned in 1.2.1.2, the curbing of obesity and overweight at a younger age is easier than when it becomes a problem extending into adolescence and adulthood and therefore more attention should be given to this problem while clients are still young.
- Parents and caregivers should work on raising the child's self-esteem and self-respect and improving their body image, so that they can withstand some of the abuse and cope with negative feelings associated with their weight.

- Due to the negative emotions that seem to be experienced by the obese child in middle childhood, attention should be given on how to deal with these emotions. How the emotions can be recognised, managed and dealt with should be of importance.

- Children should be educated in schools on emotional abuse, the different forms that it can take and the effect that it has on the abused. For example obese children are judged, teased and rejected by their peers. As judging, teasing and rejection all translate to relational bullying; children can be educated on the effects of bullying.

- With regard to family interaction, parents should nurture the obese child's psychological needs. They should not pick on these children and lower their self-esteem even further. Parents should always treat siblings the same as the obese child. Obese children's self-worth is already low due to comparing themselves to their peers; the obese child should not need to compare themselves against their own siblings.

- Families should deal with the phenomenon and not ignore it, as being open and honest about it can give the obese child a voice and teach them to not be ashamed of their problem.

- Exercise programs should be developed for schools in order to facilitate obese children's weight loss. These exercise programs should, however, be developed to such an extent that other children in the school can also participate in this.

- Schools should have dieticians in their employment, or work closely together with dieticians in order to be able to give advice to obese children and their parents regarding healthy eating habits and how to bridge from obesity to a healthier lifestyle.

- Prevention of obesity should start at government level, where the healthcare sector should run an awareness campaign regarding obesity among children and the outcomes and experiences of obesity in children. This can incorporate prevention strategies regarding obesity as well as aid in dealing with the problem once faced with it.

- The department of education should also become involved by giving workshops for teachers to inform them about childhood obesity as well as its outcomes on children and how to deal with the phenomenon.

- Communities should stand together and take action in order to force fast food outlets and restaurants in their communities to change their menus for children into healthier options.

- Positive cognitive messages should be reinforced in order to create the possibility for the obese child to develop a more positive self-concept.

4.8 FUTURE RESEARCH

The researcher is of opinion that the empirical findings of this study indicate that there is a need for further research. The following might be considered:

- How the obese child is influenced by keeping their emotions hidden away and how their lives are impacted by this emotional hideaway.

- Why obese children still choose to eat that which they know they shouldn't, even though they are aware of what is good to eat and what not.

- What is the role of the family concerning an obese child's weight problem? In other words, how can the family help to minimise the problem and support the obese child and what does the family do to encourage the obese child and discourage his/her weight problem.

- Design a study guide and notes with regards to emotional abuse among children, which can be used in schools during life orientation classes, in order to make children more aware of the outcome of their teasing, judging and bullying on other peers.

- Design an actual exercise program that can be utilised in schools during gym classes, not only for obese children but for all children.

- Research to what extent communities are aware of obesity amongst children and how much they really know about this phenomenon.

4.8 FINAL REMARK

The researcher is of opinion that the empirical findings have been successful in establishing how children in middle childhood experience their obesity. These experiences consequently lead to suffering for obese children in different spheres of their development. In light of the empirical findings the researcher is of the opinion that on a governmental level and in healthcare, school and parental sectors, obese children should be supported. The above parties should support obese children through taking personal responsibility for the increase of obesity amongst children and a willingness to put systems in place to help combat this ever-growing problem of childhood obesity. The researcher is furthermore of the opinion that the proposed ideas for future research should be further investigated and formalised in a bid to address the growing problem of childhood obesity.

BIBLIOGRAPHY

BOOKS CITED

Bagwell, C.L. 2004. Friendships, Peer Networks and Antisocial Behavior. In Kupersmidt, J.B. & Dodge, K.A. 2004. *Children's Peers Relations: From Development to Intervention.* Washington: American Psychological Association.

Baron, R.A. & Byrne, D. 2003. *Social Psychology. (10th ed).* Boston: A&B.

Beecher, M., Hagen, M. & Tessmer, K.A. 2006. *Conquering Childhood Obesity*. Indiana: Wiley.

Blom, H.J. Psychologist: Private Practice and Vista Clinic. 2007. Interview by author. [Transcript]. 11 January. Pretoria: Wingatepark.

Burniat, W., Cole, T., Lissau, I., & Poskitt, E. 2002. *Child and Adolescent Obesity*. United Kingdom: Cambridge University Press.

Butor, P.M. 2004. Some Psychological Viewpoints on Obesity. In Kiess, W., Marcus, C. & Wabitsch, M. 2004. *Obesity in Childhood and Adolescence*. Basel: Karger.

Caelers, D. 2005. *There is a Solution for Overweight Children*. *Pretoria News*, 26 April:10.

Caelers, D. 2006. SA catching up with US in Obesity Stakes. *Cape Argus*. June 26:4.

Chiarelli, F., Blasetti, A. & Verrotti, A. 2004. Physical Activity in Obese Children. In Kiess, W., Marcus, C. & Wabitsch, M. 2004. *Obesity in Childhood and Adolescence*. Basel: Karger.

Clare, S. 2000. *Releasing your Child's Potential: Empower your child to set and reach their own goals*. Oxford: Pathways.

Cole, T.J. & Rolland-Cachera, M.F. 2002. Measurement and Definition. In Burniat, W., Cole, T., Lissau, I., & Poskitt, E. 2002. *Child and Adolescent Obesity*. United Kingdom: Cambridge University Press.

Craig, W. 2000. *Childhood Social Development*. Massachusetts: Blackwell.

Dalton, S. 2004. *Our Overweight Children*. California: University of California.

Deckelbaum, R.J. & Williams, C.L. 2001. *Childhood Obesity: The Health Issue*. Obesity research: 9(4).

De Vos, A.S. 2002. Qualitative data analysis and Interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. 2002. *Research at Grass Roots for the Social Sciences and Human Science Professions.* Pretoria: Van Schaik.

De Vos, A.S. 2005. Qualitative data analysis and Interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. 2005. *Research at Grass Roots for the Social Sciences and Human Science Professions. (3rd ed).* Pretoria: Van Schaik.

De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. 2002. *Research at Grass Roots for the Social Sciences and Human Science Professions.* Pretoria: Van Schaik.

De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. 2005. *Research at Grass Roots for the Social Sciences and Human Science Professions. (3rd ed).* Pretoria: Van Schaik.

Eccles, J. 1999. The Development of Children ages 6 to 14. *The future of Children*, 9(2):30-44.

Fouché, C.B. 2005. Qualitative Research Designs. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. 2005. *Research at Grass Roots for the Social Sciences and Human Science Professions. (3rd ed).* Pretoria: Van Schaik.

Fouché, C.B. & De Vos, A.S. 2005. Problem formulation. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at Grass Roots for the Social Sciences and Human Science Professions. (*3rd ed). Pretoria: Van Schaik.

Fouché, C.B. & Delport, C.S.L. 2005. The Qualitative research report. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. 2005. *Research at Grass Roots for the Social Sciences and Human Science Professions. (3rd ed).* Pretoria: Van Schaik.

Galotti, K.M. 2004. *Cognitive Psychology: In and out of the Laboratory (3rd ed).* Belmont: Wadsworth/Thomson Learning.

Goedecke, J.H., Jennings, C.L. & Lambert, E.V. [sa]. *Obesity in South Africa. Chronic Diseases of Lifestyle in South Africa since 1995 – 2005*. UCT/MRC Research Unit for Exercise Science and Sport Medicine, Faculty of Health Sciences, University of Cape Town.

Gravetter, F.J. & Forzano, L.B. 2003. *Research methods for the Behavioural Sciences*. Belmont: Wadsworth/Thomson learning.

Greeff, M. 2005. Information collection: Interviewing. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. 2005. *Research at Grass Roots for the Social Sciences and Human Science Professions. (3rd ed).* Pretoria: Van Schaik.

Gunther, K.P. 2004. Musculoskeletal Consequences of Obesity in Youth. In Kiess, W., Marcus, C. & Wabitsch, M. 2004. *Obesity in Childhood and Adolescence*. Karger: Basel.

Hartup, W.W. 2000. The Company they Keep: Friendships and Their Developmental Significance. In Craig, W. 2000. *Childhood Social Development.* Massachusetts: Blackwell.

Hill, A.J. (2005). The psychosocial consequences of childhood obesity. *The Psychologist. 18*:280-283.

Hill, A.J. & Lissau, I. 2002. Psychosocial factors. In Burniat, W., Cole, T., Lissau, I., & Poskitt, E. 2002. *Child and Adolescent obesity.* Cambridge: Cambridge University Press.

Hume, T. 2000. *Women & Food: Exposing the relationship between women, food and depression.* Cape Town: Zebra.

Huston, A.C. & Ripke, N. 2006. Middle Childhood: Contexts of Development. In Huston, A.C. & Ripke, N. 2006. *Developmental Contexts in Middle Childhood*. New York: Cambridge University Press.

Kiess, W., Marcus, C. & Wabitsch, M. 2004. *Obesity in Childhood and Adolescence*. Basel: Karger.

Kruger, H.S., Puoane, T., Senekal, M., & Van der Merwe, M.T. 2005. *Obesity in South Africa: Challenges for Government and Health professionals.* Public Health Nutrition: 8(5).

Kupersmidt, J.B. & Dodge, K.A. 2004. *Children's Peers Relations: From Development to Intervention.* Washington: American Psychological Association.

Lafreniere, P.J. 2000. *Emotional Development: A Biosocial Perspective*. Belmont: Wadsworth.

Lincoln, Y.S. & Guba, E.G. 1985. Naturalistic enquiry. In Denzin, N.K. & Lincoln, Y.S. *Handbook of qualitative research*. Thousand Oaks: Sage.

Louw, D.A., Van Ede, D.M. & Ferns, I. 1998. Middle Childhood. In Louw, D.A., Van Ede, D.M., & Louw, A.E. 1998*. Human development*. (2nd ed). Pretoria: Kagiso.

Louw, D.A., Van Ede, D.M. & Louw, A.E. 1998*. Human development.* (2nd ed). Pretoria: Kagiso.

Mandel, J. & Anshel, D. 2004. Anger: Helping Children Cope with this Complex Emotion. *The Parent Letter*. 2(7).

Meyer, W.F. 1998. Basic concepts of Developmental Psychology. In Louw, D.A., Van Ede, D.M. & Louw, A.E. 1998*. Human development.* (2nd ed). Pretoria: Kagiso.

Meyer, W.F. & Van Ede, D.M. 1998. Theories of Development. In Louw, D.A., Van Ede, D.M. & Louw, A.E. 1998. *Human Development*. (2nd ed). Pretoria: Kagiso.

Meyer, W., Moore, C. & Viljoen, H. 2002. *Personology: From Individual to Ecosystem*. Sandown: Heinemann.

Meyer, W. & Viljoen, H. 2002. In Meyer, W., Moore, C. & Viljoen, H. *Personology: From Individual to Ecosystem*. Sandown: Heinemann.

Moran, R. 1999. Evaluation and treatment of Childhood Obesity. *Am Fam Physician*. 59(4):861-868; 871-873.

Muris, P. 2007. *Normal and Abnormal Fear and Anxiety in Children and Adolescents.* California: Elsevier.

Pretorius, J.W.M. 1998. *Sosiopedagogiek 2000*. Goodwood: Nasionale Boek-drukkery.

Rubin, A. & Babbie, E. 2001. *Research methods for Social Work. (4th ed)*. Belmont, CA: Wadsworth.

Rolland-Cachera, M.F. & Bellisle, F. 2002. Nutrition. In Burniat, W., Cole, T., Lissau, I. & Poskitt, E. 2002. *Child and Adolescent Obesity.* United Kingdom: Cambridge University Press.

Schutz, Y. & Maffeis, C. 2002. Physical Activity. In Burniat, W., Cole, T., Lissau, I., & Poskitt, E. 2002. *Child and Adolescent Obesity*. United Kingdom: Cambridge University Press.

Tauber, M & Jouret, B. 2004. Role of Environmental Factors in Childhood Obesity. In Kiess, W., Marcus, C. & Wabitsch, M. 2004. *Obesity in Childhood and Adolescence*. Basel: Karger.

Strydom, H. 2005. Information collection: Participant observation. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. 2005. *Research at Grass Roots for the Social Sciences and Human Science Professions.* (3rd ed). Pretoria: Van Schaik.

Strydom, H. & Delport, C.S.L. 2005. Sampling and Pilot study in Qualitative research. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. 2005. *Research at Grass Roots for the Social Sciences and Human Science Professions.* (3rd ed). Pretoria: Van Schaik.

Sroufe, L.A. 2000. Foreword. In Lafreniere, P.J. 2000. *Emotional Development: A Biosocial Perspective.* Belmont: Wadsworth.

Sullivan, K. 2004. *How to help your Overweight Child*. London: Rodale.

Van Heerden, W. Biokineticist: University of Pretoria High Performance Centre. 2007. Interview by author. [Transcript]. 12 January. Pretoria: Elarduspark.

Williams, M., Tutty, L.M. & Grinell, R.M. 1995. *Research in Social Work: an Introduction*. Itasca: Peacock.

Whitley, B.E. 2002. *Principles of Research in Behavioral Science*. New York: McGraw-Hill.

Yin, R.K. In Whitley, B.E. 2002. Principles *of Research in Behavioral Science*. New York: McGraw-Hill.

Zilmer, E.A. & Spiers, M.V. 2001. *Principles of Neuropsychology*. Belmont: Wadsworth.

Zwiauer, K.F.M., Caroli, M., Malecka-Tendera, E. & Poskitt, E.M.E. 2002. Clinical Features, Adverse Effects and Outcome. In Burniat, W., Cole, T., Lissau, I. & Poskitt, E. 2002. *Child and Adolescent Obesity*. United Kingdom: Cambridge University Press.

INTERNET SOURCES CITED

Brightfutures. *Middle childhood: Growth and Physical development.* [sa].
[O]. Available:
http://www.brightfutures.org/physicalactivity/mc/1.html
Accessed on 2008/04/16.

Costain, L. 2001. *Obesity facts.*
[O]. Available:
http://www.bbc.co.uk/health/healthy_living/your_weight/whatis_facts.shtml
Accessed on 2008/02/14.

DBS-STN Glossary. [sa].
[O]. Available:
www.dbs-stn.org/glossary4.asp
Accessed on 2007/03/03.

Dictionary.Net. [sa].
[O]. Available:
http://www.dictionary.net/subjective
Accessed on 2007/03/03.

Draper, D. 2004. *Your body revival: weight loss straight talk.*
[O]. Available:
http://www.davedraper.com/article-190-obesity.html
Accessed on 2007/04/06.

Emotional and social development. [sa].
[O]. Available:
http://www.psych.ku.edu/dennisk/CP333/Emotional_Mid_Child.htm
Accessed on 2008/03/03.

Encarta: Child development. [sa].
[O]. Available:
http://encarta.msn.com

Accessed 2008/02/15.

Feldman: Chapter 10 *Social and Personality development in Middle Childhood.* [sa].
[O]. Available:
http://wps.prenhall.com/hss_feldman_developmen_4/0,10405,1978908-,00.html
Accessed on 2007/03/03.

Heart and stroke foundation. [sa].
[O]. Available:
http://www.heartfoundation.co.za/childrens_corner/children.htm
Accessed on 2006/12/17.

Macmillandictionary.com. [sa].
[O]. Available:
http://www.macmillandictionary.com/dictionary/british/hopeless
Accessed 2009/11/05.

Many SA kids obese. [sa].
[O]. Available:
http://health.mweb.co.za/dietnfood/Eating_throughout_life/15-50-660,18609.asp
Accessed on 2006/12/17.

Muller, M.C. *The value of Regret.* [sa].
[O]. Available:
http://www.health.msn.com
Accessed on 2009/10/16.

Nathan Glossary. [sa].
[O]. Available:
www.nathan.com/ed/glossary/index.html
Accessed on 2006/12/17.

Neill, J. 2006. *Analysis of Professional Literature Class 6: Qualitative Research.*
[O]. Available:

http://wilderdom.com/OEcourses/PROFLIT/Class6Qualitative1.htm
Accessed on 2007/03/03.

Obesity: complications in kids. [sa].
[O]. Available:
http://health.mweb.co.za/dietnfood/Eating_throughout_life/15-50-660,33092.asp
Accessed on 2006/12/17.

Obesity epidemic in Africa. 2004.
[O]. Available:
http://www.globalnews.idf.org/2004/11/obesity_epidemi.html
Accessed on 2006/12/17.

Obesity: major health risk for kids. [sa].
[O]. Available:
http://health.mweb.co.za/dietnfood/Eating_throughout_life/15-50-660,38271.asp
Accessed on 2006/12/17.

Pesic, M. 2006. *Child Obesity and Depression.*
[O]. Available:
http://ezinearticles.com/?Child-Obesity-and-Depression&id=357327
Accessed on 2009/11/05.

Saunders, P. 2003.
[O]. Available:
http://www.cbsnews.com/stories/2003/08/11/earlyshow/health/main567737.shtml
Accessed on 2008/03/15.

Stelter, D. 2009. *Internal dialogue.*
[O]. Available:
http://ezinearticles.com/?internal-dialogue&id=2370935
Accessed on 2009/10/16.

Table to grave: Childhood obesity. 2005.

[O]. Available:
http://lang.dailybulletin.com/socal/tabletograve/info/causes.asp
Accessed on 2008/03/15.

Thefreedicionary.com. 2009.
[O]. Available:
http://www.thefreedictionary.com/resilience
2009/11/05.

Van der Merwe, T. 2006. *SA: Obesity Statistics.*
[O]. Available:
http://www.obesity-sasso.co.za/index.php?p=sa_obesity_statistics.php
Accessed on 2007/04/06.

Van der Heynden. 2006. *Qualitative research in inflammatory bowel disease.*
[O]. Available:
http://www.sciencedirect.com
Accessed on 2009//9/10.

Wikipedia. [sa].
[O]. Available:
www.wikipedia.org
Accessed on 2008/12/17.

ADDENDUM I

ADVERT PLACED IN ORDER TO FIND RESPONDENTS

11 Year old Respondents needed for Research regarding "Children's experience of Overweight and/or Obesity"

Moynene Cooke, an M.Diac. (Play Therapy) student, is currently busy with her Masters Degree thesis on the subject of children in middle childhoods' experience of their obesity.

Respondents need to meet the following criteria to partake in this study:

- Be obese or overweight;
- Age eleven;
- Any gender;
- Reside in the East of Pretoria and
- Be willing to participate and feel comfortable about participation.

Why this research study could positively impact your child:

Up to date literature has focussed on obesity and overweight and its possible causes. The literature could, however, not reflect on the experiences that children endure with regards to this problem. The goal of this research is to describe the obese child's personal experiences and consequently to inform parents, teachers as well as peers about the experiences that these children endure on a daily basis.

For further information please contact Moynene Cooke (number provided).

ADDENDUM II

INTERVIEW SCHEDULE

INTRODUCTION

- The researcher will explain the purpose of the interview as was described in the advert that was placed.
- Remind respondent of the researcher's ethical obligations.
- Remind respondent that the interview will be audio recorded to allow for final objections or concerns to be raised.
- Ask respondent to switch off cellular phones.
- Remind respondent that he/she has to speak clearly due to the interview being recorded.
- Remind respondent that there are no incorrect responses.
- Allow the respondent to ask any last questions that they may have with regard to the interview.
- Ask the respondent to sign the consent form before initiating the interview.

INTERVIEW QUESTIONS

- Question 1: Place yourself on the weight scale (refer to Addendum IV). Where did you place yourself, and what are the reasons for placing yourself there?

Goal: To explore where obese children see themselves in terms of their weight.

- Question 2: (a) How do you feel about your own weight and (b) how does this influence how you think and feel about yourself?

Goal: To explore obese children's experience of their own weight. Also to explore how these experiences influences what they think and feel about themselves (refer to Van Heerden in 1.2.1.2).

- Question 3: (Touches on question 2). Forget about your weight for a moment. How and what do think about yourself, if you cut your weight out of the picture?

Goal: To explore how obese children think about themselves, if their weight was not an issue.

- Question 4: Which aspects of your life are influenced by your weight? (Here the focus is absolutely on the experience. If they have difficulty, the researcher may choose to give an example or two.)

Goal: To explore obese children's experiences in detail. All aspects of their lives will be explored.

- Question 5: If we refer back to the weight scale (Addendum IV), where would you like to place yourself and why?

Goal: To explore where obese children would like to be in terms of their weight and how they think this would change things in their lives.

- Question 6: Who are the people in your life, whose opinion matters to you, and where do you think would they place you on the scale?

Goal: To give the researcher information on how the child thinks and experiences how others see them.

- Question 7: Do you think that your weight changes who you are? And what would you like to tell others about your weight?

Goal: The researcher would like to give the power back to the child, and discuss a more positive component in order to end the discussion.

ADDENDUM III

CONTRACTUAL AGREEMENT OF INFORMED CONSENT

I, _____ hereby give permission that my child _____ may participate in the research study “Children’s Experience of their Obesity”.

Please take note of the following (as discussed during this session) and discuss it with your child again after the interview session.

- Interview sessions that are recorded will only be used for my analysis purposes and will not be shown to any other persons without your child’s written consent.
- Your child’s name and personal details will not be disclosed in my thesis.
- All information discussed in this interview will be treated as confidential and will not be discussed with anyone else.
- If your child feels that the process of partaking in this interview raises any emotions that he/she feels they require professional help or assistance with, the researcher offers free follow-up therapy with a qualified individual.
- Your child has the freedom of choice to participate in the study and to withdraw at any stage during the study if they feel so.
- No deception will be used in this study as the aim and goal of the study has been disclosed from the placing of the advert.

Kind regards,
Moynene Cooke

Signed on this _____day of _____ 20___ at _____.

_____ _____

Parent Signature Child Signature

ADDENDUM IV

WEIGHT SCALE